MONEY TALKS

Tessa van Dijk

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Untangling the dynamics between banks, health insurers and healthcare organizations in the context of a regulated market

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# Money Talks

Untangling the dynamics between banks, health insurers and healthcare organizations in the context of a regulated market

# Wie betaalt, bepaalt

Het ontrafelen van de dynamiek tussen banken, zorgverzekeraars en zorgorganisaties in de context van een gereguleerde markt

## Thesis

to obtain the degree of Doctor from the
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by

Teuni Sara van Dijk
born in Soest, the Netherlands

Erasmus University Rotterdam

# Doctoral committee

| | |
|---|---|
| **Promotors:** | Prof.dr. R.T.J.M. Janssen<br>Prof.dr. W.K. van der Scheer |
| **Other members:** | Prof.dr. H.M. van de Bovenkamp<br>Prof.dr. P.P.T. Jeurissen<br>Prof.dr. J.K. Helderman |
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# Chapter I

## The financial arena of Dutch healthcare

2022

# NEWSPAPER

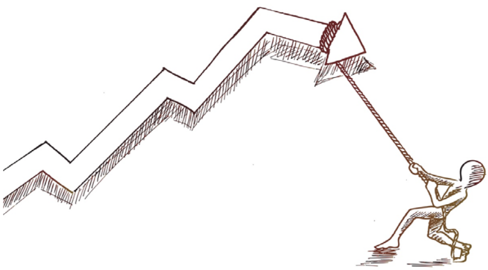
Healthcare

Skipr: March 10th, 2022

## Ikazia reports losses of €5.2 million and awaits judgment on additional support

In 2020, Ikazia Hospital suffered a loss of €5.2 million. Due to the absence of COVID-19 compensation, Ikazia no longer meets financial covenants set by the bank. However, the bank has granted an exemption until July 1st, 2022.

Although the hospital still adheres to the agreed-upon covenants with another bank, additional COVID-19 compensation for both 2020 and 2021 is required to remain within the bank's credit limits. Ikazia's discussions with banks and the largest health insurer indicate that they have confidence in the hospital and are prepared to offer support if necessary.



Skirp: August 22nd, 2022

## Ikazia faces crisis following significant loss and bank withdraws credit

Ikazia Hospital faces a crisis, as revealed in its annual report released this Monday. The hospital incurred a substantial loss of €8.5 million in 2021. The primary bank, ING Bank, has issued a warning of terminating the credit facility and a long-term loan amounting to €17.5 million by October 1st. "The current financial situation is concerning," expressed the hospital's board of directors. The hospital's accountant stated, "Ikazia is reliant on the banks' willingness to continue financing and on health insurers for temporal financing and contract adjustments."

Last month, the hospital presented a recovery plan to the banks and health insurers. However, the insurers deemed the plan insufficient and lacking clarity to address the challenges effectively. In response, the five largest health insurers have assured Ikazia's board of directors of financial support until at least October 1st. Ikazia is seeking additional financial assistance from both insurers and banks, along with announcing impeding cost-cutting measures.

2022 | **NEWSPAPER** | Healthcare

Skipr: September 9th, 2022

## Ikazia receives an additional three months by ING Bank to finalize a recovery plan

The primary bank, ING Bank, along with the five largest health insurers, has granted Ikazia Hospital an additional three months to finalize a recovery plan. ING Bank has opted to prolong the credit facilities until the year's end, a decision initially scheduled for determination by October 1st. A spokesperson cited that Ikazia "has taken the requisite steps for improvement and is collaboratively developing a sustainable plan with health insurers". Additionally, the health insurers express their interest in contributing to the recovery plan.

Skipr: December 8th, 2022

## Consensus reached regarding the bailout of Ikazia by banks and health insurers

Health insurers and banks have reached an agreement to rescue Ikazia Hospital, which has been on the verge of bankruptcy for several months. In an effort to bolster the hospital's financial stability, health insurers have agreed to provide Ikazia with increased reimbursements for the period between 2022 and 2024. At a cost of millions of euros, according to an ad-interim member of the executive board, "We also anticipate that the banks will be willing to extend current loans based on the recovery plan. We have been deeply concerned in recent months as bankruptcy seemed imminent. We witnessed a rapid decline in the bank balance. It was a very close call for Ikazia, but we have managed to avert disaster."

In the summer of 2022, several newspapers reported on the precarious financial situation of Ikazia Hospital in Rotterdam, the second largest city in the Netherlands. The hospital suffered substantial financial losses over 2020 and 2021 (€5.2 million and €8.5 million, respectively) due to unexpected lower COVID-19 compensation, high costs of sick leave and unfavorable contract agreements with health insurers. It soon became a hotly debated topic in the media and unrest grew among patients, local residents and staff. Particularly, because the hospital has a deep-rooted connection to the neighborhood with its small-scale and patient-centered approach. This local embeddedness traces back to the hospitals' foundation in the 1970s, when it was funded with contributions from local churches. Today, it can still count on support from surrounding religious communities. The hospital also serves an important societal role for other local residents as it is situated in one of Rotterdam's more vulnerable areas, with socio-economic challenges including unemployment, a lack of proper housing, safety concerns, income disparities and health inequalities. The hospital thus holds a special place in the hearts of many with its distinct identity and communal function within the immediate vicinity.

In late summer, the critical financial situation of Ikazia Hospital gained political attention when the Minister of Health received questions from concerned members of parliament who wanted the Minister to act and save the hospital. The Dutch healthcare system – with its emphasis on regulated competition – is organized in such a way, however, that only two parties are in a position to save the hospital and restore its financial stability: banks and health insurers. They are the main stakeholders of healthcare organizations in times of financial distress since banks provide capital and health insurers annually purchase care services. As the accountant of the hospital put it: *"Ikazia is depending on the willingness of banks to continue financing and on health insurers for temporal financing and the adjustments of contracts"*. Nevertheless, the involved bank threatened to stop financing within a couple of months, which would have resulted in an immediate bankruptcy of Ikazia Hospital, and health insurers indicated that they were unhappy with the hospital's proposed recovery plan. Banks and health insurers thus drove a hard bargain and executives of Ikazia Hospital faced a huge task; they needed to guarantee the survival of the hospital by convincing banks and health insurers of Ikazia's added value in the region and its capacity to transform into a financially sustainable organization. And so, during the summer, representatives of banks, health insurers and hospital executives were in constant deliberation while the hospital was on the verge of bankruptcy.

After the summer, the situation seemed completely changed. Banks and health insurers had promised to provide extra time and financial resources to the hospital and in December 2022, the board announced that the hospital was saved. Banks would continue their loans, health insurers would provide higher reimbursement rates, and the hospital appointed an interim-executive while agreeing to close a ward, scale back ICU capacity, cut costs and reduce sick leave. Despite the close call, it appears that all turned out well in the end.

We are however left with numerous questions. What had happened over the course of those months between banks, health insurers and executives? Why did banks and health insurers, seemingly unwilling to cooperate, change their mind? How did they find agreement? Why is a healthcare organization, such as Ikazia, so depending on banks and health insurers in the first place and are there any countervailing powers in place? The case additionally shows that not only the existence of Ikazia Hospital was at stake, but also the continuation of and access to care services in the wider region of Rotterdam. This raises questions on the far-reaching influence that financial parties have on the accessibility of healthcare services. These questions – and more specifically the dynamics between banks, health insurers and healthcare organizations and its consequences – are the focus of this thesis. Our aim is to understand the intricacies of the roles, dynamics, and relations between these actors as well as the shifting dependencies between them in an ever-changing institutional environment. A setting I will refer to as the *financial arena of Dutch healthcare*.

In this introductory chapter, I will first expand on the formal roles and responsibilities of banks, health insurers and healthcare organizations, and provide the (historical) context in which they have been operating. Next, I will introduce several theoretical lenses that will help to interpret the dynamics within the financial arena of Dutch healthcare. Then, I set out the methodological approaches used. And finally, I conclude with the outline of the remaining chapters of this thesis.

## Roles and responsibilities

The roles and responsibilities of Dutch banks, health insurers and healthcare organizations vis-à-vis one another can be best illustrated in the shape of a triangle[1] (Figure 1). Each of the vertices represents a key actor involved in the financial arena of Dutch healthcare, with the sides representing their mutual relationships. I will describe each of these key actors and their formal relations below.

The first relationship to address is between healthcare organizations and banks. Dutch healthcare organizations are private entities that serve a public goal, while remaining responsible for their own financial stability and real estate. To secure financial capital, Dutch healthcare organizations rely on banks for both long-term loans as well as short-term credit. Long-term loans are mainly used to finance real estate, renovations to buildings and facilities and to fund innovation projects (e.g., IT-services and medical devices). Real estate often serves as collateral for these long-term mortgage loans. Short-term credit is provided to healthcare organizations to increase liquidity and pay daily expenses, wages, and supplies (Box I provides additional information on the banks that operate in the Dutch healthcare sector). In return, healthcare organizations pay interest rates to banks. This financial construction is used in all types of care organizations: primary care, medical specialized care, mental healthcare, and long-term care (i.e., nursing care, home care, well-being, and disability care). Some healthcare organizations opt for a guarantee on their loans with the National Guarantee Fund for the Healthcare Sector. With a guarantee on loans, banks are able to provide lower interest rates to healthcare organizations (Box II provides an explanation of the Fund).

[1] Visualizing Dutch healthcare in the shape of a triangle is not uncommon. This triangle is an adaptation of another frequently used triangle that divides Dutch healthcare into three markets by linking health insurers, providers and patients: the health insurance market, the health purchasing market and the health delivery market (e.g., Cattel, 2021; Wammes et al., 2020; Ginneken et al., 2011).

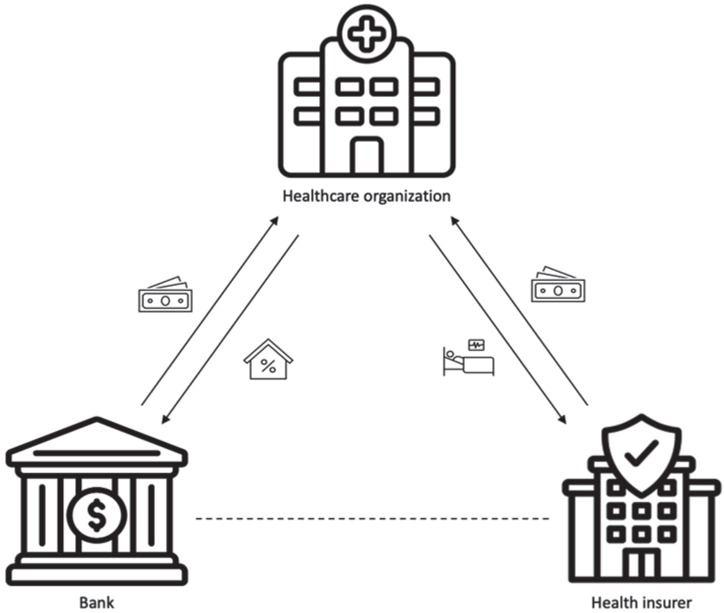



**Figure 1.** The financial arena of Dutch healthcare.

The next relationship involves the contractual agreements for reimbursement of care between health insurers and healthcare organizations. Each year, these actors negotiate over how much care they either need to purchase or deliver and against what costs. They additionally set requirements for the quality of care. Health insurers do so in the interest of their insured and are legally responsible for ensuring access to continued, timely and high-quality care. This legal obligation towards insured is referred to as "duty of care" (in Dutch: *zorgplicht*). Contracts between health insurers and healthcare organizations are often short-term (one-year) and either include a lump-sum or global ceiling as reimbursement method (Ruwaard, 2018). Health insurers are responsible for purchasing care that is covered by the basic health insurance package, encompassing medical specialized care, general practice services, curative mental healthcare for the duration of up to three years and district nursing care[2] (Kroneman et al., 2016). But the role of health insurers extends beyond just purchasing care. The explanatory memorandum of the *Health Insurance Act* states that health insurers are also assigned to reduce overall healthcare costs and act as national orchestrators of care (Kamerstukken II 2003/04; Noort et al., 2021). Therefore, health insurers play a vital and central role in the Dutch healthcare system (Box III provides additional information on Dutch health insurers).

The (dotted) line at the bottom of Figure 1 depicts the relationship between banks and health insurers. In everyday situations, there is no direct link between banks and health insurers. However, both parties are strongly dependent on each other through the agreements they establish with healthcare organizations. It is important for banks that healthcare organizations and health insurers close favorable contracts, so that healthcare organizations have a stable income and are able to (re)pay loans and interest in time. Similarly, health insurers find it important that banks provide capital to healthcare organizations, so that appropriate care facilities and buildings are available in which care can be delivered to their insured. In that way, health insurers can fulfill their legal "duty of care". In situations that the continuity of healthcare organizations is at stake, the link between banks and health insurers becomes more apparent – as we have seen in the case of Ikazia Hospital.

[2] Although not the scope of this research, it is important to know that other types of care are purchased by regional procurement offices or procured by municipalities. Regional procurement offices are responsible for long-term care, including mental healthcare services for durations exceeding three years, institutional care, disability care and personal and nursing care at home. Municipalities are responsible for child and youth care, domestic care, social support, protected living and day care (Kroneman et al., 2016; Westra et al., 2016; VWS, 2016). In practice, this means that a healthcare organization providing various types of care must navigate diverse purchasing partners and contracting principles (e.g., annual negotiations and public tenders). Consequently, this adds complexity to the financial governance of healthcare organizations.

**Box I. Dutch banks**

Only a few banks and health insurers are active in Dutch healthcare. Banks are either commercial banks (i.e., *ABN AMRO Group, ING Bank, Rabobank and Triodos Bank*) or public sector banks (i.e., *Bank Nederlandse Gemeenten* and *Nederlandse Waterschapsbank*). Recently, the European Investment Bank also provided capital to a couple of (larger) healthcare organizations. Banks are regulated on a national and European level, with the Dutch Bank, Authority Financial Markets and the European Central Bank acting as supervisors. Another important regulatory body is the Basel Committee on Banking Supervision, that sets global standards for the banking sector.

**Box II. National Guarantee Fund for the Healthcare Sector**

The National Guarantee Fund for the Healthcare Sector (in Dutch: *Waarborgfonds voor de Zorgsector*) can issue guarantees on loans between healthcare organizations and banks. Established in 1999, its goal is to reduce capital costs and improve access to financial capital for healthcare organizations. This is possible because the Fund guarantees payment of loans (through government backing) to banks when healthcare organizations fail to fulfil financial obligations. This mitigates financial risks for banks. In turn, banks can provide more favorable terms on loans to healthcare organizations (i.e., lower interest rates).

**Box III. Dutch health insurers**

Ten health insurance concerns are active in Dutch healthcare. These are either (private for-profit) public limited companies or (not-for-profit) mutuals. The four largest concerns had a combined market share of 85.1% in 2022 (i.e., *Achmea, VGZ, CZ and Menzis*) (NZa, 2022). In addition to their central role in the healthcare system, health insurers are also private financial entities subject to financial regulatory regimes. The National Health Authority oversees insurers' purchasing practices, continuity of care, fair competition and adherence to the *Health Insurance Act* and the *Healthcare Market Regulation Act*. Meanwhile, the Dutch National Bank, along with the Consumers and Markets Authority ensures that health insurers fulfil their obligations as financial institution operating under private law (Kroneman et al., 2016).

## Historical context and the introduction of regulated competition

The formal roles described above, as well as the different ways in which they are enacted in practice, are historically contingent. To make sense of them and the dynamics between Dutch banks, health insurers and healthcare organizations, it is important to understand their historical context. In this section, I will describe how the financial arena of Dutch healthcare has developed over time and how *regulated competition* was eventually implemented as a steering mechanism. By doing so, we gain a more profound understanding of how past events have shaped the current roles and responsibilities of banks, health insurers and healthcare organizations. This historical overview not only reconstructs the development of the financial arena of Dutch healthcare, but also provides insights into the forces driving the current behavior of banks, health insurers and healthcare organizations within their complex environment.

Until roughly the 2nd World War, care was mainly organized and financed by religious institutions and the wealthy middle class. The first hospitals, care homes and asylums in the Netherlands stem from their efforts to put their religious and ideological convictions into practice. Capital for the building and maintenance of care facilities was provided through legacies, donations, gifts, and land renting. In addition, municipalities could provide capital or subsidies for the establishment of care institutions, while banks and other financial parties were only rarely involved (RVZ, 2006; Van der Scheer, 2013). The communal sentiment that inspired the foundation of care institutions, also paved the way for the emergence of the first small-scale insurance companies. These companies, initiated by workers in the 19th century and later continued by physicians, investment funds, labor unions and commercial parties, shared financial risks after sickness and labor disabilities (Companje et al., 2009; Bertens and Palamar, 2021). In the years leading up to World War II, a combination of social injustices, wars and economic crises fueled demand for government interference in healthcare in order to ensure public values such as equality and justice (Fenger and Broekema, 2019). At the same time, medical advancements changed demand for healthcare, posing challenges for non-profit, religious, and charitable organizations in delivering and financing care. As a result, they increasingly depended on external capital provision (RVZ, 2006).

After World War II, the Dutch population grew, building costs increased and the need for large-scale hospitals and care facilities grew. To finance these new and modern institutions, debt capital became the main source of funding. First by issuing bonds and through private loans, later from the banking sector. In line with a growing state, the Dutch government started to partially finance the building of care facilities – which was quickly abolished in 1958 – and directly guaranteed capital costs (i.e., reimbursement of depreciation and interest) on the loans of healthcare organizations (RVZ, 2006; Wijdeveld, 2006). Guarantees were often issued at various levels of government: the national government guaranteed capital costs for hospitals, provinces oversaw mental healthcare organizations and disability care, and municipalities provided guarantees for nursing homes. As a result of these new arrangements, construction of new buildings surged, and government started to regulate the number and distribution of care facilities through a licensing system in the 1970s (RVZ, 2006). With obtaining a building license, healthcare organizations received ex-post compensation for the capital costs on their loans[3].

During this period, Dutch government also introduced several laws to extend the social health insurance scheme. This scheme was introduced by the German occupiers during the 2nd World War and encompassed a state controlled and compulsory social health insurance for employees earning below a specified income threshold. At the same time, voluntary health insurance through private insurance companies remained in place for those earning above the specified income threshold. The Dutch government aimed to guarantee solidarity and increase universal access to care. To create economies of scale, the many different and scattered health insurance companies started to merge and concentrate, leading to a handful number of sickness funds and private insurers (Companje et al., 2009; Bertens and Vonk, 2020).

[3] Appendix I provides an overview of policies related to the planning, construction and tariffs of healthcare organizations between 1950-2006 (In Dutch).

In the 1970s and 1980s, the focus of the Dutch government shifted from ensuring equal access to cost containment (Cutler, 2002; Bertens and Vonk, 2020; Schut, 1995). Government appointed the “structure and financing of healthcare” committee to find a structural solution for rising healthcare costs and increasing waiting lists. In 1987, the committee published a report (*Plan Dekker*) in which they advised the government to implement collective and mandatory health insurance, competition elements and market-like incentives. Influenced by economists and an emerging “new public management” ideology, the idea was to combine free-market principles with government regulation; a governance mechanism that became known as *regulated competition* (CSFG, 1987; Helderman et al., 2005; Enthoven and Van de Ven, 2007). The prelude of a changing healthcare system in combination with the abolishment of governmental guarantees on the capital costs of healthcare organizations in 1988, led to uncertainty and increased financial risks among banks. It eventually resulted in the foundation of the National Guarantee Fund for the Healthcare Sector by representative organizations and care associations, and with help of the government (Box II) (RVZ, 2006). Nonetheless, the implementation of *Plan Dekker* and the adoption of a market-oriented approach in healthcare did not occur immediately. Political and societal support were lacking, leading to twenty years of incremental policy changes toward privatization and deregulation[4]. Examples of such incremental changes included the simplification of the building licenses process, the abolition of direct government guarantees on loans (RVZ, 2006), the implementation of rules to integrate social and private health insurance companies by providing insurance companies with more freedom and the possibility for citizens to choose their insurer (Bertens and Palamar, 2021).

It was only in the 2000s that regulated competition gained momentum with the introduction of the *Health Insurance Act* and the *Market Regulation Act* in 2006. With this, responsibilities of various healthcare actors shifted. Government became responsible for ensuring “good market conditions” and

[4] The details of this process have been extensively described by others (Groenewegen, 1994; Hassenteufel et al., 2010; Helderman and Stiller, 2014; Van de Bovenkamp et al., 2017; Vonk and Schut, 2019; Tuohy, 2018; Bertens and Vonk, 2020).

gradually deregulated the ex-post compensation for capital costs. Healthcare organizations became entirely financially responsible, signifying that investing in them was no longer a risk-free endeavor for banks. Health insurers further consolidated and were given responsibility as purchasers and orchestrators of care (Enthoven and Van de Ven, 2007).

The period following the introduction of regulated competition in 2006 is the starting point of this thesis. With the implementation of regulated competition, the financial arena of Dutch healthcare entered a new era in which financial risk became an increasingly negotiated commodity. This created space for external influences, which followed soon as a consequence of the global financial crisis in 2007. This crisis had a significant impact on the banking and insurance sectors, through the adaptation of regulatory frameworks (i.e., Basel III and Solvency II) that had to prevent another financial crisis, strengthen the sectors, and mitigate financial risks. Most impactful were the capital requirements that demanded banks to reserve capital to cover financial risks when providing loans (i.e., Basel III) and requirements for health insurers to reserve a certain amount of solvency capital (i.e., Solvency II). The following empirical chapters in this thesis will show how the adaptations of the Basel and Solvency frameworks had a significant, albeit invisible, impact on the dynamics between banks, health insurers and healthcare organizations. These chapters will also explore how a combination of market reforms and the financial crisis were translated into practices between banks, health insurers and healthcare organizations. Furthermore, they will demonstrate that the financial arena of Dutch healthcare is not only defined by formal relations and contractual agreements, but that dynamics between actors also comprise other elements that shape interdependencies between actors (e.g., trust, uncertainty, power, legitimacy, persuasion, strategical behavior and emotions).

## Theoretical lenses: Beyond formal roles and responsibilities

Parts of the financial arena of Dutch healthcare have been researched in the fields of health economics. More specifically, these studies have focused on examining the role and behavior of health insurers in a healthcare system characterized by regulated competition. Some of these studies hint towards a rather complicated dynamic between health insurers and healthcare organizations with little trust (Groenewegen et al., 2019; Maarse and Jeurissen, 2019; Boonen and Schut, 2011), short-term strategies and poor relationship management (Noort et al., 2020), powerful bargaining positions that hamper the finalization of contracts and prolong negotiation processes (Halbersma et al., 2011; Schut and Varkevisser, 2017) and a lack of consensus between insurers and providers on quality aspects of care (Ruwaard, 2018; Stolper et al., 2019). However, most studies in this field focus on the organizational and economic value of regulated competition as steering instrument in general, and the role of health insurers and their contribution to improving efficiency and reducing healthcare expenditure more specifically. These studies adopt a rather formal, rational and calculative approach towards the behavior of health insurers and view financial parties as purposeful, competitive and strategical actors who, in line with their interests, try to minimize costs and maximize outcomes (e.g., Schut et al., 2023; Stadhouders et al., 2023; Douven et al., 2020; Gaspar et al., 2020; Croes et al., 2018; Krabbe-Alkemade et al., 2017; Schut and Van de Ven, 2011; Duijmelinck et al., 2015; Varkevisser and Van der Geest, 2002). Such economic theories and perspectives have been very influential in informing (austerity driven) policymaking that seeks to improve healthcare systems (Hirschman and Berman, 2014; Frankel et al., 2019; Vonk et al., 2020). They have, however, adopted a blind spot for how financial stakeholders enact their financial roles in everyday practice and vis-à-vis other healthcare actors enrolled in healthcare systems.

Literature on the *financialization of healthcare*, takes a more sociological perspective on the growing role of financial parties in the economy, political arena and (semi-)public sector. Studies in this area focus on the causes, consequences and implications for society when financial parties increasingly penetrate other domains and gain a powerful position. With governments that try to constrain public spending, healthcare organizations rely more and more on loans and investments from external financing parties. This growing dependency on and influence of financial parties, makes that financial instruments, language, goals and structures become engrained into healthcare management and practices. A financial logic therefore becomes an increasingly important driver for decision-making processes in healthcare, possibly overruling other public values (Engelen, 2008; Hunter and Murray, 2009; Van der Zwan, 2014; Cordilha, 2021).

Most studies into financialization take on a macro perspective and try to explain the growing role of financial parties in relation to broader and structural societal changes. They focus, for example, on contemporary capitalist shifts "from 'real' production (primary, manufacturing and services) to finance (investment banking, insurance, arbitrage, asset management, venture capital, currency trading and so on)" (Mawdsley, 2018, p. 265). This type of research allows us to understand why financial parties invest in the healthcare sector in the first place: healthcare offers a stable and relatively low-risk source of income for financial parties, especially since care is a necessary good and expenditure on health is (almost) ever-rising (Lavinas, 2018). The more critical approaches have warned us that such developments are taking-over welfare systems while financial vulnerability is increasing (Lavinas, 2018).

To date, the academic literature on financialization has not touched upon the micro-processes and practices of how financial actors gain influence, nor their dynamics with other actors, such as healthcare organizations. Studying these processes requires adopting more practice-based and relational approaches towards understanding the roles and practices of financial actors in healthcare, such as stakeholder theory, translation theory and institutional theory (Schatzki, 2018; Callon, 1986; Muniesa et al., 2007; Mitchell, 2008). Since these approaches play an important role in this thesis, I will briefly introduce them.

*Stakeholder theory* provides insights into the position of financial stakeholders and other actors in healthcare as being parties with something at stake. Whether that be capital investments, a “duty of care” or one’s very existence; stakeholders are mutually dependent. Stakeholder theory especially points towards how power, influence and perceived legitimacy are not equally distributed among stakeholders and how that affects their valuation of each other (Mitchell et al., 1997; Parent and Deephouse, 2007; Magness, 2008; Neville et al., 2011). *Translation theory* offers another – more relational and practice based – perspective, one that foregrounds the negotiations, calculations and acts of persuasion that actors employ in relation to others, in order to shape shared interests and to achieve collective goals. Translation theory is able to foreground the work that actors perform to forge and maintain (financial) alliances, while also highlighting how partnerships can fall apart (Callon, 1986; Freeman, 2009; Wæraas and Nielsen, 2016).

Furthermore, this thesis is informed by *institutional theory* to emphasize that financial actors are embedded within a broader context of rules, norms, values and regulatory frameworks that inform and regulate their behavior (Hall and Taylor, 1996; March and Olsen, 1995). Such institutions change over time, for example, in response to external pressure, such as (financial) crises, regulatory changes or bottlenecks that require major shifts in the way we organize care. These events make it possible to renegotiate institutional arrangements (Thelen, 1999; Wilsford, 2010), which means that actors need to adjust their roles and actions as well (Mahoney and Thelen, 2010; Wallenburg et al., 2016; Lawrence and Suddaby, 2006). Actors, in turn, also actively and continuously try to reshape their institutional context to improve their position. Their efforts and influence can maintain, create or disrupt institutional structures (Dorado, 2005; Lawrence and Suddaby, 2006; Mahoney and Thelen, 2010).

Together, these theoretical lenses allow me to observe the financial arena of Dutch healthcare as a web of social relations and activities that are continually shaped and reshaped by the actions and interactions of individuals and the broader context in which they are embedded. This enables me to move beyond discussions and economic quests to uncover generalizable patterns that optimize the functionality of healthcare systems or the macro-effects of the growing influence of financial actors in healthcare. Instead, by adopting a relational and practice-based approach, I can open the black-box of the financial arena of Dutch healthcare and provide new insights into *why* and *how* actors think, act and react.

## Research design

This thesis aims to contribute to our knowledge of the dynamics between financial parties (i.e., banks and health insurers) and healthcare organizations. Informed by gaps identified in previous research on health insurers, a lack of knowledge regarding the role and behavior of banks and drawing on insights from various theoretical lenses, the research question of this thesis is formulated as follows:

**How can we understand the dynamics between banks, health insurers and healthcare organization in the context of regulated competition?**

Because answering the main question can be done in different ways, I have divided this question into three sub-questions to further delineate my approach:

1. What roles do banks and health insurers play vis-à-vis healthcare organizations and how have these roles changed over time?
2. How have banks, health insurers and healthcare organizations translated layered policies and regulatory changes into their practices?
3. How do banks, health insurers and healthcare executives interact under pressure of increased financial uncertainties?

Answering these questions is relevant for several reasons. First, it raises awareness for how dynamics between healthcare organizations and financial parties, as well as changes on the financial market, influence the provision of healthcare. As suggested by the Ikazia case, agreements made between banks, health insurers and healthcare organizations significantly impact care practices and the lay-out of Dutch healthcare. This thesis redirects attention to the financial arena of Dutch healthcare and helps understand how financial parties influence healthcare practices. Additionally, this thesis is the first to specifically focus on the role and practices of banks in Dutch healthcare. While health insurers have always been recognized as important players in healthcare, banks have traditionally been positioned outside the sector, leading to their neglect in healthcare policymaking and research. Therefore, it is imperative that this research pays specific attention to the banking sector to understand its role in Dutch healthcare.

Second, the financialization of care, characterized by the growing influence of financial parties, extends beyond the Dutch context or countries with market-oriented or privatized healthcare systems (Cabiedes and Guillén, 2001; Light, 2001; Maarse, 2006). Financialization processes are also evident in countries with more publicly oriented healthcare systems (Cordilha, 2021; Horton, 2022; Vural, 2017). Therefore, this thesis is relevant for all healthcare systems where financial organizations seek to expand their influence, offering valuable insights into their mechanisms and ways of working. Additionally, it raises awareness for the potential of financial considerations to supersede public interest in healthcare policymaking.

Third, recent developments such as the COVID-19 pandemic, staff shortages, energy crisis and adaptations to banking and insurance regulations, put financial strains on healthcare organizations (Kruse and Jeurissen, 2020). This research reveals how mutual relations between the three key actors are shaped and institutional realities are changed by such events. It also suggests that reliance on the willingness of financial stakeholders to provide aid during financial distress is likely to increase. By better understanding the dynamics between healthcare organizations and financial parties, we can better prepare policymakers and executives and managers of both healthcare organizations, banks and health insurers for unforeseen situations and financial distress, enabling them to find long-term and sustainable solutions to address growing power imbalances.

Finally, improving healthcare systems and ensuring high quality, accessible and affordable care, is a challenge for many countries worldwide. In the Netherlands, for example, discussions about the desirability of competition and a call for more collaboration have recently increased (Van der Woerd et al., 2024; Varkevisser et al., 2023). Such debates often revolve around ways in which banks, health insurers and healthcare organizations have developed roles, relations and routines. Revisiting their roles, interdependencies and ways of collaborating requires a deeper understanding of how they emerged and how ingrained perceptions of each other influences their interactions and behavior. This research is therefore relevant for countries that have introduced market mechanisms as steering instruments as well as those that depend on collaboration or are dealing with transformations in the governance structure of healthcare.

## Research methods

To study the social relations and dynamics between banks, health insurers and healthcare organizations in the context of regulated competition, I combined various qualitative and quantitative methodologies.

For the qualitative part, I adopted an interpretative approach in which my aim was to understand and describe the social phenomena that is the financial arena of Dutch healthcare. Consequently, I derived data through in-depth semi-structured interviews, document analysis and case studies (Schwartz-Shea and Yanow, 2013) (chapter two, four and five). Interviews were held with representatives of banks, health insurers, healthcare organizations and other relevant parties (e.g., Dutch National Bank, Dutch Healthcare Authority and financial experts). Document analysis provided additional context and background to the interviews and enriched the interpretation of the data. It further served to enhance the validity of the research through data triangulation. The case studies that I selected were two “extreme or outlier cases”, since the relations between banks, health insurers and healthcare organizations are, in general, not characterized by financial distress (Flyvbjer, 2006). Researching such “extreme cases” helps to uncover the hidden details and nuances of the relationship between these actors. And although the situation is rather unique, recent reports suggest an increase in the number of healthcare organizations that face financial difficulty (EY, 2023; WfZ, 2024). By analyzing the interviews, documents and case studies through an abductive and iterative approach, I was able to form a detailed understanding of the relations, dynamics and social and institutional contexts in which banks, health insurers and healthcare organizations operate (Tavory and Timmermans, 2014).

Additionally, I gathered quantitative survey data (chapter three) from healthcare executives. The dataset included questions on how executives experienced their interactions with banks and health insurers and how they perceived financial stakeholders in terms of power, legitimacy and urgency. The survey was disseminated in collaboration with the Dutch Association of Healthcare Executives (in Dutch: *NVZD*) that shared the survey among its members. Both qualitative and quantitative methods complement one another; the qualitative data increases our understanding of the behavior of banks, health insurers and healthcare organizations, while the quantitative data enables me to draw conclusions that are applicable to the broader range of Dutch healthcare (Greene, 2007).

## Outline

The following chapters cover four separate empirical studies, each contributing a piece to the puzzle in answering the research question.

***Chapter two*** dives into two important events: the healthcare reform starting in 2006 and the global financial crisis beginning in 2007. Both shaped the relations and practices between banks, health insurers and healthcare organizations in the decade to come in unanticipated ways. This chapter illustrates the context of the financial arena of Dutch healthcare and how roles and practices of banks, health insurers and healthcare organizations are receptive to internal changes and external events.

***Chapter three*** explores the impact of these new practices on the perceptions that healthcare executives, as representatives of their healthcare organizations, have of banks and health insurers in their new role. Based on representative survey data, I draw further lessons on the perceived influence and legitimacy of banks and health insurers on healthcare organizations.

***Chapter four*** zooms-in on two specific cases of financial distress in a hospital and mental healthcare organization. By tracing the process of financial distress, I unravel the complex dispositions, strategies and actions of banks, health insurers and healthcare organizations.

***Chapter five*** examines the mental healthcare sector as a case in point for new dynamics between health insurers and healthcare organizations. These new dynamics emerge from systemic issues and a policy move towards a collaborative governance regime. Such a move proves difficult as parties experience distrust and perceive the other with suspicion instead of as equal partners with shared purposes. The banking sector is left out of this study because this policy shift only impacts the relations between health insurers and healthcare organizations (for now).

***Chapter six*** contains the discussion and conclusions of this thesis. In this chapter, I highlight the key empirical findings, provide answers to the research questions, reflect on the theoretical and practical implications and suggest a future research agenda.

# Chapter II

## Healthcare reform and financial crisis in the Netherlands: Consequences for the financial arena of healthcare organizations

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# Abstract

Over the past decade, many healthcare systems across the Global North have implemented elements of market mechanisms while also dealing with the consequences of the financial crisis. Although effects of these two developments have been researched separately, their combined impact on the governance of healthcare organizations has received less attention. The aim of this study is to understand how healthcare reforms and the financial crisis together shaped new roles and interactions within healthcare. The Netherlands – where dynamics between healthcare organizations and their financial stakeholders (i.e., banks and health insurers) were particularly impacted – provides an illustrative case. Through semi-structured interviews, additional document analysis and insights from institutional change theory, we show how banks intensified relationship management, increased demands on loan applications and shifted financial risks onto healthcare organizations, while health insurers tightened up their monitoring and accountability practices towards healthcare organizations. In return, healthcare organizations were urged to rearrange their operations and become more risk minded. They became increasingly dependent on banks and health insurers for their existence. Moreover, with this study, we show how institutional arenas come about through both the long-term efforts of institutional agents and unpredictable implications of economic and societal crises.

## Introduction

Over the past decade, many healthcare systems across the Global North have implemented elements of market mechanisms while also dealing with the consequences of the financial crisis. The impact of both policy reforms and financial crises on healthcare has been researched extensively, each in their own terms. Studies on policy reforms, for instance, show how the introduction of pro-competitive policies have affected access to and prices of care (Lisac et al., 2010; Maarse et al., 2016; Pan et al., 2016). In turn, research on financial crises shows how such crises can deteriorate health (Stuckler et al., 2009; 2015; Karanikolos et al., 2013; Quaglio et al., 2013), change the institutional environment in which healthcare is organized (e.g., the growing role of the EU in health policy) (Clemens et al., 2014a; Helderman, 2015) and decrease government spending on social policies (Cylus et al., 2012; Clemens et al., 2014b; Letho et al., 2015; Morgan and Astolfi, 2015; Saltman, 2018). Our study draws from both strands of literature and specifically focusses on how reforms and crises can resonate with one another and together lead to new ways of working and interacting between healthcare organizations and their financial stakeholders, such as banks and health insurers.

The Dutch healthcare system provides an illustrative case since an important healthcare reform, introduced in 2006 – one that implemented market principles and made healthcare organizations increasingly risk-bearing organizations – was quickly followed by the global financial crisis, starting in 2007. Soon after that, regulatory agencies, in particularly the EU and banking sector, sought to mitigate the consequences of the financial crisis through new regulatory frameworks introduced in 2009 and 2011: Basel III for banks and Solvency II for insurers. Both regulations had unexpected consequences for healthcare organizations that were dependent for their capital provision and income on their interactions and negotiations with banks and health insurers after the 2006 policy reforms. Reforms and crisis thus together and iteratively shaped the transformation towards a more competitive way of working, forcing banks and health insurers to rethink their role and position towards healthcare organizations and the other way around.

In this paper, we study, through the lens of institutional theory, how banks, health insurers and healthcare organizations responded to the reform and financial crisis and subsequently took part in the creation of a new institutional "reality". We answer the following question: *How have roles, practices and interactions between banks, health insurers and healthcare organizations changed in response to healthcare reforms and the financial crisis?*

Although both the Dutch reform and global financial crisis took place more than a decade ago, researching their impact is still relevant; particularly so because (in the Netherlands) the discussion about the desirability of competition in healthcare continues and often revolves around the ways in which banks, health insurers and healthcare organizations have developed new roles, relations and routines (Van Dijk et al., 2021). Moreover, Basel III and Solvency II regulations are under regular evaluation. Basel III is, for example, recently adjusted with newly added measures to be implemented by 2027 (so called Basel IV). New rules and stricter capital requirements can again change the "institutional reality". Lastly, by focusing on how the healthcare reform and financial crisis impacted the dynamics between banks, health insurers and healthcare organizations, we shift attention to an understudied relationship that has become essential for the organization and provision of healthcare services in welfare states that adopted principles of regulated competition. Better understanding roles, relations and interactions between healthcare organizations and their financial stakeholders can help to improve and safeguard access to healthcare and manage overall healthcare costs.

## Institutional change and different ways to understand it

Our inquiry into changing relations in the financial arena of Dutch healthcare has been informed by institutional theory. Classically, institutions are considered as sets of rules and norms that prescribe what roles actors play in a particular setting and how their conduct is shaped by it (Hall and Taylor, 1996). Through their reproduction, institutions were deemed as static and self-reinforcing (March and Olsen, 1995). The stable and enduring nature of institutions was further considered to be fostered by the difficulty to diverge from a chosen path; for instance because of the ways in which institutions inscribe how to give meaning to the world (making it difficult to think beyond them; cf. David, 1985; Arthur, 1989) or the ways in which institutions were implicated in confirming extant roles, power relations and social hierarchies (DiMaggio and Powell, 1983).

Because of the emphasis placed on the stabilizing character of institutions, it was difficult to understand institutional change through this approach. Most commonly, institutional change was explained as induced by exogenous shocks. These were considered external events with far-reaching and unpredictable consequences. Examples include the collapse of communist rule (Clark and Soulsby, 1995), the 9/11 terrorist attack (Stratch and Sapiro, 2011; Corbo et al., 2015), financial crises (Luong and Weinthal, 2004; Moschella, 2015) and, more recently, the Covid-19 crisis (Deruelle and Engeli, 2021). Such events were considered to put stress on conventional meaning-making schemes and power relations, providing time-spaces to renegotiate institutional arrangements and the ways in which they inform roles and relations (Thelen, 1999; Wilsford, 2010).

As institutional theory started to place more emphasis on practices, different readings of how to understand institutional change started to emerge (Lawrence and Suddaby, 2006; Mahoney and Thelen, 2010). Of particular importance was the consideration that actors do not just enact institutional arrangements, but actively and continuously try to shape their institutional context in order to improve their institutional positions, roles and relations; for instance, by contributing to the introduction, replacement, accumulation or reinterpretation of institutional arrangements (Dorado, 2005; Lawrence and Suddaby, 2006; Wallenburg et al., 2016). This way, institutional changes come about over longer periods of time and through slow, subtle and incremental processes (see Mahoney and Thelen (2010) for a comprehensive overview of such processes).

This latter reading of institutional change has gained much traction in recent institutional literature; particularly so through concepts such as institutional work and institutional layering. Concepts that emphasize the work that actors invest in shaping their own roles, relations and positions and the ways through which these roles, relations and positions are inscribed, informed and supported by their institutional environments (Lawrence and Suddaby, 2006; Van de Bovenkamp et al., 2014; Van Oijen et al., 2020; Felder et al., 2021). These concepts have therefore been important to show the complex and negotiated character of institutions, institutional changes and institutionally informed roles and relations.

By foregrounding institutional processes such as layering and institutional work, the role of exogenous shocks has been pushed to the background a bit in contemporary institutional analysis, although there are some exceptions. Bacharach et al. (1996), for instance, demonstrate how deregulation of the airline industry (exogenous shock) evoked institutional work from actors to create a new form of collaboration between professionals and management; Luong and Weinthal (2004) show how a financial crisis drove the Russian government and Russian oil companies to the mutual realization that incremental tax reform was necessary; Deruelle and Engeli (2021) observe that the mandate of the European Centre for Disease Prevention and Control has expanded gradually over the years, but only really gained momentum during the Covid-19 crisis. In line with these authors, we argue in this paper that exogenous shocks and incremental changes are not necessarily different or contradictory approaches towards understanding institutional change and its consequences. In fact, they often intertwine in the forging of new institutional contexts.

# Institutional change in the financial arena of Dutch healthcare

## Healthcare reforms

The institutional arrangements that are currently central in the financial arena of Dutch healthcare also result from a combination of exogenous shocks and incremental changes. Here, the classical way of organizing healthcare through a mix of state-based regulation and public initiatives has been complemented with the introduction of market mechanisms (Van der Scheer, 2013). The introduction of these market mechanisms and the way in which they shape current stakeholder dynamics did not come out of the blue. Rather they are the always preliminary outcomes of an intensive and incremental process of negotiations between stakeholders (such as policymakers, banks, health insurers and healthcare organizations). The financial crisis, however, did come unexpected and brought a more cautious perspective on financing healthcare, one that placed emphasis on monitoring and financial assurance. We will use this section to introduce the main changes in the financial arena of Dutch healthcare over the last decade and discuss its implications for healthcare organizations and their financial stakeholders, starting with the introduction of regulated competition and followed by the financial crisis.

The introduction of market mechanisms is often set in 2006 with the ratification of the Health Insurance Act and Healthcare Market Regulation Act. These acts were however, preceded by numerous smaller, incremental policy changes that paved the way for regulated competition and eventually resulted in the current system (Groenewegen, 1994; Hassenteufel et al., 2010; Helderman and Stiller, 2014; Van de Bovenkamp et al., 2014; Tuohy, 2018; Vonk and Schut, 2019; Bertens and Vonk, 2020). Already in 1987, the “structure and financing of healthcare” committee advised the Dutch government to implement collective, mandatory health insurance and market-like incentives to address rising costs, waiting lists and inefficiency. Successive healthcare ministers attempted to implement the committee’s plans but failed due to a lack of public and political support (Kamerstukken II 1987/88; Kamerstukken II 1989/90; Kamerstukken II 2000/01; Bertens and

Palamar, 2021). Over a longer period, however, many policies aligning with the committee's vision were added piecemeal. For example, people were allowed to switch health insurers every year, insurers were no longer obliged to contract every healthcare organization, and convergence between sickness funds and private insurers was stimulated. Parties in the sector gradually prepared to adopt principles of regulated competition and lengthy waiting lists roused political support for systemic reform (Bertens and Palamar, 2021). The following political compromises, the adding of new policies without replacing others, the gradual implementation of new rules (e.g., free price negotiations; adding curative mental healthcare to the Health Insurance Act) and the fine-tuning of rules after 2006 (e.g., Diagnoses Treatment Combinations), make Dutch healthcare an institutionally layered healthcare field in ongoing state of reform (Van de Bovenkamp et al., 2014; Maarse et al., 2016).

The move towards regulated competition had a major impact on banks, health insurers and healthcare organizations. Since 2006, health insurers have to negotiate annually with healthcare organizations on price, quantity and quality of services. They also became national orchestrators of care (Kamerstukken II 2003/04). Moreover, in 2008, government real-estate policies were phased out; government no longer provided ex-post compensation for real-estate costs and healthcare organizations were made responsible for their own business and bore the full risk of running their organizations (Enthoven and Van de Ven, 2007; Van der Zwart et al., 2010). For banks – the sole financers of healthcare real estate and providers of short-term credit for liquidity and daily expenses – this meant that indirect government security on loans disappeared and financing risks increased (Van der Zwart et al., 2010; NVB, 2017). Thus, banks perceived healthcare organizations as increasingly risk-full investments. The focus on market incentives and competition forced healthcare executives to become more entrepreneurial and focus on efficiency, product improvement and competition (Van der Scheer, 2007). This new way of thinking and working also implied taking risks. Actors had to re-interpret their roles, reposition themselves towards other actors and translate market principles into their daily practices.

## Financial crisis

In the middle of adapting to these new arrangements, the world was struck by a global financial crisis, that had far-reaching consequences for the healthcare sector. The crisis disrupted financial systems and required governments to assume state debts, leading to budget deficits and, eventually, austerity measures. In the Netherlands, government provided capital injections to support businesses and the banking sector. They also nationalized a bank, guaranteed state debts and increased deposit assurance. The following austerity measures mainly targeted public expenditure and the income of provinces and municipalities (Kickert, 2012; Batenburg et al., 2016). Measures taken relating the healthcare sector focused on shifting costs from public to private sources or between statutory sources. Also, care was substituted and there was an increased focus on improving efficiency and eliminating fraud (Batenburg et al., 2016).

The shock of the financial crisis also set in motion another series of events that impacted healthcare in an unexpected way. Banking and insurance regulators responded by amending existing regulations to prevent another crisis and improve the resilience of financial systems. Basel III was developed by the Basel Committee on Banking Supervision as mandated by the Bank for International Settlements, and Solvency II by the European Insurance and Occupational Pensions Authority, an official advisory body of the European Commission. The Basel Committee operates on a global level and its members are the central banks and supervisory authorities of countries with large financial sectors, while the European Commission is a European institution.

The Basel III and Solvency II frameworks are often pictured as three-pillared entities. The three pillars represent (1) quantitative, (2) qualitative and (3) disclosure requirements. The first pillar consists of capital requirements (capital ratios for banks and solvency capital requirements for insurers). The second pillar focuses on the qualitative interpretation of risk models, expressed in the Internal Capital Adequacy Assessment Process (ICAAP) for banks and the Own Risk and Solvency Assessment (ORSA) for health insurers. The third pillar sets requirements for financial reporting to enhance transparency and market discipline (European Parliament, 2009; Basel Committee on Banking Supervision, 2011). The frameworks impacted the allocation of capital and required an internal paradigm shift for banks and insurers, with a sharper focus on quantifying risks, risk-thinking and risk management. Early on, both Basel III and Solvency II were expected to have unknown consequences, for example, for the funding patterns of banks and health insurers, the interconnectedness of the frameworks and the possibility of risk transfers to consumers and other sectors (Al-Darwish et al., 2011). Banks, health insurers and healthcare organizations needed again to re-interpret the changes that were happening in their surroundings. By adapting their roles and interactions they give meaning to this new "reality", which we will further elaborate on in the result section.

# Materials and methods

## Data collection

This study is based on semi-structured interviews and document analysis that cover developments within the financial arena of Dutch healthcare over the past 40 years (starting with a report published by the expert committee on the "structure and financing of healthcare"). Seventeen interviews took place in 2017, which were complemented with seven additional interviews in 2018, 2019 and 2020. Author one was present during all interviews and authors two and four occasionally. In total, 24 respondents have been interviewed. They were chosen based on their role in the healthcare sector and identified through the network of the second and fourth author or the organizations they represent. Respondents included financial specialists and representatives of banks, health insurers, healthcare organizations[5] and supervisory authorities. A list is provided in Table 1.

[5] All healthcare organizations had loans with banks. However, the organization for long-term care (n=1) does not negotiate with health insurers and questions were therefore limited to its own role and that of banks.

We first interviewed financial experts working as independent advisors for healthcare organizations and as mediators between healthcare organizations and their financial stakeholders. This produced a list of key topics and helped us grasp the dynamic between healthcare organizations, banks and health insurers. We then interviewed representatives of these three main actors. We ended by interviewing policymakers and supervisory authorities, chosen for their insights into policy changes in the healthcare sector. The Dutch National Bank also supervises health insurers and the implementation of Basel III and Solvency II. The National Guarantee Fund for the Healthcare Sector is a mutual guarantee fund for capital loans in healthcare and has a firm grasp of the financial topics and changing relationships that interested us.

Information derived from document analysis was used to complement, expand and confirm the insights obtained during the interviews. In addition, it helped us to better understand the process and context of the policy reforms and the financial crisis. We identified and analyzed annual reports, letters to parliament and policy documents from the Ministry of Health, policy documents and working papers from government (advisory) bodies, and codes of conduct and reports from umbrella organizations. The selection was based on available documents that were published by organizations that are important for the financing of Dutch healthcare (e.g., Ministry of Health, National Guarantee Fund for the Healthcare Sector, Dutch Banking Association). We furthermore selected documents that provided information on the financial crisis, Basel III, Solvency II and the run-up to the healthcare reform (Appendix II).

**Table 1.** Respondents.

| Respondent | Description | N |
|---|---|---|
| Financial specialist | Independent consultant | 3 |
| Banks | Director | 2 |
| | Risk manager | 2 |
| | Account manager | 1 |
| Health insurers | Director | 2 |
| | Risk manager | 1 |
| | Purchaser | 1 |
| | Business controller | 1 |
| Healthcare organizations | CEO long-term care | 1 |
| | CEO mental healthcare organization | 2 |
| | Controller mental healthcare organization | 1 |
| | CFO hospital | 2 |
| Policymakers and supervisors | Ministry of Health, Welfare and Sport | 1 |
| | Dutch National Bank | 2 |
| | Dutch Healthcare Authority | 1 |
| | National Guarantee Fund for the Healthcare Sector | 1 |
| Total | | 24 |

## Data analysis

Interviews were audio-recorded and transcribed verbatim. We used Atlas.ti and coded the interviews inductively. This resulted in 46 thematic codes, labelled closely to the words used by respondents. Codes were then compared and matched and subsequently abstracted to either the "role perception" or "changing practices" of actors in relation to the healthcare reforms or the financial crisis.

As mentioned, the documents provided background during and after the interviews and helped us understand the framework, intentions, specifications and consequences of the studied changes. They allowed us to interpret the "language" used by different actors and put the interviewees' statements into context. They also made it possible to triangulate the data. Our initial interpretation was sent to respondents for a member check; they affirmed our findings and had no remarks. Finally, quotes were translated from Dutch to English.

## Changing dynamics: How and why banks and health insurers adopt new roles, practices and interactions

The introduction of regulated competition and the Basel and Solvency frameworks led to a shift in the dependencies between banks and healthcare organizations and between health insurers and healthcare organizations. Banks and health insurers had to interpret and translate new rules and regulations into their roles, interactions and practices and reposition themselves in the field and towards one another. Below, we elaborate on these changing positions and practices. We start with banks, followed by health insurers and a short description of the consequences for healthcare organizations. We end with a discussion of two intersectional themes where all three actors cross paths. Table 2 provides an overview and summary of the results.

**Table 2.** Changing roles and practices of banks, health insurers and healthcare organizations.

| | Banks and healthcare organizations | Health insurers and healthcare organizations |
|---|---|---|
| Role | From “waiter” to “critical partner” and “trusted advisor” | Financial organization with complex societal mission |
| Practices | Intensified relationship management<br>▪ More contact<br>▪ New requirements for healthcare executives’ competences<br><br>Changing demands on loan applications<br>▪ Business plan<br>▪ Stricter loan conditions<br>▪ Valuing real estate<br>▪ Forming consortiums | Managing mutual debts and speeding up invoicing<br>▪ Setting up monitoring systems<br>▪ Anticipating financial risk |
| Healthcare organizations | More accountability towards banks and health insurers<br>Professionalizing financial administration and data management | |
| Interaction | Credit loans and negotiating positions<br>Multi-annual contracts | |

## Banks

*Role perception*

The introduction of regulated competition led to a change in how banks approached healthcare organizations. Like other private organizations, healthcare organizations had become risk-bearing entities. Government ex-post compensation for real-estate costs was steadily reduced and healthcare organizations had to rely increasingly on their sales and negotiation skills towards health insurers. This also meant a greater financial risk for banks.

> "Since 2006, we carry more risk. But we don't mind because that's what we do in every other sector. In fact, we're now taking on the role that we normally like to play."
> *Representative bank (1)*

Banks started to reframe their role vis-à-vis healthcare organizations. One of the respondents describes the old role as "waiter" and the new role as "trusted advisor" and "critical partner" (representative bank 1 and 2). In the old role, banks passed loan applications to the "kitchen" and returned with the order without asking further questions. They simply executed the order. The new role emphasizes trust and such values as "knowing the customer" and "being a best friend". It means advising on financial topics and making a long-term commitment to healthcare organizations. A critical partner, however, is not afraid to ask difficult questions and makes demands before investing, not only because of the risks involved but also because banks have a responsibility to society for ensuring financial sustainability in healthcare.

Banks did not adopt this new role overnight. They too had to adapt. Account managers had to learn to be trusted advisors and critical partners, for example, by training in board-level discussions of strategy. One bank manager shared what he told his account managers were the core values of this new mindset.

> "The most important thing about banking is to know your customer. And not just by doing their annual accounts but by visiting them regularly. Call them even if nothing's wrong, treat them like your best friend. Make a personal connection, know what's really going on with them, what keeps them awake at night. Don't just talk to the financial people, talk to stakeholders. Go meet the Supervisory Board once a year, or the medical specialists."
> *Representative bank (1)*

In keeping with their changed roles, banks use language and knowledge strategically in their business-like approach to healthcare organizations. The "partner" and "best friend" narrative is somewhat misleading, however. It suggests an equal relationship, and yet Dutch healthcare organizations rely heavily on banks to finance their business, as they have few other ways to access capital.

> "We have an enormously powerful position in the negative sense. Because if we turn off the money tap, or become averse, we can, to a certain extent, direct an organization."
> *Representative bank (1)*

*Intensified relationship management*

Banks intensified their relationship with healthcare organizations to get more grip on their finances, strategic choices and any risks that might affect financial results. Respondents indicate that contact between healthcare organizations and bank account managers has increased from annual to biannual meetings with the board and bimonthly meetings with the CFO. Banks prefer to be the principal banker, making them responsible for transactions and payments and allowing them to monitor the financial status of the healthcare organization and implement early-warning systems for financial distress.

Banks now also focus increasingly on healthcare executive performance, given executives' important role in strategic and financial planning. Their knowledge and skills, vision and relationship with external partners are crucial for banks, in addition to the relationship between the executive and supervisory boards and the organization's relationship with health insurers and its medical staff. Many respondents point out that the relationship with health insurers is of particular interest to banks since insurers can guarantee income and revenue for healthcare organizations and thus indirectly guarantee interest payments.

> "Banks started having very different conversations with directors [...] What does your health insurer think? Can they commit too? You're asking us to commit for 15, 20, 25 years, but the health insurer, the party that determines the volume of business you're going to do, has a one-year commitment. So, we asked health insurers to commit for five years, or at least three. That's a big change for healthcare executives. Financing has really become a boardroom topic."
> *Representative bank (2)*

*Changing demands on loan applications*

Fueled by the financial crisis and subsequent Basel III regulations, banks were urged to re-evaluate their previous and future investments in healthcare. One way for banks to mitigate and manage financial risk is by changing the loan conditions and application process, for example, by introducing business plans (1), tightening up contract conditions (2), valuing real estate (3) and making consortium deals (4).

First, a business plan furnishes banks with the information needed to assess risk and decide on further financing. Bank representatives explain that the plan should contain information on the organization's mission, strategy and long-term vision, financial projections for the next 20 years, long-term property plans, forecasts of healthcare services, the organization's financial assets and the type and amount of financing required. The quote below illustrates how unfamiliar healthcare organizations were with this new practice.

> "Healthcare organizations had become risk-bearing, especially in terms of real-estate development. And that was a reason for banks to say: 'If you want money from us, you must submit a solid business plan.' Well, that concept alone was totally unknown at the time. I remember people asking 'What exactly is that? Can you send me examples?'. So, the whole idea of having to underpin your plans, especially for the future [...] Well, that was unfamiliar to them."
> *Representative bank (1)*

Second, contract conditions changed because healthcare organizations became risk-bearing entities and banks placed them in higher risk categories. Basel III further required banks to bolter capital buffers based on their outstanding loans. Banks, financial specialists and supervisory authorities say that this led to a decrease in capital spend, a rise in interest margins and financial ratios, and to increasingly picky banks. Contracts now contain clauses that make the terms conditional on changes in the Basel regulations. Financial specialists were especially indignant about this:

> "The entire risk profile, the risk you take as a bank in your market, shifts directly to the other party."
> *Financial specialist (1)*

Moreover, the financial crisis meant that banks had difficulty attracting long-term capital. This in turn affected the loan terms offered to healthcare organizations, reducing them from 30–40 to 10–25 years. Since real estate often serves as collateral for long-term loans and has a 30-year depreciation period, healthcare organizations face a refinancing challenge for both the loan and the relevant interest rate. One executive shared that he had two loans to refinance. The first was easy and they were able to lower the interest rate, but the second was not. They had to make new arrangements with the original bank, which altered the terms of the loan and raised the interest rate. For banks, such arrangements offer a strategic edge because they can then reassess loan agreements and adapt them to reflect the financial risks.

Third, banks find it increasingly precarious that the collateral (real estate) on their loans is unusable and unmarketable since healthcare facilities can serve almost no other purpose. One of the banks even refers to their value as "the value of land minus demolition costs" (representative bank 2). Although there are some sector differences in terms of redevelopment options, banks struggle with the right valuation method and now ask for a valuation to be included in the business plan. This gives them some security on the value of their returns in the event of bankruptcy, as required by Basel III, but also has implications for the interest rates on loans.

Fourth, banks share the risk of financing by forming consortiums. Since the healthcare reforms and introduction of Basel III, they are no longer willing or able to provide the entire capital for larger financial projects on their own, preferring to do so as part of a consortium. Because only five banks operate in the Dutch healthcare sector, consortium formation narrows healthcare organizations' options considerably and diminishes their negotiating power. As most respondents point out, they have no alternative and are more or less obliged to agree to the consortium's terms. One respondent is especially concerned about the impact on the position of healthcare organizations.

> "Do I still have a choice? No, I can choose between zero and no quotation. That quotation is nothing more than the sum of various wish lists held together by a staple, and I have nowhere else to go. So those conditions have become 'take it or leave it' contracts, because I have no choice [...] I bear all the risk that banks don't want, all the uncertainties."
> *Representative National Guarantee Fund for the Healthcare Sector*

## Health insurers

*Role perception*

The 2006 Health Insurance Act (HIA) granted health insurers a crucial role in the healthcare sector, making them responsible for access to care and for reducing overall healthcare costs (Kamerstukken II 2003/04). As a result, health insurers now approach healthcare organizations as "prudent buyers". They negotiate the type and price of healthcare services and take a regional view of the distribution of care based on their insured population. This sometimes clashes with the interests of individual organizations.

> "Hospital X requested a new medical device. Our accountant did a quick calculation: 'No way, we're not going to cover it.' They were pissed off. We said: 'If we zoom out, we see that hospital Y specializes in this very device and is located within a radius of 1.5 kilometers. And it has overcapacity, so get together with them.' But it's about prestige, their own interests; medical specialists' interests differ from the interest of total care provision in that region. We often have to be the bad guy."
> *Representative health insurer (1)*

The task assigned to health insurers under the HIA often results in conflict, as the quote shows. Health insurers say they have long struggled with their new role and how to play it. They are private organizations and represent their insured, but they often receive negative publicity for their role during negotiations with healthcare organizations and for their focus on finances.

> "On the one hand, we're a financial service provider. That's how we're treated, that's how we're held accountable. On the other hand, we try to take the lead in our region when it comes to the quality and development of care."
> *Representative health insurer (1)*

After the adoption of Solvency II, health insurers – like banks – increasingly focused on risk management. Although respondents indicate that Solvency II mainly had consequences for health insurers' internal organization, healthcare organizations were also affected.

*Managing mutual debts and speeding up invoicing*

The financial transactions that take place between health insurers and healthcare organizations consist of invoices and prepayments. Specifically, healthcare organizations charge for healthcare services and health insurers pay these charges. Owing to the lengthy contracting and slow invoicing processes[6], however, health insurers furnish advance payment, allowing healthcare organizations to continue delivering care. This system results in a jumble of mutual debts that take years to settle.

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[6] Healthcare organizations can only invoice for services after the care episode has ended. This can take more than a year.

The delay in debt settlement results in financial risks that have become especially critical under the Solvency II regime. If a healthcare organization is in debt to a health insurer, the latter must reserve capital (solvency capital requirements) to cover the risk of default. To ensure better oversight of who is in debt to whom and for how much, health insurers increasingly deploy systems to monitor mutual debts. This requires an enormous effort from both health insurers and healthcare organizations and has shifted the focus in interactions between them to directly available financial information.

Having a better grasp of mutual debts allows health insurers to anticipate financial risks, periodically adjust the prepayment amounts and intervene when healthcare organizations deliver care in excess of their contracts.

> "Standard policy is that if all goes well, we monitor. And the second the contract ceiling is reached, we stop paying. Of course, we may have a conversation about the delivery of extra care and extended contracting. That sometimes leads to extra contracting, and sometimes not [...] So we've developed a whole contracting administration system that registers all the agreements with healthcare providers in detail."
> *Representative health insurer (2)*

Health insurers thus started to expedite payment and urged healthcare organizations to speed up invoicing.

## Consequences for healthcare organizations

Healthcare organizations were obliged to respond to the measures taken by banks and health insurers. Healthcare executives indicate that banks and health insurers put pressure on them to furnish information on both the financial and governance aspects of their organization. Executives feel growing pressure to account for themselves with their financial stakeholders, even though they do not always understand the reasons for certain requirements.

Healthcare organizations were also urged to professionalize their financial departments and accountability practices. New job titles were created, such as internal account managers, auditors and sales managers, to draft financial prognoses for business plans and financial reports and to negotiate with health insurers. With health insurers urging them to speed up invoicing, healthcare organizations also invested in IT and support services. Many organizations professionalized their financial administration and boosted their liquidity positions. As with banks and health insurers, these changes increasingly steered healthcare organizations towards financial risk management.

To deal with this new “reality”, some executives say that they act strategically to establish trust relationships with their financial stakeholders. Trust is conditional, however, healthcare organizations can earn it if they perform well financially, adhere to financial ratios and share the same vision. This has its perks: organizations that show longer periods of financial stability and have “earned” the trust of banks and health insurers have better access to capital or multi-annual contracts. Other executives are more resistant. They try, for example, to evade the influence of banks by actively seeking alternative investors to spread their own financial risk or find allies and media outlets with which to share their discomfort with the insurers’ negotiating practices.

## Interactions

There are two situations in which the interests of banks, health insurers and healthcare organizations clash or converge owing to the strategies they deploy to cope with financial risk. The first is when the actions of banks affect the negotiating position of healthcare organizations vis-à-vis health insurers. The second is when all three parties align their interests in a multi-annual contract.

### *Credit loans and negotiating positions*

After Basel III, banks re-assessed not only their outstanding long-term loans but also their short-term credit facilities. They set limits on and increased provision rates for unused credit to reduce their risk. These moves met with resistance from healthcare organizations, however.

> "There is huge resistance from healthcare organizations. They say: 'We want to keep that credit facility. Our backs are against the wall if we can't come to an agreement with health insurers. And then we'll have to sign a contract that we disagree with because otherwise we can't pay salaries next month.'"
> *Representative bank (1)*

This example illustrates how the interests of banks, health insurers and healthcare organizations interact and conflict. Health insurers only want to pay for services that are delivered (and preferably invoiced); they do not want to bear the financial risk for undelivered services. Banks do not want the credit facility to be used to cover the expenses of the healthcare organization that could have been paid from income provided by health insurers. Finally, as the quote shows, healthcare organizations use the credit facility as a buffer during negotiations with health insurers. By setting stricter limits on credit facilities, banks might indirectly weaken the negotiating position of healthcare organizations vis-à-vis health insurers.

*Multi-annual contracts*

Multi-annual contracts are a topic of interest for banks, health insurers and healthcare organizations alike. All three benefit from such contracts in terms of risk containment or role fulfilment. Banks aim to mitigate financial risk and often furnish capital under the condition that healthcare organizations sign a multi-annual contract with health insurers. Both banks and healthcare organizations then have a guaranteed income for the term of the contract and are assured that long-term and short-term liabilities are covered. For health insurers, multi-annual contracts provide an opportunity to fulfil their national orchestrating role. Such contracts often see health insurers stipulating that healthcare organizations must re-organize and reduce their services, the idea being that this will lower overall healthcare costs. Such contracts appear to offer certainty, with parties sharing and allocating financial risks.

Although banks push for multi-annual contracts, health insurers say that only the healthcare organizations and health insurers are contracting parties and contracts are only concluded when the conditions are met, and mutual trust is established. Now that “downsizing” is an increasingly important factor in these contracts, banks have become more critical of them. They argue that scaling back activities may damage the business operations of healthcare organizations and thus hurt banks too, since healthcare organizations will earn less, jeopardizing their financial obligations towards banks and posing a new financial risk.

> “Let me put it this way. Agreements about downsizing have an impact on the business case and existing financing. We provided financing based on a certain estimated output. If that decreases, then we must decide together whether we should restructure the loan, because less income means fewer repayments on loans and lower interest obligations. So, we sit down together, which isn’t always fun.”
> *Representative bank (3)*

Criticisms notwithstanding, in many cases multi-annual contracts have allowed the interests of banks, health insurers and healthcare organizations to converge by giving them a common purpose with individual benefits.

## Discussion and conclusion

Informed by institutional theory we show how institutional arenas come about through both the long-term efforts of institutional agents and unpredictable implications of economic and societal crises. As others (e.g., Bacharach et al., 1996; Luong and Weinthal, 2004; Deruelle and Engeli, 2021) have also shown, exogenous shocks and incremental changes can be intertwined as agents make sense of, reflect on and translate the implications of crises and stepwise transformations into emergent practices. Moreover, the institutional change perspective helped interpret how reforms and crises shaped roles, practices and interactions between healthcare organizations and their financial stakeholders in the Netherlands.

In the new arrangements that emerged, banks and health insurers took on new roles and responsibilities as critical partners or purchasers of care. This had implications for their relations vis-à-vis healthcare organizations. Banks became increasingly proactive and changed loan procedures unilaterally by requiring business plans, imposing stricter loan requirements, forming consortiums and valuing real estate. They also demanded more financial information and sought more contact with healthcare organizations. Health insurers, in turn, struggled with their new dual role: on the one hand, they had become a financial organization; on the other, they had a role in society in ensuring access to and affordability of care. They tightened up their monitoring and accountability practices, started tracking mutual debts meticulously and expedited the invoicing cycle. The new practices imposed on healthcare organizations required internal adjustments. Since banks and health insurers increasingly based their decisions on financial information, healthcare organizations had to invest in new data and invoicing systems and expand their support services. They were forced to learn more about finances to deliver the required information, draft a business plan and speak the language of banks and health insurers.

The increased focus on mitigating and shifting financial risks by banks, health insurers and consequently healthcare organizations started with the introduction of regulated competition and was further amplified by the financial crisis and the following regulatory frameworks. Managing financial risks became an important topic in the boardrooms of all three actors. For healthcare organizations, this was however a new phenomenon, one which they had to adapt to. Besides, dependence on banks and health insurers for the survival of healthcare organizations also increased. Healthcare executives were challenged to, in line with regulated competition, act as entrepreneurs (Van der Scheer, 2007), which became challenging because of restrictions on access to capital by banks and health insurers.

While Basel III and Solvency II were developed specifically for banking and insurance, they also impact other sectors. Both are currently subject to revision or already revised. How new rules are shaped on a global or European level has consequences for local healthcare organizations. Beck (1992) has argued that organizing processes in an attempt to control risk produces new risks. These ideas resonate with economists who warn of risk-shifting mechanisms arising from regulation: regulation does not eliminate financial risks in a system but shifts them onto “shadow banks” and then further down the system (Van Poll, 2017). We observed the same behavior in our study, with banks in particular trying to shift financial risks onto healthcare organizations in their contracts.

The focus on risk management and efforts by banks, health insurers and healthcare organizations to minimize their own risk also resonates with literature on risk work (Horlick-Jones, 2005; Gale et al., 2016). This perspective provides an interesting alternative lens for future research into the sociological dynamics between financial institutions and healthcare. We observed, for instance, different forms of risk work that include the interpretation of risks, negotiation of risk ownership, risk monitoring, risk containment, risk shifting and risk-sharing behavior. We have also seen that banks and health insurers mainly focus on maintaining and protecting one’s own (financial) position. These actions complement already existing forms of risk work (Gale et al., 2016; Labelle and Rouleau, 2016) and might provide new insights.

Our results invite discussion on the involvement of private parties in a sector with important public goals and the organization of healthcare systems in general. The relationship between banks, health insurers and healthcare organizations is not static but dynamic; it is constantly being renegotiated, reworked and translated into the financial practices of the healthcare sector. This requires constant reflection on the role and practices of private parties in healthcare and what effect these have on the societal mission of healthcare organizations. It is essential that the relationship between banks, health insurers and healthcare organizations is in balance. As mentioned, some healthcare organizations are seeking alternative ways to raise capital to lessen their dependence on banks. Such actions may indicate that the power balance is skewed. Stadhouders et al. (2023) conclude the same when they show that a better financial position of healthcare organizations not necessarily leads to a more advantageous interest margin. As our study shows, the organization of healthcare systems remains a complex matter in which the top-down implementation of reforms and frameworks influence the roles and behaviors of actors, while simultaneously, the day-to-day practices of the various stakeholders also affect the state of the system and influence its sustainability.

# Chapter III

## Power, legitimacy and urgency: Unravelling the relationship between Dutch healthcare organizations and their financial stakeholders

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## Abstract

Healthcare organizations rely on their financial stakeholders for capital to invest in state-of-the-art buildings, equipment, innovation and the delivery of healthcare services. Nevertheless, relations between healthcare organizations and their financial stakeholders have not been well studied. Here, we studied the relations between Dutch healthcare organizations and two of their main financial stakeholders (banks and health insurers) against the backdrop of system reforms and the financial crisis. We conducted a survey of healthcare executives to evaluate their relations with banks and health insurers in terms of power, legitimacy and urgency. These three attributes are based on the salience model of Mitchell et al. (1997). We further tested for differences in power, legitimacy and urgency across organizational sector and size. The results showed that healthcare organizations value banks as legitimate stakeholders with a well-demarcated influence and a clear-cut function. The relationship with health insurers is more complex. Healthcare organizations experience considerable influence from health insurers but question the legitimacy of their claims. Since health insurers play a crucial role in the Dutch healthcare system, these findings question the workability of the relationship between healthcare organizations and health insurers and the position of health insurers in the overall healthcare sector. Our results are relevant to countries with public-private health systems and contribute to the development of the salience model by showing the individual value of stakeholder attributes and the relevance of context.

## Introduction

Financial stakeholders such as health insurers, governments, other third-party payers and capital providers are crucial partners for healthcare organizations. Their commitment to healthcare organizations provides financial stability and guarantees the continued existence of the organization and the continued delivery of healthcare services. Financial stakeholders also provide opportunities for building, exploiting and renovating healthcare facilities, as well as funding medical equipment and large innovation projects. They can also influence the course and strategy of organizations through contracts and purchasing conditions. In this paper, we distinguish two types of financial stakeholders: those that purchase healthcare services and act as third-party payers and those that provide long-term capital (e.g., private parties, banks and public-private partnerships).

Over the last decade, the dependence between healthcare organizations and financial stakeholders in many Western European countries has become more complex and diffuse because of (1) health policy changes, which have encouraged competition in healthcare, and (2) the 2007 financial crisis, which has influenced how financial stakeholders (and indirectly healthcare organizations) perceive risk. The health policy changes that occurred in the early 2000s created competition between providers of care and health insurers (Cutler, 2002; Maarse, 2006). Governments implemented "business-like" and "market-oriented" models that placed more focus on performance indicators, accountability and control systems, and risk management in the healthcare sector (Van Erp et al., 2018; Simonet, 2011). The healthcare organizations' financial affairs and relationships with financial stakeholders became an important focal point for all concerned in the healthcare sector.

In the years following the 2007 financial crisis, European healthcare organizations encountered difficulties gaining access to capital since capital expenditure is affected by financial crises (HOPE, 2011; OECD, 2018). Governments adopted austerity policies aimed at reducing healthcare budgets (Quaglio et al., 2013; Mladovsky et al., 2012; Stadhouders et al., 2019). Institutions such as banks and (health) insurers faced stricter capital regulations from international and European supervising authorities. The Basel III regulation for banks and Solvency II regulation for (health) insurers influenced the conditions under which capital was provided, creating stringent loan conditions for healthcare organizations and shifting the focus of both banks and health insurers towards risk management (Colla et al., 2015; Janssen, 2017). These developments, derived from the financial crisis, created obstacles to getting capital and affected financial stakeholders' perceptions of healthcare organizations.

In light of these developments, role perceptions have changed and the relations between healthcare organizations and financial stakeholders have reshaped and redeveloped. A deeper understanding of the dynamics of these complex relations is necessary to revisit roles, interdependencies and ways of collaborating. Changing relations between healthcare organizations and their financial stakeholders have not been well studied, despite their importance for the functioning of individual healthcare organizations and the healthcare system as a whole. To address this gap, we have used stakeholder theory, particularly the salience model developed by Mitchell et al. (1997), to disentangle the relations between healthcare organizations and their financial stakeholders. This model enables us to analyze how executives of healthcare organizations value and prioritize stakeholders based on three attributes: power, legitimacy and urgency. Although the salience model intends to identify all stakeholders and then compare them to their relative salience, we have followed the approach of Magness (2008) and apply the model to two types of stakeholders.

Based on the relevance of financial stakeholders for healthcare organizations and the salience model, our research question was: *How do healthcare organizations value their financial stakeholders in terms of power, legitimacy and urgency and what does that value tell us about their mutual dependence?* We also discuss how this affects the functioning of the healthcare system. We investigated Dutch healthcare organizations that were subjected to healthcare reforms towards regulated competition in 2006 and to the consequences of the 2007 financial crisis. We especially focus on their relations with two financial stakeholders: health insurers as purchasers of care and banks as providers of capital.

In this paper, we first explain the setting and tasks of Dutch banks, health insurers and healthcare organizations. Then we provide our theoretical framework, which elaborates on the salience model. In the methods section, we describe our survey of healthcare executives after which we present our results. Finally, we conclude and discuss the implications of our work.

## Setting the stage: The role of financial stakeholders in Dutch healthcare

This section explains the role of banks and health insurers in Dutch healthcare, and the shifting dependencies between banks, health insurers and healthcare organizations. An essential difference between these financial stakeholders is that banks take on a more distant role from healthcare organizations than health insurers, who have a legally assigned role within the sector, do.

### Banks

In the Netherlands, the banking sector provides both long-term loans and short-term credit to healthcare organizations to meet capital needs. Long-term loans are mainly used to finance real estate, renovations to buildings and facilities and to fund innovation projects and programs for new equipment (e.g., IT, medical). Short-term credit is used to pay daily expenses, wages and suppliers.

Five banks are involved in the Dutch healthcare sector; these are either commercial banks (i.e., ABN AMRO Bank, ING Bank, Rabobank) or public sector banks (i.e., BNG Bank and NWB Bank). The healthcare sector comprises about five percent of the total loans provided by Dutch monetary financial institutions (DNB, 2020).

Since the introduction of regulated competition in 2006 and the deregulation of governmental healthcare real-estate policies in 2008, Dutch healthcare organizations are responsible for their own financial stability and real estate (Enthoven and Van de Ven, 2007). This break with the previous risk-free policy – which based financing of real estate on subsequent funding by the government – has considerably affected the relations between banks and healthcare organizations. It has raised barriers to accessing capital for healthcare organizations and has made the financing of healthcare real estate more uncertain and riskier for both healthcare organizations and their capital providers (Huisman et al., 2020; Kroneman et al., 2016; Van der Voordt, 2016; Van der Zwart et al., 2010). Banks have been affected by stricter regulations (Basel III) induced by the financial crisis. This affected loan conditions, making healthcare organizations increasingly reliant on their financial stakeholders (Janssen, 2017).

## Health insurers

Since the introduction of regulated competition in 2006, Dutch health insurers, including former public sickness funds and private insurers, consolidated into 23 competing health insurers that operate under ten concerns (2018). The four largest insurance concerns (Achmea, VGZ, CZ and Menzis) have a total market share of 86.5% (NZa, 2018). Dutch health insurers operate in regulated competition in two markets: the health insurance market and the health purchasing market (Enthoven and Van de Ven, 2007). In the health insurance market, health insurers offer annual health plans to Dutch citizens, who are obliged to select one. In the health purchasing market, health insurers annually negotiate on price, quantity and quality of services with healthcare providers (Maarse et al., 2016). In practice, these markets are interrelated; they depend on each other as the health plans offered to citizens are based on the negotiations for healthcare services.

Contracting healthcare services is one of the main tasks of health insurers. Health insurers contract healthcare services included in the Health Insurance Act (in Dutch: *Zorgverzekeringswet*). In practice, this means that health insurers contract all services provided in hospital care, mental healthcare and primary care and some services in nursing care, homecare and well-being (NHW), and disability care. This last group of healthcare organizations also closes contracts with regional procurement offices and municipalities for other services. The contracts with health insurers only entail a smaller part of their total revenue.

The contracting process is crucial for health insurers to fulfil their legal obligation to provide healthcare for the insured ("duty of care"). However, this can be a stringent process. Not only do health insurers find it difficult to negotiate on quality of care (Stolper et al., 2019), there are also powerful bargaining positions at play that hamper the finalization of contracts and prolong the process (Halbersma et al., 2011; Schut and Varkevisser, 2017). This already indicates a complex relation between health insurers and healthcare organizations.

## Theoretical framework: Stakeholder theory and the salience model

Clarkson defines stakeholders as "voluntary and involuntary risk bearers" (Clarkson, 1994). Both banks and health insurers place voluntary stakes and resources in healthcare organizations, whose activities put them at risk. For banks, the stakes and resources at risk are capital investments and short-term credit availability. For health insurers, the stakes and resources at risk concern outsourcing their legal responsibility to provide care for the insured by contracting healthcare services.

To better understand the relations between healthcare organizations and banks and between healthcare organizations and health insurers, we use the salience model developed by Mitchell et al. (1997) (Figure 2). This model has two functions: it identifies and values stakeholders and describes how salient managers are to these stakeholders. Mitchell et al. define salience as "the degree to which managers give priority to competing stakeholder claims" (1997, p. 854). Salience has three essential stakeholder attributes: power, legitimacy and urgency. To determine overall salience, managers rate these three attributes for each stakeholder. Thus, besides offering a typology of stakeholders, the model reveals the power, legitimacy and urgency of the stakeholder–manager relationship. Combined, the stakeholder attributes represent different types of stakeholders depending on the presence of either one, two, or three attributes.

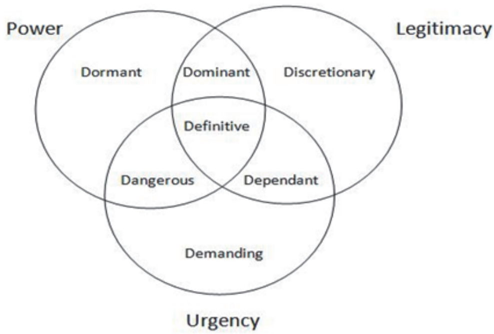


**Figure 2.** Salience model as proposed by Mitchell et al. (1997).

Mitchell et al. defined the three stakeholder attributes as follows (1997, p. 869): power "as a relationship among social actors in which one social actor (A) can get another social actor (B) to do something that B would not have done otherwise"; legitimacy "as a generalized perception or assumption that the actions of an entity are desirable, proper, or appropriate in some socially constructed system of norms, values, beliefs and definitions" (Neville et al., 2011); and urgency "as the degree to which stakeholder claims call for immediate attention." For the power attribute, the overall role of the stakeholder is emphasized, while for legitimacy and urgency the focus is on the actions and claims of that specific stakeholder (Neville et al., 2011; Eesly and Lenox, 2006). The main idea behind the model is that the more attributes a stakeholder can employ, the more salient managers will be towards that stakeholder. Over the years, several studies have confirmed the reliability of the model (Eesley and Lenox, 2006; Agle et al., 1999; Gago and Antolin, 2004; Gifford, 2010; Guerci and Shani, 2013; Knox and Gruar, 2007;

Magness, 2008; Parent and Deephouse, 2007; Ryan and Schneider, 2003; Su et al., 2009; Thijssens et al., 2015).

However, there is also criticism. The two main criticisms relevant to this study involve the discrepancy between the method to calculate the degree of stakeholder attributes (on a continuum) and the stakeholder typology (binary), and the lack of context included in the model. The first criticism (Neville et al., 2011; Zimmerman and Zeitz, 2002) relates to the discrepancy between a model that assumes attributes to be either present or absent and measuring them on a Likert scale continuum (Agle et al., 1999). We argue that interpreting stakeholder attributes and typology involves normative judgements, whether a Likert scale or a threshold is used. This is, for example, reflected in the names assigned to the different types of stakeholders (Figure 2). Results should be interpreted in relation to the context that stakeholders operate in and should be relative to all stakeholders. Therefore, we adopt a rather flexible interpretation of stakeholder typology in contrast to some other authors.

The above argument aligns with the second criticism on the model: its lack of context (Neville et al., 2011). Mitchell et al. (1997) acknowledged that stakeholder relationships are dynamic, can change over time and can be different in certain situations. However, they do not incorporate this in their model, thereby possibly overlooking important aspects of the relationship between managers and stakeholders. Some authors have tried to incorporate context (Agle et al., 1999; Parent and Deephouse, 2007; Jones et al., 2007; Pfarrer et al., 2008) with no or limited success. We attempt to incorporate context here by looking for differences in outcomes across sectors and in size of the organization. We added questions on the influence of stakeholders on certain governance areas and interpreted our results in the context of stakeholder roles. This partly resolves the absence of context in the salience model and explains why certain attributes are valued lower or higher than others. Accordingly, we do not consider stakeholder attributes as static and fixed, but rather as a reflection of the institutional context.

To our knowledge, the model has not been applied in the healthcare setting before. It provides a new point of view in healthcare research, taking the perspective of healthcare organizations in their relations with vital financial stakeholders, thereby enabling us to better understand this relation. This research also further develops the salience model. Although management literature on the model has focused on salience, we show that its three attributes are informative and insightful both individually and together. We apply the stakeholder attributes in the broadest sense, using them to gain a deeper understanding of the relations between healthcare organizations, banks and health insurers, and thus giving insight into the dependencies between actors and the characteristics of their relations in context.

## Material and methods

### Survey questions

We conducted a survey of healthcare executives to answer the research question. The questions on stakeholder attributes were based on the operationalization of the salience model proposed by several authors (Mitchell et al., 1997; Agle et al., 1999; Guerci and Shani, 2013). We altered the question on legitimacy as suggested by Neville et al. (2011). Other questions in the survey explicated the power attribute in terms of influence on several governance areas of the healthcare organization. There were also general questions on respondents and their organization. To minimize confusion, the bank was specified as the primary bank (in Dutch: *huisbankier*) and the health insurer as the one with whom respondents closed the largest contract for 2018[7]. Four executives from different sectors tested the survey for clarity and validity. Agle et al. demonstrated the reliability and validity of the model (1999, p. 514) and the questions they proposed and tested form the basis of our survey. We also performed a reliability test for the composition of salience for banks (Cronbach's

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[7] A complete overview of the survey questions can be found online in the article's supplementary material. See: https://doi.org/10.1016/j.healthpol.2021.05.002

Alpha=0.605[8]) and health insurers (Cronbach's Alpha=0.595[9]). Outcomes were slightly higher when legitimacy was deleted as an attribute for salience (respectively 0.746 and 0.714).

## Respondents and their organization

Healthcare executives were chosen as the most suitable respondents to evaluate and value relations with banks and health insurers on behalf of the healthcare organization. Executives are often in touch with both financial stakeholders. They have regular meetings with the bank on financial issues and lead the negotiations with the health insurer over healthcare services.

To reach respondents, the survey was sent out in collaboration with the Dutch Association of Healthcare Executives (in Dutch: *NVZD*) at the beginning of 2019. The NVZD is a professional association representing executives in the Dutch healthcare sector. In total, 714 members received an invitation, and 308 (43%) respondents began the survey. The exact number of Dutch healthcare executives is not known. The NVZD claim that they represent two-thirds of all Dutch healthcare executives (NVZD, 2019)[10].

Respondents were informed about the goal and background of the study. We excluded respondents from analysis if their organization was not a healthcare organization (n=1), their main funder was not a bank or if they had no relations with a health insurer (n=6). Some executives were only excluded from questions regarding the health insurer because they indicated that they had no contract with health insurers (n=31). Ultimately, 269 (38%) respondents completed the survey.

Information on participating healthcare executives and their organizations is displayed in Table 3. Based on the organizational size of the primary care sector, we believe that this dataset mainly contains regional GP

[8] Reverse-coded for legitimacy attribute.
[9] Reverse-coded for legitimacy attribute.
[10] Source not publicly accessible. Document is available from the corresponding author on request.

organizations, out-of-hours cooperatives and/or care groups[11]. Overall, characteristics of healthcare executives and their organizations are convincingly representative of the sector as they are similar to available information of the NVZD on their members (NVZD, 2019) and to previous studies of Dutch healthcare executives (Bijloos et al., 2017; Van der Scheer, 2013; Postma and Roos, 2016). Therefore, results from our study population can likely be generalized to the total population of Dutch healthcare executives.

**Table 3.** Respondents and their organization.

| | | No. | Percentage/Mean |
|---|---|---|---|
| Age | | | 55 years (sd=5.71) |
| Years of experience | | | 9 years (sd=6.93) |
| Gender | Male | 168 | 62.5% |
| | Female | 101 | 37.5% |
| Board composition | One-person board | 126 | 46.8% |
| | Multi-headed board, CFO | 83 | 30.9% |
| | Multi-headed board, not CFO | 60 | 22.3% |
| Healthcare sector | Hospitals | 55 | 20.4% |
| | Mental healthcare | 47 | 17.5% |
| | Nursing care, homecare and well-being (NHW) | 79 | 29.4% |
| | Disability care | 35 | 13.0% |
| | Primary care | 19 | 7.1% |
| | Combination[12] | 34 | 12.6% |
| Size of the organization[13] | Less than €15 million | 51 | 19% |
| | €15–50 million | 70 | 26% |
| | €51–100 million | 39 | 14.5% |
| | €101–150 million | 36 | 13.4% |
| | €151–200 million | 25 | 9.3% |
| | More than €200 million | 48 | 17.8% |

[11] A cross table of organizational sector and size can be found online in the article's supplementary material. See: https://doi.org/10.1016/j.healthpol.2021.05.002
[12] When respondents (healthcare executives) stated that their organization offered several types of care, these were placed under 'combination'. The most frequent combinations concern mental healthcare combined with disabled care; NHW combined with hospitals; NHW combined with disabled care.
[13] Based on the annual revenue in 2018

## Analysis

The purpose of this research is to analyze information on the three main stakeholder attributes and possible differences across organizational sector and size. This was done in a descriptive and in-depth way, making use of SPSS and contextual information.

The three attributes were checked for outliers, but no outliers had a significant influence on the results. Legitimacy had no outliers at all, indicating that healthcare executives have a shared view regarding this attribute. Salience was calculated as the average of all attributes weighted equally. This is in line with earlier research that found a positive relation between the cumulative stakeholder attributes and salience (Agle et al., 1999, p. 518; Guerci and Shani, 2013, p. 520).

To assess possible differences in stakeholder attributes across organizational sector and size, we merged some of the categories of these variables. Size was reconstructed for a better distribution and new sector variables were created in accordance with the conventional Dutch sector classification. We then performed a one-way ANOVA and Tukey post-hoc test. The test was in line with assumptions of an approximately normal distribution, homogeneity of variances (using Levene's test and the Brown–Forsythe test if assumption of homogeneity was violated) and independence of samples.

# Results

## Stakeholder attributes

Figure 3 shows the mean outcomes of stakeholder attributes and salience as perceived by healthcare executives. The outcomes of the stakeholder attributes were reversed for banks and health insurers, which led to a difference in salience. For banks, power (n=294; sd=2.46) and urgency (n=296; sd=2.47) were perceived relatively low by healthcare executives compared with health insurers. The legitimacy (n=296; sd=1.45) attribute of banks, however, was relatively high. The opposite was the case for health insurers, where power (n=253; sd=1.78) and urgency (n=253; sd=2.00) were relatively high and legitimacy (n=254; sd=1.72) was relatively low. The overall outcome for salience showed a relative higher score for health insurers compared with banks.

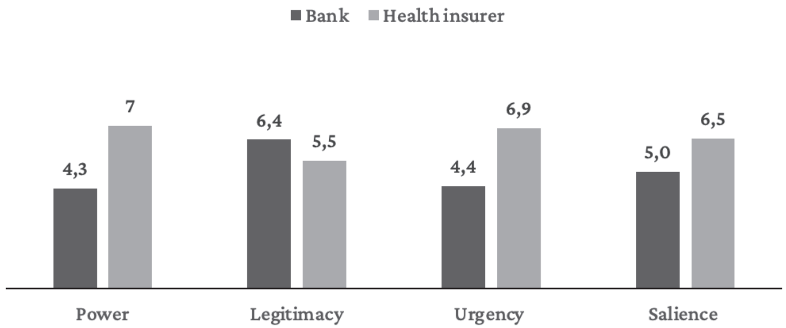


**Figure 3.** Healthcare executives' perceptions of mean stakeholder attributes and salience of banks and health insurers.

## The exercise of power

There is a considerable difference between banks and health insurers regarding the power attribute (4.3 vs. 7.0). To decompose this attribute and discover where influence is exercised, respondents were asked to indicate the degree of influence on certain governance areas within the organization (Figure 4).

Healthcare executives reported that banks mainly influenced real estate and housing (n=126; 43.7%), investments (n=109; 37.9%) and finance (n=107; 37.2%) whereas health insurers influenced every aspect of the healthcare organization. Notable were quality of care (n=125; 49.8%), strategy (n=137; 60.2%) and finance (n=183; 72.9%) – where the perceived influence of health insurers was considerably higher than that of banks.

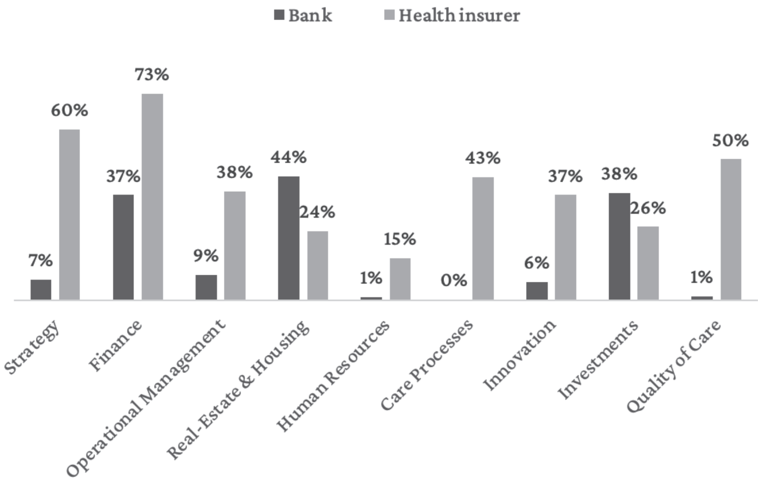


**Figure 4.** Healthcare executives' perceptions of the (very) high influence (%) that banks and health insurers have on governance areas in the healthcare organization.

## Stakeholder attributes across sectors and size

For each stakeholder attribute, the differences in outcomes were compared across organizational sector and size. Table 4 reports the significant differences based on one-way ANOVA and Tukey post-hoc tests. Significant differences ($p<0.05$) for banks were found between types of healthcare organizations on the power attribute ($F(5263)=4.395$, $p=0.001$) and between different-sized healthcare organizations regarding the power attribute ($F(5263)=6.518$, $p=0.001$) and urgency attribute ($F(5263)=4.749$, $p=0.001$). Significant differences ($p<0.05$) for health insurers were found between types of healthcare organizations on the power attribute ($F(5233)=2.446$, $p=0.035$), the legitimacy attribute ($F_{asymp}=2.706$, $df1=5$, $df2=128.48$, $p=0.023$) and the urgency attribute ($F_{asymp}=4.884$, $df1=5$, $df2=189.931$, $p=0.001$).

The distinction between groups across sector and size account for contextual factors that are generally overlooked by the salience model. Therefore, the results presented in Table 4 contribute to the understanding and interpretation of the stakeholder attributes.

**Table 4.** Significant differences between groups for banks and health insurers.

| Banks (n=288) | Attribute | Sector and Size | Mean | Sector and Size | Mean | P-value |
|---|---|---|---|---|---|---|
| Sector | Power | Primary care | 2.53 | Hospitals | 5.04 | .001 |
| | | | | Mental Healthcare | 4.68 | .013 |
| | | | | Combination | 4.94 | .007 |
| Size | Power | EUR < 15 million | 3.55 | EUR 151 – 200 million | 5.44 | .014 |
| | | | | EUR > 200 million | 5.13 | .012 |
| | | EUR 15 – 50 million | 3.36 | EUR 51 – 100 million | 4.74 | .040 |
| | | | | EUR 101 – 150 million | 4.97 | .012 |
| | | | | EUR 151 – 200 million | 5.44 | .002 |
| | | | | EUR > 200 million | 5.13 | .001 |
| | Urgency | EUR < 15 million | 3.63 | EUR 151 – 200 million | 5.40 | .036 |
| | | | | EUR > 200 million | 5.15 | .025 |
| | | EUR 15 – 50 million | 3.64 | EUR 151-200 million | 5.40 | .025 |
| | | | | EUR > 200 million | 5.15 | .014 |
| **Health Insurers (n=251)** | **Attribute** | **Sector** | **Mean** | **Sector** | **Mean** | **P-value** |
| Sector | Power | Mental healthcare | 7.61 | Disability care | 6.17 | .032 |
| | Legitimacy | Primary care | 4.58 | Disability care | 6.38 | .007 |
| | Urgency | Nursing care, homecare and well-being (NHW) | 6.42 | Mental healthcare | 7.64 | .034 |
| | | | | Primary care | 8.16 | .008 |
| | | Primary care | 8.16 | Disability care | 6.25 | .019 |

The results for banks show that smaller (< €50 million) healthcare organizations experience both the influence of banks and the ability of banks to pressure claims significantly differently compared with larger (>€151 million) healthcare organizations. The perceived differences for banks between primary care and hospitals, mental healthcare and combined healthcare organizations might be related to differences in size. The included primary care organizations all have an annual revenue below €50 million, while hospitals, mental healthcare and combined healthcare organizations have greater revenues[14].

Health insurers are valued significantly differently across sectors, particularly across disability care, primary care and the mental healthcare sectors. Executives working in disability care value health insurers significantly differently than executives in mental healthcare do in terms of power, than executives in primary care do in terms of legitimacy, and than executives in NHW and primary care do in terms of urgency. Primary care experiences significantly different degrees of legitimacy and urgency than disability care and NHW do. The mental healthcare sector stood out on the power and urgency attributes.

## Discussion

This research tried to unravel the relationship between Dutch healthcare organizations and two crucial financial stakeholders: banks and health insurers. Our use of the salience model – interpreting results by taking contextual factors into account and by contrasting two financial stakeholders – made it possible to explore the relations in depth using data from a large group of respondents. The first part of the research question focused on the healthcare executives' valuation of the relationship in terms of power, legitimacy and urgency. The results showed that healthcare executives experienced more influence by health insurers than by banks. However, the claims of banks are perceived to be more legitimate than those of health insurers, while the claims of health insurers are more pressing. The results on the salience attribute indicate that healthcare executives prioritize the claims of health insurers over the claims of banks. Furthermore, banks have a clear-cut interest in certain areas of the organization, which makes them an unambiguous stakeholder. The influence of health insurers is more diverse and diffuse. Based on the stakeholder typology of the salience model (Figure 2) and considering the relative outcomes and context, healthcare

[14] A cross table of organizational sector and size can be found online in the article's supplementary material. See: https://doi.org/10.1016/j.healthpol.2021.05.002

executives perceive banks as “discretionary” stakeholders and health insurers as “dangerous” stakeholders.

For the valuation of banks, organizational size is a contextual factor that matters. Banks invest more capital in larger organizations, therefore interdependencies increase, and more financial risks are at stake. It is likely that banks will exercise relatively more power on larger healthcare organizations and pressure their claims accordingly (e.g., through increased monitoring).

For the valuation of health insurers, we found significant differences between sectors, indicating that sector-specific circumstances are at stake. For instance, the mental healthcare sector not only faced major reforms on the payment structure but also dealt with ongoing struggles regarding reimbursement practices (Janssen, 2017). Regional GP organizations, out-of-hours cooperatives and care groups employ GPs who are open about their dissatisfaction with health insurers, which is in line with our finding on significantly lower legitimacy (Schut and Varkevisser, 2017). In regard to other sectors, differences might be related to the share of health insurer contracts on the total revenue of the organizations.

The second part of the research question aimed to determine perceived interdependencies between healthcare organizations and financial stakeholders in relation to the overall healthcare system. Several implications can be drawn from our results, starting with the bank and followed by the health insurer. The outcomes suggest that banks are accepted, credible and appreciated stakeholders. Despite the increased dependency and complexity of the relationship after healthcare reforms and regulations (Basel III) were introduced, banks have been able to secure an acknowledged position. This might be explained by their somewhat distant role in the sector and their single focus on financial governance areas. Banks also possess a thorough knowledge of financial issues that is often not present in healthcare organizations, and they barely mingle with other strategic domains. The role, interests and expertise of banks are clear and demarcated, and their authority seems undisputed.

The position of health insurers in relation to healthcare organizations proved to be more complex. Health insurers have a legal obligation to negotiate the price, quantity and quality of healthcare services with healthcare organizations. In line with this, our study shows that health insurers exert a great deal of influence on healthcare organizations that covers both financial aspects and substantive topics (e.g., quality of care). However, healthcare executives are questioning the desirability and appropriateness of this legal obligation. A lack of legitimacy will in most cases obstruct interactions between health insurers and healthcare organizations – as suggested by others (Stolper et al., 2019; Halbersma et al., 2011; Schut and Varkevisser, 2017). Altogether, such impediments make negotiations an unsatisfying process from the perspective of healthcare organizations.

Although this study focuses on healthcare systems in the Netherlands, these outcomes are relevant for other countries as well, especially those with healthcare systems that include private investors, public–private partnerships and health insurers. In an international context, our study shows that one should be careful in assuming a workable and satisfied relationship between healthcare organizations and their financial stakeholders. It is possible that there are underlying obstacles in place that impede a good relationship, which in turn affect the practices of healthcare organizations. In Western Europe, the cost and demand for healthcare is increasing, and dependencies between healthcare organizations and their financial stakeholders will increase simultaneously. Raising awareness of relations between financial stakeholders and healthcare organizations and acknowledging the claims and roles of the other party are the minimum requirements for finding solutions. Good relations will prove equally important.

## Strengths and limitations

A strength of this study is that the salience model has not been applied to the healthcare setting before. This study has added to the salience model by showing that all three attributes contain relevant in-depth information in themselves and are therefore individually important. This research has also shown that context and setting are important aspects when interpreting the results of the salience model. We also argued that stakeholder typology requires a normative interpretation of stakeholder attributes and what type of stakeholder is faced. Future research should take these points into consideration.

Our study has limitations, especially concerning the survey. It might be possible that multiple executives working for the same organization are members of the NVZD and have filled in the survey. We believe that this is not very plausible because executives are more likely to consult with one of their board members on who completes a time-consuming survey. Another difficulty might be that our use of legitimacy as “desirable and appropriate” contains two different aspects. We believe both terms together refer to a situation that is “ideal” or “should be” and are not mutually exclusive. They complement each other in the construction of legitimacy by adding a moral characteristic as proposed by Neville et al. (2011). Nevertheless, it could be wise to separate these terms in future surveys or to choose one of the two terms. Finally, additional questions might have provided more specific information on the stakeholders, such as the type of bank (i.e., public or private sector) and the share of health insurer contracts on the total annual revenue.

This research focused on the perceived value of financial stakeholders by healthcare organizations. However, it did not show how these relations work in practice and how relations are formed and maintained. Furthermore, this study focused on one perspective: that of healthcare executives as representatives of healthcare organizations. We cannot draw conclusions on how financial stakeholders value their relationship with healthcare organizations. For future research, it would be interesting to involve more perspectives and to study how relations between healthcare organizations and health insurers can move on to a sustainable and fruitful partnership, since much depends on it.

## Conclusion and recommendations

Given the mutual dependency between healthcare organizations and their financial stakeholders, it is important to research the complexity of their relationship. The position and role of banks, health insurers and healthcare organizations in the Dutch healthcare system are crucial for the quality of the collaboration and for finding a balance between experienced power, legitimacy and urgency.

The results show that the role of health insurers in the Netherlands is under pressure. Despite their crucial role in the system, it is questioned whether insurers have sufficient support among healthcare executives. Two recent studies (Groenewegen et al., 2019; Maarse and Jeurissen, 2019) have illustrated the danger of low trust in health insurers from the perspective of the insured. Here we show a different threat: the workability of the healthcare system when healthcare executives do not accept health insurers as parties with a legitimate claim. This highlights a broader legitimacy issue for health insurers to resolve on both the health purchasing market and the health insurance market.

To transcend this issue, the discussion should move beyond the question of whether health insurers fulfil their legal task correctly. Instead, the discussion should focus on the quality of the collaboration between health insurers and healthcare organizations. In everyday practice, both parties need to come to agreements. This proves difficult in a situation where at least one party does not accept the claims and actions of the other. It is therefore important that healthcare organizations and health insurers come to a shared understanding on their future collaboration and strategy based on a long-term shared vision. We already see some examples of this in the Netherlands, where several health insurers and healthcare organizations have signed long-term contracts. These contracts include agreements for future developments based on common goals. Another Dutch example, in which long-term partnerships are formed, is the development of regional visions. Here, health insurers and healthcare providers work together to make healthcare future-proof for certain challenging regions. It is plausible that such initiatives lead to a better collaboration and valuation between health insurers and healthcare organizations. But, most importantly, healthcare organizations and health insurers should develop trust, mutual appreciation and a willingness to cooperate to make healthcare work.

# Chapter IV

## For better or worse: Governing healthcare organizations in times of financial distress

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# Abstract

Due to processes of financialization, financial parties increasingly penetrate the healthcare domain and determine under which conditions care is delivered. Their influence becomes especially visible when healthcare organizations face financial distress. By zooming-in on two of such cases, we come to know more about the considerations, motives and actions of financial parties in healthcare. In this research, we were able to examine the social dynamics between healthcare executives, banks and health insurers involved in a Dutch hospital and mental healthcare organization on the verge of bankruptcy. Informed by interviews, document analysis and translation theory, we reconstructed the motives and strategies of executives, banks and health insurers and show how they play a crucial role in decision-making processes surrounding the survival or downfall of healthcare organizations. While parties are bound by legislation and company procedures, the outcome of financial distress can still be influenced. Much depends on how executives are perceived by financial stakeholders and how they deal with threats of destabilization of the network. We further draw attention to the consequences of financialization processes on the practices of healthcare organizations in financial distress.

# Introduction

Healthcare organizations in financial distress[15] are in a contentious and uncertain situation that may lead to restructuring, acquisition, closure or bankruptcy and initiate a lengthy period of turmoil and stress for those directly affected: patients, local communities, nursing staff, medical staff, managers, other employees, executives, suppliers and investors (Dent, 2003; Pescosolido et al., 1999; Stewart, 2019). These stakeholders see their continuity of care, employment and/or income endangered (Holmes et al., 2006; Pescosolido et al., 1999). Moreover, because healthcare organizations are embedded in local communities and bear societal meaning (Kirouac-Fram, 2010; Moon and Brown, 2001; Stewart, 2019), financial distress affects these communities and draws media attention, public outrage and political involvement (Brown, 2003; Thomson et al., 2008).

Researchers have looked closely at the experiences of patients, medical staff, managers and local communities undergoing processes of financial distress. These actors often try to protect the future of endangered healthcare organizations but are not mandated to take part in negotiations and have little formal influence (Brown, 2003; Haas et al., 2001; Kirouac-Fram, 2010). What earlier studies lack is empirical evidence concerning the crucial roles, interests, interactions and practices of actors involved in decision-making in periods of financial distress, such as financial stakeholders, healthcare providers or governments. This is not surprising, as decision-making typically occurs behind closed doors and in the background of media-covered public outrage. We had a unique opportunity to analyze two Dutch healthcare organizations in financial distress and focus on the dynamics between healthcare executives and their most important financial stakeholders. In the Netherlands, these are banks (for long- and short-term financing) and health insurers (the main purchasers of care and responsible for guaranteeing access for patients). The increased dependency of a healthcare organizations' survival on financial parties and the growing

[15] The term financial distress refers to the process in which an organization is (or is becoming) financially unstable and faces difficulty in fulfilling its obligations to creditors and other stakeholders (Sun et al., 2014).

influence of banks and health insurers on how care is organized and where it takes place, is a process that especially took off after the introduction of regulated competition in Dutch healthcare and the financial crisis (Van Dijk et al., 2023). This process, often described as “financialization” (Engelen, 2008; Van der Zwan, 2014), is not bound to the Netherlands, but also takes place in other countries and leads to the adoption of financial language, instruments and structures in healthcare. This often results in the preference for decisions and policies that lower costs and quantifiable risks over other values in healthcare. In the end, it not only influences the allocation and organization of care but also the daily practices of those working in the healthcare sector (Cordilha, 2021; Horton, 2022; Vural, 2017).

In this article, we provide insights into the underlying practices of financial stakeholders in healthcare, how they relate to the sector and try to influence other healthcare parties and how and where care services are delivered. We examined the roles, interdependencies, interactions and strategies of banks, health insurers and executives to better understand why healthcare organizations did or did not survive times of financial distress. We asked the following research question: *How do healthcare executives, banks and health insurers negotiate the future of healthcare organizations in times of financial distress?*

Our analysis is informed by translation theory (Callon, 1986), allowing us to dissect the work invested in networks of actors with a shared purpose. Thereby helping us to show how (a) financial distress is made visible; and (b) alliances to manage and resolve financial distress are forged (or not). This approach is relevant in two ways. First, we contribute to the literature on healthcare organizations in financial distress by providing a constructivist view on a topic that is often examined in a one-dimensional way and from an economic perspective (e.g., predictors and effects). This is in line with a recent call made by Fraser et al. (2019) and Jones et al. (2019) for more sociological research on service changes and its complex and politicized decision-making. The potential closure of healthcare organizations due to bankruptcy is such a service change and while the focus of both authors is mostly centered around decision-making by governments, we broaden the scope by opening up room for other important actors who have a say in the closure of healthcare organizations, such as financial stakeholders. This is especially relevant for healthcare systems that have introduced market mechanisms as steering instruments or privatized healthcare services (Cabiedes and Guillén, 2001; Light, 2001; Maarse, 2006).

Second, this research also contributes to literature on financialization and the limited knowledge we have of the (changing) roles that financial parties play in healthcare (Engelen, 2008; Sowada et al., 2020; Van der Zwan, 2014; Van Dijk et al., 2021). While financial parties increasingly penetrate the healthcare domain, it is important to understand how they operate and influence the layout of the healthcare landscape, health service changes and the daily practices of those working in healthcare. By zooming-in on healthcare organizations in the midst of financial distress, we come to know more about the actions of financial stakeholders. In the near future, dependency on financial stakeholders will most likely further increase, due to the COVID-19 pandemic, staff shortages and energy crisis that have increased costs and put financial strains on healthcare organizations (Kruse and Jeurissen, 2020). With our research, we reveal what happens behind closed doors and where there is room for influence and negotiations in cases of financial instability within healthcare organizations.

## Financial distress and bankruptcies in a financialized healthcare system

It is in times of financial distress that the growing influence of financial parties on healthcare becomes especially foregrounded. This is when banks and health insurers are able to outweigh financial arguments over other arguments that are present. With this research we bring together two streams of literature: on the one hand that on financialization and on the other literature on financial distress and bankruptcies in healthcare.

Financialization refers to the "increasing dominance of financial actors, markets, practices, measurements and narratives, resulting in a structural transformation of economies, firms, States and households" (Aalbers, 2019). Meaning that the logic previously belonging to financial specialists becomes ingrained in healthcare practices and an important driver for decision-making (Engelen et al., 2014). By adopting financial instruments, language, techniques, goals and structures, financialization has caused an institutional shift towards a financial regime in healthcare. This new regime requires its own financial expertise, working culture, new infrastructures and job positions. Financialization has introduced concepts such as financial risks by adopting forms of debt financing and led to a new perspective on healthcare services as financial products (Appelbaum and Batt, 2021; Benoît, 2023; Cordilha, 2021; Hunter and Murray, 2019; Mosciaro et al., 2022; Vural, 2017). Processes of financialization are observed in many different countries, with different health systems ranging from public to private and everything in between.

Financialization is often an unnoticed and insidious process. It takes time and many capital investments before financial parties have gained prominence and are able to change the course of healthcare (Cordilha, 2021). However, when healthcare organizations are facing financial hardship, relations and dependencies become crystal clear. Financial parties then have an obvious say in the future of healthcare organizations, where care is delivered and to whom. This is a situation that often leads to much resistance and efforts of concerned actors trying to influence the process and outcome of healthcare organizations dealing with financial distress. Medical specialists, patients and their families, managers and the "public" often mobilize resistance (Barnett and Barnett, 2003; Brown, 2003; Dent, 2003; Kirouac-Fram, 2010; Oborn, 2008; Pescosolido et al., 1999; Stewart, 2019) and may, for example, use media outlets to frame and reshape the narrative and influence public opinion (Haas et al., 2001; Hutter, 2019; Moon and Brown, 2001; Thomson et al., 2008). Their resistance often stems from a concern about deteriorating healthcare services and the desire to participate in healthcare decision-making (Abelson, 2001; Goyder, 1999; Stewart et al., 2020).

Although these groups may have some influence on the outcomes of financial distress processes, they are hardly in a position to turn the tide. The mandate to “close” or “restructure” a healthcare organization in (mostly) public financed healthcare systems often resides with the state and is part of a government policy of retrenching and deinstitutionalizing the healthcare sector (Daniels et al., 2013; Fredriksson et al., 2019; Lepnurm and Lepnurm, 2001; Lorne et al., 2019; Williams et al., 2021). Financialization has left its mark in these countries as well, and financial parties play an important, although somewhat hidden, role (Cordilha, 2021). In healthcare systems with private elements, such as the Netherlands, private parties have a more up-front role and healthcare organizations themselves are responsible for their finances (Maarse, 2006). Thereby being heavily depended on their financial parties.

By combining insights from both strands of literature, we can understand why financial parties have penetrated the organization of healthcare and how these parties negotiate over the survival of healthcare organizations. Thus, deciding on the future landscape of healthcare.

## Actor dynamics in translation theory

Previous research on financial distress and bankruptcies in healthcare can be best divided into three main strands. The first focuses on (community) resistance, and some of these conclusions are described in the previous paragraph. The other two strands emphasize either the predictors of and explanations for financial distress (e.g., Holmes et al., 2017; Kaufman et al., 2016; Lindrooth et al., 2018; Yarbrough and Landry, 2009) or the diverse effects of a bankruptcy or closure, for example, on patient welfare, access to care and unemployment (e.g., Buchmueller et al., 2006; Crandall et al., 2016; Holmes et al., 2006; Lindrooth et al., 2003; Lui, et al., 2001). Here we focus on the considerations, motives and actions of the decision-making parties. To better understand the interactions and negotiation dynamics between the responsible parties and their differing interests and interdependencies, we make use of translation theory.

Translation theory encompasses all negotiations, efforts and acts of persuasion that actors employ to forge a network with others to accomplish a certain goal. It follows the development of these new relationships and how certain actors seek to move others. This approach particularly helps to draw attention to the strategic and emotional (dis)positions and (inter)actions of actors under political, societal and temporal pressure (Callon, 1986). It provides a deeper understanding of the interactions between actors, with networks as places where negotiation and persuasion takes place and decision-making is an intricate process. In other words, being embedded in a broader constructivist epistemology, translation theory offers an interpretive lens through which to make sense of the iterative and formative process that unfolds when healthcare organizations face financial distress.

Translation theory was first coined by Callon in 1986 and elaborated by others to study actor relations and interactions (Czarniawska and Sevón, 1996, 2005; Wæraas and Nielsen, 2016). The theory is practice-oriented (Freeman, 2009) and applied in various fields, including healthcare. It assumes that interaction between actors takes place in networks in which knowledge, problems, objectives and stakes are continuously articulated, managed and changed to contribute to a common goal and mobilize collective action. The goal can vary, for example, harmonizing international auditing standards (Mennicken, 2008), customizing a national electronic patient record (Petrakaki and Klecun, 2015) or adapting HPV vaccinations (Paul, 2016). To create and maintain networks, those involved must continuously translate interests (Callon, 1986; Latour, 1984, 1987), an uncertain and complex process that is hard work.

Callon (1986) distinguishes four stages of translation: problematization, interessement, enrollment and mobilization. Problematization refers to the work an actor invests in defining a problem that needs to be solved with the help of others. By framing the problem so that it becomes attractive—or rather necessary for other parties to act and join the network—the initiator aligns their goal with the interests of other stakeholders. During the stages of interessement and enrollment, the initiator tries to convince others that it is their problem too and subsequently articulates specific roles for those involved. Interessement and enrollment are closely connected; successful interessement leads automatically to the enrollment of stakeholders in the network, each with their specific roles, goals and interests. As the network grows, enrolled stakeholders can define and redefine problems, roles and stakes through acts of translation. The constant maintenance work needed to get actors to adhere to their role and envisaged actions is referred to as mobilization. It ensures the stability of the network and role-fulfilment of stakeholders, especially because networks can be (temporarily) endangered by actors that reject or redefine problem-definitions or enrollment. Stakeholders can commit treason and abandon common goals, translation can fail and networks disentangle (Callon, 1986; Greener, 2006). Translation is thus an ongoing process in which networks are continuously stabilizing and destabilizing.

Translation theory helps to understand the behavior of (financial) parties that have penetrated healthcare. It reveals the dynamics between them and other pivotal stakeholders and the actions required to form a network of like-minded people who share the same goal: to save the healthcare organization in financial distress.

## Methods

Processes of financialization are no exception for the Netherlands and especially banks and health insurers have grown in influence over the past decade (Van Dijk et al., 2023). To better understand how their roles manifest in healthcare, we focus on two cases of financial distress. It is during such a social phenomenon, that the capital investments of banks and the purchasing power of health insurers are at stake and their influence in the organization of care becomes especially visible.

## Case selection

To select cases, and since healthcare organizations in financial distress are largely unpublicized, we searched for news articles that reported on or hinted at financial instability among healthcare organizations. We specifically searched for cases with differing outcomes (bankruptcy vs. successful reorganization), as we expected this would provide different insights. We selected several potential organizations and, making use of the extensive network of the third and fourth authors, contacted board members directly to explain the goal of our research. Being able to contact potential respondents personally helped gain their trust and cooperation. We approached three executives in this way, and two agreed to participate. The organization that declined did not want to jeopardize their relationship with banks and health insurers by recalling past events. The participating executives reached out to the spokespersons of their respective banks and health insurers and asked for their cooperation. We provided documents explaining the research goals and procedure and were available for questions. All parties ultimately agreed to participate, giving us a unique opportunity to access key stakeholders involved in a financial distress process.

## Data collection

Between March and July 2021, we interviewed executives, supervisory board members, financial managers, chief medical staff, representatives of the banks' special accounts unit, account managers working for health insurers, trustees and financial advisors. After securing informed consent, we interviewed 21 respondents: 9 associated with the hospital and 12 with the mental healthcare organization. The first author was present during all interviews and the second author participated in four. Interviews lasted from 60 to 120 minutes.

To prepare the interviews, the first author compiled an extensive timeline of events preceding and during the period of financial distress for both healthcare organizations, based on public information found online (such as annual reports, newspaper articles and trustee reports), and internal information obtained from the selected healthcare organizations (such as internal presentations and memos). During the interviews, we used open questions and asked respondents to reconstruct events depicted in the timeline and describe their experiences, motivations and actions. The data gathered during interviews was used to constantly update and inform both the timeline and subsequent interviews. All interviews were recorded and transcribed verbatim. We received ethical approval from the Research Ethics Review Committee of the Erasmus School of Health Policy and Management (20–31 Van Dijk).

### Data analysis

Data was analyzed iteratively and informed by the literature on financial distress and translation theory. This abductive approach allowed us to go back-and-forth between conceptual and empirical analysis and connect the two. The first and second authors (open-) coded the interviews individually, followed by comparison of codes and further analysis. All authors met several times to discuss the analysis and triangulate data. At the outset of our analysis, we identified the dispositions, underlying values and strategies of relevant actors. We subsequently linked these themes to the four stages of translation (Callon, 1986) allowing for a more dynamic understanding of stakeholder involvement and the outcomes of financial distress processes.

We assigned pseudonyms to the involved healthcare organizations, banks, health insurance companies and respondents. We further presented one of the final drafts to all respondents for a member-check. Except for some minor comments about the traceability of our cases and our interpretation of the role of the medical staff at the hospital (all resolved in the final version), respondents indicated that they agreed with our analysis.

## Results

Below, we introduce our cases and describe what preceded the financial problems. We then reconstruct how healthcare executives made financial distress visible and how a network of actors was (or was not) constructed to save the organizations from bankruptcy.

## Case descriptions

To understand our cases, it is important to take note of policy changes in the Dutch context that promoted financialization processes and affected healthcare organizations in financial distress and their relation vis-à-vis financial parties. Until 2006, healthcare organizations were regulated by government, which also decided on bailouts or closures. Regulated competition was introduced in that year and healthcare organizations became responsible for their own business operations. Government withdrew guarantees for building expenses, interests and repayments (Van de Zwart et al., 2010) and dissolved regulatory agencies that decided on infrastructure, such as the Board for Healthcare Facilities (in Dutch: *College Bouw Zorginstellingen*)[16]. Banks remained the principal capital providers, offering long-term loans for the construction, renovation and maintenance of property and short-term loans for monthly payments such as salaries and supplies. Health insurers became the principal purchasers of care, negotiating annually with healthcare organizations over price, quantity and (increasingly) quality of healthcare services. They were named national orchestrators of care and instructed to reduce overall healthcare costs (Kamerstukken II 2003/04; Noort et al., 2021), in line with subsequent administrative agreements[17].

Despite government's apparent withdrawal after the introduction of market mechanisms, it still coordinates some tasks and responsibilities of healthcare organizations and health insurers through laws and regulations. The most prominent example is the "duty of care" imposed on health insurers making them legally responsible for ensuring access to continued,

[16] The Board for Healthcare Facilities was an independent regulatory agency responsible for the infrastructure of healthcare organizations and for regulating the construction and acquisition of healthcare properties. The agency was dissolved between 2006 and 2008.

[17] Since 2012, the Ministry of Health and relevant stakeholders have drawn up administrative agreements setting a ceiling for increases in healthcare expenditure. Spending in excess of the ceiling can be reclaimed from individual healthcare organizations.

timely and high-quality care for their insured. Consequently, when a healthcare organization in financial distress is facing bankruptcy and there is no other healthcare organization in the region that can reasonably deliver timely care to health insurers' clients there, then the health insurers are obliged to help that organization stay afloat (NZa, 2020).

The policy changes introduced after 2006, changed relations and instantly made banks and health insurers crucial stakeholders for healthcare organizations, especially in periods of financial distress.

*Hillside Mental Health*

Hillside Mental Health's financial problems began back in 1996 and 1999, when the mental healthcare organization obtained land at a high-end location and its board announced plans to transform the original building. These plans were rejected by the Board for Healthcare Facilities. New plans were delayed for many years because local residents objected to having a mental healthcare organization in their neighborhood and the municipal government was divided. In the meantime, the organization agreed to rent an alternative location and signed a 10-year lease in 2009. 2010 was a turbulent year for the organization. Its work council objected to a proposed merger and won legal proceedings. The executive resigned and was replaced by an interim executive. Construction of the new care facility began; 11 years after the initial land purchase. Three years later, the organization moved into the brand-new building under the supervision of yet another new executive. In 2011, however, the Ministry of Health and field parties had agreed to deinstitutionalize mental healthcare, leading to a reduction in "beds" in favor of ambulatory health services (VWS, 2012). This was problematic for the organization, because their contract with the bank was based on a different business case. The new building was now too big and the organization's income no longer covered expenses. As a result, it entered a state of financial distress.

*General West Hospital*

The financial problems of General West Hospital can be traced to the policy change in 2006. The move towards regulated competition never seemed to get going in the organization, and the transition from having pre-determined budgets to being a "risk-bearing enterprise" negotiating with health insurers was impeded for several reasons. From 2011 onwards, the organization received compensation budgets from government to allow it to take full responsibility for its own property. Although this budget was gradually phased out and ended in 2016, it gave the organization a false sense of security. Without a professional team leading its negotiations with health insurers, it agreed on organizational growth in return for lower prices. This proved unfavorable when the growth never materialized and the organization received less income than expected. A lengthy contracting and expense claim process also meant that health insurers overpaid the organization for several years, leading to a cumulative debt of €45 million to be repaid starting in 2016. All in all, the organization suffered considerable losses in 2017.

## Problematization: Making financial distress visible

In our two cases, the "discovery" of financial distress started with a hunch, a feeling that something was off. It went hand in hand with a change in management and required considerable effort to make visible. For example, when a new executive, George Wilford, began at General West Hospital in 2017, his predecessor recommended running the numbers again because "things were not going well". George did so and discovered that the organization was heading towards a deficit. At Hillside Mental Health, successive executives were aware of financial troubles but failed to resolve them as deficits mounted. When Owen Hackett joined the organization in 2012 as new executive, he was informed about (some) financial problems, but it took some time to fully discover its severity.

Once George Wilford and Owen Hackett became aware of the deteriorating financial situation, they launched an investigation and talked to their financial managers, supervisory board and other personnel to trace the causes of the distress. They also identified necessary actors to involve, most importantly banks and health insurers as sources of financing. To gain their support, both George and Owen problematized the situation in such a way that banks and health insurers were induced to help. As the next quotes reveal, they did so in their own way.

> "In September, I visited all health insurers to explain why they had to raise prices. However, if I had only told them that I wanted prices raised, they would have asked me what I was going to do in return. So, I told them that I would implement value-based healthcare, which would eventually decrease volume. The health insurers thought that was a good idea. [...] Why value-based healthcare? That was extremely opportunistic back then."
> *George Wilford, healthcare executive of General West Hospital*

> "My strategy was to tell the account managers of Goldleaf Bank that they'd paid 30 million for an air bubble. Which was my problem now. So, my question was: 'how are we going to solve that together?'"
> *Owen Hackett, healthcare executive of Hillside Mental Health*

George Wilford, the executive of General West Hospital turned to the health insurer, of which Agora Insurance was the most important since they had closed the largest contract together. George argued for a switch to value-based healthcare, something health insurers were keen to introduce given the long-term effects on volumes. He thus approached Agora Insurance as a strategic negotiating partner and promised a win-win situation. Owen Hackett, the executive of Hillside Mental Health framed the issue differently. He turned to Goldleaf Bank, their primary bank, and argued that the unfavorable financial contract had been agreed with the preceding executive. He framed the bank as sharing responsibility for Hillside Mental Health's financial problems. Owen Hackett thereby absolved himself and his organization from the financial troubles and sought to gain a new commitment from the bank to solve the problems together.

In the problematization phase (Callon, 1986), George Wilford and Owen Hackett thus had to make an effort discovering impending financial troubles and making financial stakeholders aware of their problems in the hope of convincing them to save the organization and guarantee its future. Both become aware that they rely heavily on financial parties and try to acknowledge insurers and banks as strategic partners (Cordilha, 2021). In the case of General West Hospital, George Wilford presented an attractive future that aligned with the insurers' interests, whereas Owen Hackett, the executive of Hillside Mental Health held Goldleaf Bank accountable for the organization's situation. While feeling depended on financial parties, the executives also try to maintain their agency in a highly uncertain situation. They are still able to decide who to inform about what and how as they hold all information.

## Interessement and enrollment: Involving banks

Once Owen Hackett and George Wilford disclosed the financial problems of the organizations to the regular account managers of their primary banks, Goldleaf Bank and Optimum Bank, respectively, and relations instantly changed. Regular account managers were replaced by special accounts; a unit specializing in organizations in financial distress. The special accounts unit of Goldleaf bank was represented by Adam Miller and William Vaughn, that of Optimum Bank by James Abbot and Robert Edwards. Their activities are heavily formalized and bound by the approval of a credit committee. Special account managers consider different scenarios for each of their financially distressed cases and adapt their strategy based on the most-likely outcome. The unit has two specialized divisions: restructuring and recovery.

> "Standard procedure is that organizations are first assigned to the restructuring division. The idea is to get a handle on the situation: How big is the problem? Is it solvable? [...] If we think that bankruptcy is imminent, then the organization enters recovery."
> *James Abbot, special account manager at Optimum Bank*

While the goals of the restructuring unit and the healthcare organization initially align (making the organization profitable again), the goal of recovery is to limit the bank's financial losses at the cost of the healthcare organization's survival.

Banks follow their own procedures regarding healthcare organizations in financial distress. The special account managers set the requirements for their enrollment in the network, form a counterforce and challenge the executive's control over the network. The enrollment of the special account managers depends on how they assess the severity and solvability of the healthcare organization's financial problems. To make this assessment, James Abbot, Robert Edwards, Adam Miller and William Vaughn, gather information and draft a situation report detailing the organization's background, financial problems, causes, potential ways of making the organization viable, and what that will require from the bank in terms of financial arrangements.

In determining the feasibility of potential financial solutions, special account managers also depend on the involvement of another actor: the health insurer. James, Robert, Adam and William (and George Wilford and Owen Hackett) want the insurers' long-term commitment to the healthcare organization, often materialized in multi-annual contracts.

> "We have loans with a payback period of five or ten years. Sometimes even longer. Health insurers conclude one-year contracts, so next year things can change. That's difficult for us, because the healthcare organization only repays part of the loan in a year. We want to know what health insurers and healthcare organizations will agree for the next two to ten years. That's where we try to negotiate."
> *James Abbot, special account manager at Optimum Bank*

It also works the other way around: health insurers want banks to act, alleviate financial pressure and make new financial agreements. In that process, health insurers and banks increasingly seek each other out and negotiate finances while also re-problematizing the issue at stake and reshaping their enrollment. At this stage, the healthcare executives are reduced to linking pins and it is increasingly difficult for them to control potential allies. Despite this changing role, it is possible for George Wilford, the executive of General West Hospital to organize a meeting with James Abbot and Robert Edwards from Optimum Bank and representatives of Agora Insurance: Rowan Murphy and Sarah Meyers.

> "I brought Optimum Bank and Agora Insurance together. Initially the bank said, 'The health insurer finances, so they have to solve the financial issues'. That was basically its story. The health insurer said: 'We're not a bank, we're not allowed to provide capital. That's the bank's job'. They brandished all sorts of rules and stuck to their guns. We had two meetings. I sat there listening, but I didn't mind, I thought, 'Let them do their thing, they'll notice soon enough that this won't solve anything'. And at a certain point I said, 'Guys, this isn't going to work. I'll make a proposal and I expect both of you to agree with it.'"
> *George Wilford, healthcare executive of General West Hospital*

George was able to bring the (special) account managers of Optimum Bank and Agora Insurance together and broaden the interpretation of their roles, eventually getting James Abbot and Robert Edwards to agree to alleviate financial pressure and re-finance loans.

The disposition of Goldleaf Bank in the Hillside Mental Health case was different. Instead of a commitment, Adam Miller and William Vaughn distanced themselves from the organization's financial problems and refused to share responsibility, as the executive had wanted.

> "I was naïve to think that we could solve it together with Goldleaf Bank and Securago. We were all facing the same problem and I imagined that we could talk it through. Well, I was wrong. I remember one of the first conversations I had with the special account unit, I told them, 'We need to come out on the other end together.' They replied: 'Mister Hackett, there is no "together" here, this is your problem.'"
> *Owen Hackett, healthcare executive of Hillside Mental Health*

## Interessement and enrollment: Involving health insurers

Once account managers of Agora Insurance had learnt of General West Hospital's financial distress, they called in their procurement team, senior management and financial units. Securago, the health insurer with whom Hillside Mental Health had closed their largest contract, alerted a staff member especially appointed to deal with financially distressed organizations.

Like banks, the account managers of health insurers investigate the severity of the financial distress, its causes and possible solutions. This fact-finding serves to legitimize their decision to assist or refuse the healthcare organization. The enrollment of Agora Insurance and Securago depends, however, on one question only: can they fulfil their “duty of care”? The account managers thus focus on whether the organization in financial distress is crucial to the provision of care in the region. In the case of General West Hospital, that analysis was clear.

> “That was a no-brainer. General West Hospital is very important in a region where we have a market share of more than fifty percent. It was immediately clear to us that if the hospital went bankrupt, there would be a huge “duty of care” problem.”
> *Rowan Murphy, account manager at Agora Insurance*

The enrollment of Rowan Murphy and Sarah Meyers, representing Agora Insurance in General West Hospital’s network was guaranteed by their legal obligations. Their eagerness to find a structural solution also served another goal. Bounded by administrative agreements, health insurers must attempt to lower healthcare costs, which is a major challenge. When Rowan Murphy and Sarah Meyers help financially distressed healthcare organizations, they find themselves with more leverage to control healthcare expenditure.

> “We’ve been able to bring about huge transformations and long-term sustainability in hospitals with financial problems. They are then more dependent and we can set conditions for purchasing care. Insurers have agreed, under the administrative agreements, to halt the growth of healthcare expenditure. A multi-annual contract means we can include “downsizing” and transition pathways in financial agreements.”
> *Lillian Walker, manager at Agora Insurance*

Rowan Murphy and Sarah Meyers are enrolled in General West Hospital’s network as it was in their interest to do so. They agreed on a multi-annual contract[18] with George Wilford, stipulating additional financial compensation for the costs of transition. Rowan and Sarah not only expressed their trust in the organization by committing to the hospital for 4 years, but also extended their role from a mere “purchaser of care” to an “orchestrator of care” and provider of capital. The contract gave General West Hospital financial certainty for several years, while Agora Insurance could lower healthcare costs under the administrative agreement. Optimum Bank also benefitted because it gained more assurance about the repayment of loans. In return, it was willing to negotiate new financial agreements.

The situation for Hillside Mental Health was different. The care it offered could be delivered by other organizations. Account managers of Securago were therefore less inclined to aid the organization and support possible solutions. Although they recognized the mental healthcare organization for their excellent care and named them as preferred supplier, Securago did not sign up to any solutions and did not consult Goldleaf Bank. Instead, it restricted its role to that of “purchaser of care”. This illustrates how, in financialized healthcare systems, financial arguments can prevail over arguments regarding the quality of care (Cordilha, 2021; Engelen et al., 2014).

> “I kept my distance. We’re not a bank. You don’t come to us for a loan. You need to go to the bank for that. If you want something financed, visit the bank. And if the bank makes it difficult, tough - but don’t come to us.”
> *Ben Smith, account manager at Securago*

Ben Smith, representing Securago is clear: he is not legally bound to help the organization and specifically differentiates his role from that of Goldleaf Bank, with huge consequences for the organizations’ future.

[18] The multi-annual contract has both a financial and a substantive component. General West Hospital and the health insurer agreed to transform care, which should result in the “downsizing” of healthcare services. Services are either reallocated to primary care, reshaped in regional networks or deemed obsolete.

In conclusion, we have seen that in the interessement and enrollment phases (Callon, 1986), both executives asked their most important stakeholders to assume the role of partner and help save their organization by brainstorming, advising and making concessions on existing agreements. They tried to lock allies into certain roles, but (special) account managers of banks and health insurers did not easily go along with this. As financialization literature shows, financial parties take control and impose their logic onto healthcare organizations (Engelen et al., 2014). They followed their own procedures and considered their legislative boundaries, reframing the problem as a “duty of care” issue (health insurer) or a “restructuring/recovery” issue (bank). As a result, while banks and health insurers did enroll in the hospital’s network, they did not (or only in part) in the mental healthcare organizations.

## Mobilization: Successful and unsuccessful network stabilization

The subsequent period shows how negotiated roles and actions play out in practice. The hospital and mental healthcare organization draft an improvement plan, perceptions of transparency become an important issue and network stability is tested and (temporarily) endangered. The latter occurs in different forms, at different stages of the process and is caused by different actors. The outcome of such tests and threats often leads either to trust or to distrust among the network partners and to the stabilization or destabilization of the network.

General West Hospital drafted an improvement plan specifying how Optimum Bank and Agora Insurance would contribute to alleviating financial pressure on the organization. The plan also served as a tangible document that indirectly articulated the roles, expectations and required actions of all parties. After George Wilford presented the improvement plan, however, James Abbot and Robert Edwards, representing the interests of Optimum Bank, tested George by questioning whether he was the right person to execute the plan, given his lack of experience with organizations in financial distress. The supervisory board supported George as executive, who was allowed to stay. By expressing their doubt, James Abbot and Robert Edwards not only tested the executive but also his support in the broader organization, while simultaneously increasing the urgency of the situation. In response, George Wilford was more motivated than ever to successfully execute the plan.

Right from the start, George Wilford chose to be transparent on the financial numbers with his counterparts at Optimum Band and Agora Insurance to win their trust. The (special) account managers appreciated this and felt they could rely on George Wilford to provide correct information and to honor the agreements made.

> "When the healthcare organization falls short of projections, it's important to communicate about it, to indicate how they are going to improve. This calls for an open attitude. The problem is not when the organization deviates from the prognoses. The problem is when they do not communicate about it, when they do not intervene to reduce the damage. The bank is not scared by a profit warning, but we are scared by a profit warning without a plan to limit it or turn it around."
> *James Abbot, special account manager at Optimum Bank*

Eventually, the relationship between (special) account managers of Optimum Bank and Agora Insurance and George Wilford improved and even became amicable.

However, General West Hospital's network then faced another threat. In 2018, employees of the hospital and account managers of Agora Insurance worked closely on the agreements made in the multi-annual contract. Medical specialists had become an important ally in the practical implementation of transformative care and accompanying cost reduction. They joined the network and were involved in ongoing meetings with Rowan Murphy, Sarah Meyers, other managers and George Wilford; much progress was made on executing the multi-annual contract. However, at a certain point, George Wilford, Rowan Murphy, Sarah Meyers and the special account managers of Optimum Bank noticed the commitment of medical specialists fading. The contract stipulated that the hospital would generate a certain amount of money from the buyout of a medical group that would be fully privatized. However, the other medical groups disagreed with the terms of the privatization. The issue became so sensitive and relations between the medical specialists and George Wilford so fraught that the (special) account managers of Agora Insurance and Optimum Bank believed the collaboration and, therefore, the stability of the network were jeopardized.

After consulting James Abbot, Robert Edwards, Rowan Murphy and Sarah Meyers, George Wilford decided that the situation could not continue. They needed full commitment from the medical specialists and he organized a meeting to pressure medical staff to cooperate and honor the multi-annual contract, including the medical group's privatization.

> "We set up a meeting. I used the health insurer and bank to up the ante internally. I told the account managers of Agora Insurance, 'Don't sign [the multi-annual contract] yet, then they'll get nervous'. So, during the meeting, the special account managers of Optimum Bank, keeping a straight face, told the medical specialists how serious things were. The account managers of Agora Insurance did the same. Eventually medical staff said, 'We feel committed to contribute'. That meant we could sign the contract."
> *George Wilford, healthcare executive of General West Hospital*

This incident reveals just how committed James Abbot, Robert Edwards, Rowan Murphy, Sarah Meyers and George Wilford were to saving General West Hospital from a bankruptcy. They closed ranks to stand up to the medical specialists. It also showcases how George could take back some control in an uncertain situation by mobilizing his counterparts at the bank and health insurer to exert pressure on resistance from within the organization. Mutual trust grew and the network stabilized. Clear communication, close collaboration around the improvement plan, and the execution of a multi-annual contract with Agora Insurance had united the parties in a shared purpose.

Mobilization took a different course at Hillside Mental Health. Its improvement plan focused solely on measures the organization itself had to take, since Securago had not enrolled in the network and Goldleaf Bank only in part. Owen Hackett's actions were aimed at reorganizing care processes and improving the organization's image so that it would be more attractive and indispensable in the region. The hope was that Goldleaf Bank and Securago would be persuaded to join the network after all.

That hope was in vain. Instead, the organization's financial situation and the relationship between Owen Hackett and the special account managers of Goldleaf Bank worsened due to a lack of perceived transparency. From 2014 onwards, the organization got by month to month and juggled creditor positions to pay salaries. The financial manager, Nathan Larson, attempted to increase liquidity by speeding up the billing cycle. This had the desired effect but only for a short time, as liquidity eventually diminished again. Owen Hackett and Nathan Larson further endeavored to find allies elsewhere and include others in their network, such as the landlord of the rented building to ease contract conditions, parties interested in buying or renting the other property and neighboring healthcare organizations with which to merge. Some of these plans reached an advanced stage but eventually fell through because buyers/tenants feared the financial risks; Adam Miller and William Vaughn opposed deals or the landlord was unwilling to ease contract conditions. And so, new potential alliances failed.

Interestingly, Owen Hackett had a different style of communication than George Wilford, the executive of General West Hospital.

> "I went to Goldleaf Bank with the narrative that I was going to solve it. We did that for several years. Everybody was comfortable with that. Of course, the special account managers had questions. They thought I was a true optimist and said, 'How are you going to do that?' The other option was to tell them that we wouldn't make it if the situation continued, but I knew if I did that, I would get into trouble with the bank."
> *Owen Hackett, healthcare executive of Hillside Mental Health*

Adam Miller and William Vaughn perceived this as a lack of transparency; they felt that Owen Hackett and Nathan Larson were not being above board. The special account managers noted unmet promises, postponed meetings, missed deadlines for projections and financial reports and, once the reports arrived, frequent incorrect figures. These "soft" signals forced them to conclude that Owen Hackett had no control over the organization's financial management. They lost trust in the executive and increased the pressure, growing less willing to cooperate and even frustrating the healthcare organization by denying it extra liquidity while demanding repayments on long-term loans. The fragile state of the coalition also led Adam Miller and William Vaughn to attempt to replace Owen Hackett. The supervisory board of Hillside Mental Health, however, did not bend.

> "We found the situation so worrisome that we contacted the supervisory board. It's very rare for banks to do this. We do it sometimes, when we're concerned about the quality of the executive board."
> *William Vaughn, special account manager at Goldleaf Bank*

This threat marked a turning point in Goldleaf Bank's attitude, heralding the final steps towards complete alienation between them and Owen Hackett. The supervisory board's expression of faith meant that Owen Hackett could remain, but Adam Miller and William Vaughn added Arthur White to the team, a lawyer from the recovery department, making it clear that they would only be considering the banks interests from then on. They also increased the risk profile of the organization, reduced its credit facility (thereby limiting the organization's direct access to capital) and reserved capital for a possible loss on their loans. Arthur White further tracked the organization's monthly prognoses meticulously. In other words, he was now taking a potential bankruptcy seriously. Discussions grew pointed again, became personal and entrenched in anger and frustration. The special account managers began to log their exchanges with Owen Hackett in detail and compile a file, indicating complete distrust. They deployed their entire arsenal of measures, which more or less meant the dissolution of the already feeble coalition and disintegration of the relationship between them and Owen Hackett.

While stepping up the measures they took against the healthcare organization, William Vaughn and Arthur White also made a final attempt to involve Ben Smith from Securago and other creditors in discussing possible solutions. After this also failed, Owen Hackett made a final attempt: he found another potential buyer. William Vaughn and Arthur White attended the negotiations with this party and the stakes were higher than ever: it was Owen Hackett's final attempt to save Hillside Mental Health. The buyer only wanted to assume parts of the organization's debt, which would mean a loss for Goldleaf Bank. Both played hard to get; they had no common goal and there was no one to bring them together.

> "The buyer told us, 'Take it or leave it.' My partner from special account management and I wanted a time-out to have a sandwich. We were having lunch together and I asked, 'What are we going to lose on this deal?' We calculated the figure on the back of a cigar box. The loss would run to millions."
> *Arthur White, special account manager at Goldleaf Bank*

The acquisition failed and the special account managers of Goldleaf Bank decided to stop providing financial services to Hillside Mental Health. The fragile network was officially dissolved. Bankruptcy followed. The unstable and constantly changing network was unable to save the healthcare organization.

As we saw in both cases, the executives tried to stabilize the network in the mobilization phase (Callon, 1986) and execute plans to save the healthcare organization, with or without the help of the banks and health insurers. The commitment of financial parties was important for a good ending, although executives still had some agency left (Mosciaro et al., 2022). Executives had to deal with networks being tested and there was the constant threat of different actors becoming alienated. Eventually, this resulted in a stable network for General West Hospital, in which actors trusted one another, and in a destabilized network for Hillside Mental Health, governed by distrust (Figures 5 and 6 depict an overview of events).

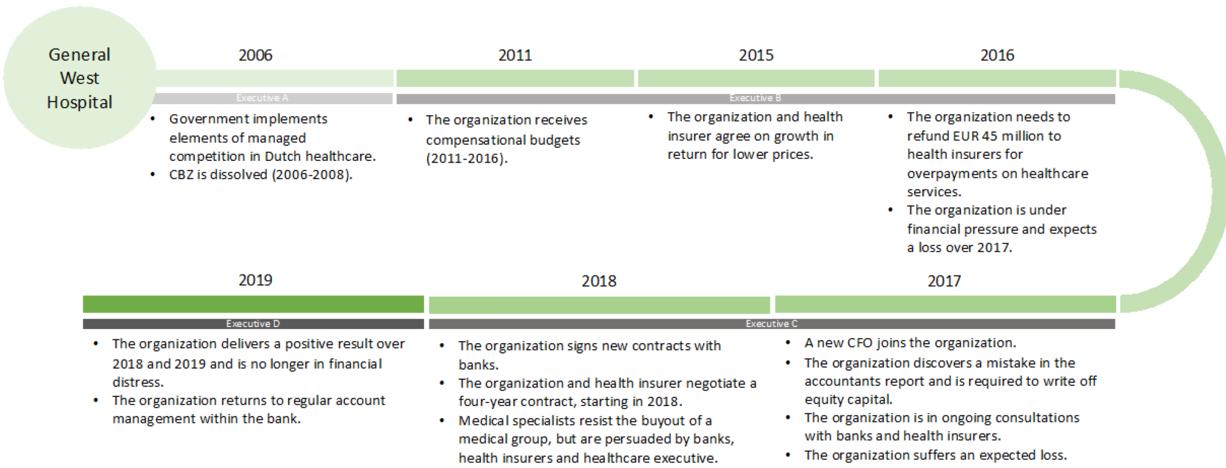


**Figure 5.** Timeline General West Hospital.

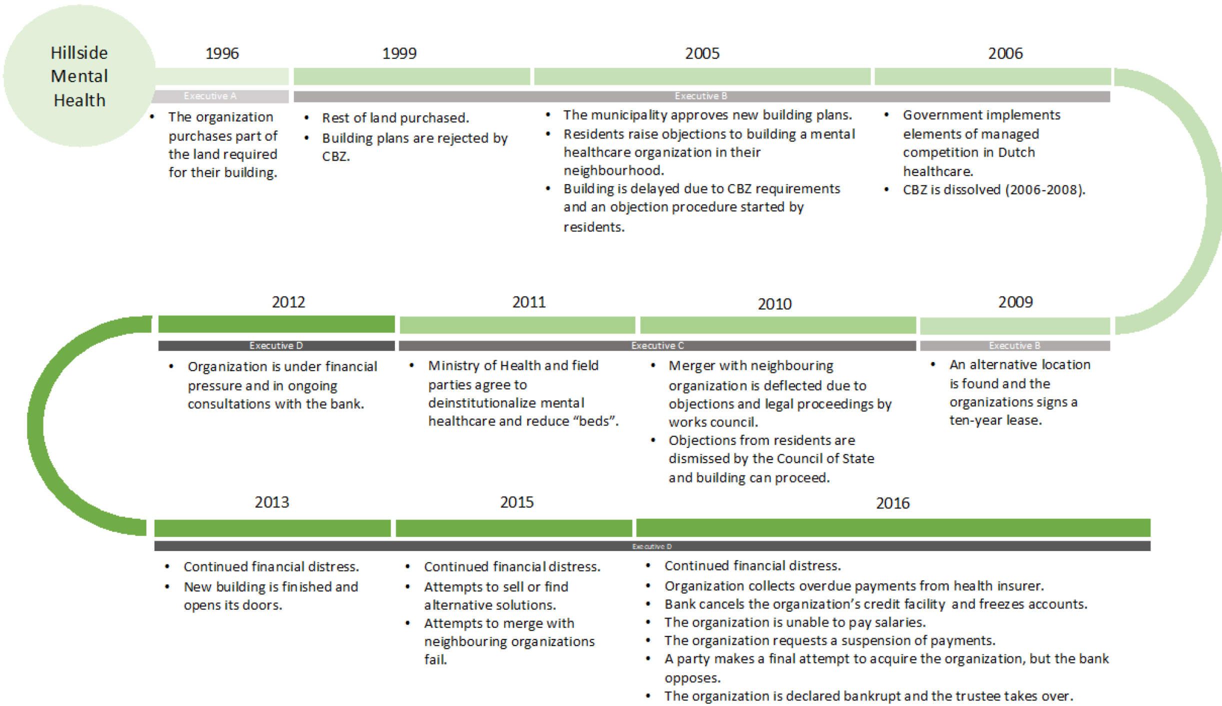


**Figure 6.** Timeline Hillside Mental Health.

## Discussion and conclusion

This study sheds light on the crucial role that financial parties play in decision-making processes surrounding healthcare organizations in periods of financial distress. Through the financialization of healthcare, banks and health insurers have grown in prominence and importance; healthcare organizations depend on them for their existence and by extension, banks and health insurers are able to determine where care is delivered, how care is organized and who can receive it. Especially when healthcare organizations face financial distress, financial parties operate from a position of strength and have influence reaching far into the organization. Banks and health insurers follow their own logic and, in the process, reframe the financial problems as one of "restructuring/recovery" or as a "duty of care" problem.

Though the influence of financial parties in times of financial distress is far-reaching and legal obligations ("duty of care") had a major impact on the strategy of stakeholders, they were not all-important. They did not lead to a pre-determined outcome but did give the organization a more or less favorable starting position. We have shown how executives and other parties still have possibilities to affect the process. For example, executives made financial distress visible, framed the problem strategically and endeavored to shape banks and health insurers into partners by aligning interests. For healthcare executives, it was important to understand the banks' and health insurers' motivation and be able to tap into their interests. The success of the networks also depended on whether banks and health insurers perceived enough transparency from executives, how executives dealt with tests and threats of alienation and with trust in the plan (and persons involved) either growing or deteriorating. The cases show that if trust falters, and actors are alienated from one another, the network destabilizes; if trust is confirmed, however, the commitment of actors grows, the relationship eases and the network stabilizes.

Drawing on translation theory, we took a practice-based approach to foreground and unravel how veiled negotiations, dependencies and power-relations between executives, banks and health insurers took shape. Thereby providing new insights on the underlying deliberations and motivations of financial parties to literature on financialization. Moreover, it provides input for a discussion of (1) the interdependencies and power (im)balance between healthcare organizations, financial parties and other actors, (2) the changing allocation of responsibilities during a period of financial distress and (3) ways to improve processes of financial distress in healthcare.

First, our cases show that in times of financial distress, interdependencies and power (im)balances between healthcare organizations and financial parties increase and become more and more visible. In the end, however, to save the healthcare organization, all three parties are necessary and need to make concessions. It is in the intricate interplay of the network that power and dependency constantly shifts as new information is revealed, actors are added to or replaced from the network and legal obligations are (un)met.

The influence of other actors was minimal in our cases. Medical specialists became important allies, but only later on in the process. Unlike the case described by Dent (2003), managers and employees had little opportunity to influence decision-making. Local communities remained entirely in the background; despite reports in local newspapers, the public was unaware of the organization's financial problems or disregarded the impact of a potential bankruptcy. While other studies have examined public resistance to hospital closures in detail (e.g., Stewart, 2019; Hutter, 2019; Kirouac-Fram, 2010) the public had neither the leverage nor the time to affect outcomes in our cases.

Second, who is responsible for healthcare organizations in financial distress depends on political choices that have been made. However, societal upheaval can also influence such choices and responsibilities are never black-and-white. For example, until 2006, the Dutch government decided on bailouts or closures of healthcare organizations, making it the main decision-maker in periods of financial distress. Our cases unfolded in a context that had shifted towards regulated competition (from 2006 onwards), with responsibility being borne by healthcare providers, banks and health insurers. This continued for long, and although public interest in our two cases was limited, that was otherwise for two Dutch hospitals that went bankrupt in 2018. The hospitals, *MC Slotervaart* and *MC IJsselmeerziekenhuizen*, had struggled through longer periods of financial distress and managerial instability, but their downfall was sudden and unanticipated by the public, government and politicians. In the aftermath, questions were raised about the Health Ministry's responsibilities, the arrangements regarding financial distress and the roles of both health insurers and (to a lesser extent) banks, including their reasons for not helping the hospitals. Discussions emphasized the broader public responsibility of these parties towards healthcare organizations and patients (COFZ, 2020; OVV, 2019). There were many calls to shift from individual responsibility of healthcare organizations and financial stakeholders towards government intervention. Since then, several healthcare organizations facing financial distress have received government support and health insurers have been more active in preventing bankruptcies (Kamerstukken II 2018/19a; Kamerstukken II 2018/19b). Government also implemented an early-warning system to better control threats of financial discontinuity (VWS, 2020) and so resumed increasingly more responsibility for healthcare organizations in financial distress, with communal and reputational values outweighing the current arrangements under regulated competition.

Third, the impact of bankruptcies in healthcare has long been underestimated in the Netherlands. It should be clear to all involved where responsibilities lie and what can be expected in case of emerging financial distress. Previous research has shown that the impact on patients and local communities is significant but that they have little influence (Brown, 2003; Haas et al., 2001; Kirouac-Fram, 2010). Their attempts to prevent bankruptcies and closures are rear-guard actions. As our study makes it clear, they are only informed in a late phase. In fact, their interests were seldom mentioned in our interviews. The processes that we tracked, which occurred behind closed doors, largely ignored patients and communities. Changing that would require making their interests part of the decision-making process from the very start.

## Limitations and future research

This research focused on two cases, each in a specific context and with specific challenges. While the hospital suffered incidental losses, the mental healthcare organization had to deal with long-term property issues that were difficult to resolve. This allowed us to show differences in the process, study the course of financial distress in-depth and disentangle the strategies of parties. To further develop the field of financial distress and financialization, it would be interesting to research other cases in different contexts (e.g., public healthcare systems or different financial parties). This would help compare outcomes and formulate policy recommendations that in the end, serve the needs of patients.

Another relevant angle to further investigate is that of internal processes that take place within healthcare organizations in times of financial distress. During the course of this study, many changes took place within the healthcare organization, such as reorganizations, redundancies and the implementation of new ways of working. The dynamics between employees and management, their practices being under scrutiny and the pressure from outside actors on the “inside” of the organization still need further in-depth research.

# Chapter VI

## How money talks

When thinking of healthcare, I always imagined hospitals where dedicated nurses and doctors care for their patients and where complex and advanced surgeries are performed. Or I thought of older people being helped with their daily routines in nursing homes. Never did I think of the *Zuidas*, a business district in the city of Amsterdam, where an abundance of homogenous men in tailored suits walk in and out of their corporate bank, law and insurance firms. Or what about an international brokers office, where the rooms are filled with computer screens, depicting the newest developments on the stock-market?

During the past years, however, it was exactly these unexpected and financial places that I visited to study healthcare. At first glance, they appeared to be male-dominated, formal and competitive. A place where bravura, risk-taking and rational characteristics were celebrated. The people working in the financial sector also spoke their own distinctive language, full of financial jargon and technical abbreviations. During one of my very first interviews, a healthcare-specialized financial advisor kept discussing interest rate swaps, derivatives, solvability, DSCR, EBITDA, and many more terms that were completely new to me. I improvised the entire interview, pretending to understand what this man was talking about, mimicking his emotions while quietly suppressing the slight feeling of panic I felt creeping up on me. That first period of my PhD trajectory, I often wondered how I would ever understand these financial actors and the roles they play in healthcare.

However, with time, I started to better understand this distant world. By visiting banks, advisory offices, and health insurance companies, by talking to the people working there, I was able to see beyond the suits, bravura and jargon. I learned about their organizational culture, professional ideologies and intrinsic motivation. I experienced how the work of financials, insurers and advisors revolves around risk assessments and qualitative analyses within fast-paced and short-term projects that require an efficient division of tasks and quick decision-making. They articulate visions for the long-term future of healthcare and have clear-cut ideas on how efficiency and (technological) innovation are believed to provide potential solutions for addressing rising healthcare costs. For financials, networking and connecting with (new potential) clients is important. They are often easy to talk to, prioritize their clients and aim to build a close and friendly relationship with them.

Soon, I realized that this world, which we do not often associate with healthcare, has become increasingly important in how healthcare is organized. Finances and healthcare are intertwined, and financial parties form the backbone through which care can be delivered. Throughout this thesis, I have shown what role financial parties play in healthcare, how they have become more influential over time and how that affects care practices. With that, I have brought the world of finance and the world of care together and explained how banks and financial parties let their "money talk". In this final chapter, I will revisit the key insights presented in the preceding chapters and address the main research question of this thesis:

**How can we understand the dynamics between banks, health insurers and healthcare organizations in the context of regulated competition?**

The main research question has been divided into three sub-questions, each offering distinct perspectives to explore the changing roles and dynamics of financial stakeholders within the context of Dutch healthcare governance. These questions are as follows:

1. What roles do banks and health insurers play vis-à-vis healthcare organizations and how have these roles changed over time?
2. How have banks, health insurers and healthcare organizations translated layered policies and regulatory changes into their practices?
3. How do banks, health insurers and healthcare executives interact under pressure of increased financial uncertainties?

After addressing the questions, I will discuss the practical and theoretical implications of this thesis, concluding with reflections and outlining a future research agenda.

## The changing roles of banks and health insurers in Dutch healthcare governance

One of the recurring themes in my thesis has been the increasing significance of financial stakeholders resulting from the incremental adoption of market mechanisms. In this section, I will demonstrate how this incremental system change has (re)shaped the roles of banks and health insurers, and what consequences it had for healthcare organizations. I will begin by reflecting on the role of banks, which merits special attention given their underrepresentation in healthcare practice, policy, and research. Following that, I will shift focus to the role of health insurers.

### Growing influence of banks

Many actors in the healthcare sector still perceive banks as outsiders and in their formal role as investing party. This thesis has, however, shown that the role of banks has expanded beyond that, indicating that it is unrealistic to engage with banks as solely capital providers. Over the years, banks have increasingly worked towards enlarging their sphere of influence and tried to impact the course of Dutch healthcare. This transition from being merely a moneylender to adopting a more participatory role in healthcare did not happen overnight. The current role that banks fulfill is one that was shaped over several decades and adapted in reaction to different events (Helderman et al., 2015). As I described in the introductory chapter, banks became active in Dutch healthcare after World War II, when demand for new and contemporary healthcare facilities increased. For long, banks perceived healthcare organizations as riskless investments due to governmental guarantees on capital costs of care facilities (RVZ, 2006; Van der Zwart et al., 2010). Loans were easily granted to healthcare organizations against relatively favorable conditions (e.g., loan durations of thirty years and low(er) risk premiums) and without further questions asked. Banks operated at the outskirts of healthcare, providing capital but not intentionally interfering with individual healthcare organizations or the future direction of the healthcare system.

This changed with a reform that introduced market incentives in healthcare. In the lead-up to the reform, it became evident that the government would gradually dismantle their guarantee on the capital costs of healthcare organizations. Healthcare organizations would be responsible for their own financial stability and could go bankrupt (Kamerstukken II 2011/12, p. 4). In response, banks no longer viewed healthcare organizations as riskless investment, prompting them to change their position in the sector. As the proposed measures gradually took effect starting in 2006, banks began to present themselves differently, becoming more critical of the investment plans of healthcare organizations and intervening in the internal affairs of healthcare organizations[19]. Chapter two demonstrated how banks enacted their new role by intensifying their relation management with healthcare organizations. This resulted in closer contact between them and provided banks the opportunity to intervene earlier and exert more control. Banks also developed a special interest for the competences of healthcare executives and their long-term vision for the organization. This became an important indicator for whether banks had trust in the future of the healthcare organization and their willingness to provide capital. Another effect was the adaptation of the loan application process for healthcare organizations. These processes were adapted to align with the banks' perception of healthcare organizations as riskier investments. Healthcare organizations had to, for example, present a solid business case when applying for a loan, something they had never done before. Thus, banks sought closer contact and introduced more stringent control mechanisms, thereby forging themselves into a powerful stakeholder within Dutch healthcare.

The influence of banks did not stop there. In chapter four, I demonstrated that the banking sector also impacts the lay-out of Dutch healthcare. More specifically, when healthcare organizations face financial distress, banks can steer decisions regarding where care is delivered, how care is organized and who receives care. Healthcare organizations in financial distress heavily rely on the willingness of banks to alleviate financial pressure. They must win the

[19] Banks label this change as evolving from a "waiter" into an "advisor". However, given their capacity to provide or withdraw financial funds, the role of banks extends beyond a mere advisory function.

trust of banks and demonstrate a recovery plan that includes strategies to overcome financial distress. Banks need to approve such plans and pressure healthcare organizations to reorganize care, close units, scale back certain care services and cut costs. In such situations, banks also demand commitment from health insurers by pushing for multi-annual contracts between insurers and healthcare organizations. With such agreements, healthcare organizations are ensured of their existence for the coming years and banks have a guaranteed return on their loans for that same period. This ensures the financial stability of the banks' investments and mitigates their financial risks. In most cases, agreements can last as long as four years. In one recent extreme case, we witnessed how banks were able to negotiate a ten-year (!) guarantee from health insurers for the continued existence of two merged hospitals (i.e., *HagaZiekenhuis and LangeLand Ziekenhuis*) (Baltesen, 2023). These negotiations give banks a decisive role in shaping the future of healthcare organizations. They impact not only individual healthcare organizations but also the broader healthcare landscape.

If we look closer to recent developments, we can also observe how banks try to influence health policy. They have authored numerous policy documents that communicate their vision on healthcare, and actively seek attention from the Ministry. In April 2023, for example, the banking sector, together with accountants, wrote a letter to the Minister of Health to indicate that they were worried about the decreasing financial status of healthcare organizations due to higher energy prices, inflation, staff shortages and the promised higher salaries for professionals. It would lead to decreasing investment activities by healthcare organizations, which are necessary for sustainability purposes and care transitions. In the following week, representatives of banks and accountants were invited by the Minister to talk about their concerns (NVB and NBA, 2023). This shows that the claims of banks are not neutral, they try to steer on matters of substance, especially when their own financial security is at risk.

Despite the growing influence and contribution of banks in healthcare, their role is hardly ever called into question. On the contrary, I have shown in chapter three that executives deem banks as legitimate and appreciated stakeholders. This might be explained by their seemingly single focus on financial topics (e.g., real estate and housing, investment decisions) and their thorough knowledge of financial issues that is often lacking in healthcare organizations. Regardless, banks are perceived to have a clear-cut and demarcated financial interest, and their authority is undisputed by most[20]. We can conclude that banks have gained a foothold in healthcare and worked their way from outside into the decision-making arena. They have taken up an active, influential and credible role towards healthcare organizations. Yet at the same time, banks remain rather invisible to many within and outside healthcare. This duality, having influence and being out of the spotlight, makes banks a stakeholder to reckon with. Especially when trying to understand the complex stakeholder dynamics in Dutch healthcare.

## Health insurers with a legitimacy issue

Another important financial stakeholder for healthcare organizations are health insurers, which, unlike banks, have a more complex and multifaceted role to play in healthcare. In the introduction, I illustrated that the idea of pooling risks and sharing the costs of sickness has been around for a long time. The original small-scale health insurance initiatives grew over several centuries into the large-scale insurance companies that we know today. These private initiatives gained a public status and became an important means for government to guarantee accessible, qualitative and affordable care for its citizens. In chapter two, we saw how, with the implementation of regulated competition, health insurers became purchasers of care on behalf of their insured, assigned with an orchestrating role in healthcare and supposed to reduce overall healthcare costs. For long, health insurers have been struggling to find a balance between being a financial service provider, while also playing a leading role in improving healthcare quality and reducing healthcare costs (see also Groenewege et al., 2019; Maarse and

[20] There are some executives that openly express their worries about the increased power of and dependency on banks. They have tried to find alternative investors to meet their need for capital (chapter two).

Jeurissen, 2019; Boonen and Schut, 2011; Noort et al., 2020; Halbersma et al., 2011; Schut and Varkevisser, 2017; Ruwaard, 2018; Stolper et al., 2019)

Given their multiple roles and the expectations that come with it, it is not surprising that chapters three and five demonstrate how other healthcare actors challenge the role of health insurers. Healthcare executives, for instance, do not experience the actions of health insurers as very legitimate, while they do experience much influence form them on both financial and care related topics. In their contact with health insurers, healthcare executives experience insurers as financially driven with little substantial knowledge of the sector. Annual negotiations pose challenges and have the potential to escalate into conflict. This is especially poignant in primary healthcare and the mental healthcare sector, who are open about their dissatisfaction with contract negotiations (Schut and Varkevisser, 2017) and have faced major reforms on their payment structures respectively[21].

The lack of legitimacy that healthcare executives attribute to health insurers, has consequences for the dynamics between these two actors and is problematic for several reasons. First, it leads to a frustrating contracting process between health insurers and healthcare organizations. This makes it difficult for healthcare organizations and insurers to work on healthcare challenges through contracting practices. It also obstructs health insurers in fulfilling their role as orchestrators of care, reducing healthcare costs and improving quality. Without trust and (financial and operational) transparency between the representatives of health insurers and healthcare organizations, agreements on price, quantity and quality of care are difficult to reach. Second, the difficult relation between health insurers and healthcare organizations also leads to a delayed contracting process, leaving patients in the unknown as to which healthcare providers are contracted by which health insurers and whether they will receive full insurance coverage. Lastly, troubled relations between health insurers and healthcare executives

[21] Healthcare executives are not the only ones who question the role of health insurers. We know from previous research that professionals and insured have little trust in health insurers either (Groenewegen et al., 2019; Maarse and Jeurissen, 2019; Boonen and Schut, 2011). Health insurers, thus face difficulty in fulfilling two of their tasks – on purchasing care and negotiations with healthcare executives, but also with representing their insured.

hamper the move towards collaboration as new steering mechanism. As illustrated in chapter five, more collaboration in healthcare is seen by policymakers, providers and health insurers as the way forward to solve systemic problems that the healthcare sector is facing (e.g., staff shortages and waiting lists). Such a move requires trust and shared interests between parties. In chapter five, I showed, how these fundamental relational elements are absent between (mental) healthcare organizations and health insurers and how negative perceptions between them persist. It is difficult for parties to overcome such engrained prejudices, and it will not help in developing sustainable collaborations. Throughout the previous chapters, however, I have also highlighted cases where relations between health insurers and healthcare organizations have developed into a solid partnership. In these cases, relational, financial and operational transparency or financial pressure were important drivers in building a good relationship. It would be in the interest of health insurers and healthcare organizations to overcome legitimacy issues, requiring hard work and a focus on relationship management.

## Unexpected influences and seeking certainty

The introduction of market mechanisms in healthcare not only changed the roles of banks and health insurers but it also created a complex and layered institutional environment that opened the door for entanglements with unexpected financial developments such as the global financial crisis and international policy responses to it (Basel III and Solvency II). This institutional shock necessitated radical changes and translation of new rules by banks and health insurers into their practices (Thelen, 1999; Wilsford, 2010), to ensure compliance and survival. Here, I will first explore how such events have influenced dynamics between banks, health insurers and healthcare organizations in the context of Dutch healthcare. Subsequently, I will delve into two trends that we should be aware of: the growing emphasis on risks and (un)certainty in interactions among banks, health insurers and healthcare organizations, and the ongoing necessity for awareness regarding the consequences of Basel III and Solvency II for Dutch healthcare.

This thesis has shown that banks and health insurers had to make sense of and translate new international rules into their practices vis-à-vis healthcare organizations (Mahoney and Thelen, 2010; Wallenburg et al., 2016). While roles and practices between financial stakeholders and healthcare organizations were already changing due to the implementation of regulated competition, the financial crisis and regulatory responses (Basel III and Solvency II) further emphasized and amplified these effects. As mentioned before, banks intensified their contact with healthcare organizations and adapted their loan application processes. In the wake of Basel III, banks also had to adopt stricter capital requirements, leading to an increased risk premium for healthcare organizations and a significant reduction in loan duration (from 30-40 years to 10-25 years), leaving healthcare organizations with a refinancing risk on their loans. In addition, banks restricted the total amount of capital lend to one individual healthcare organization, leading to the formation of banking consortia for larger investment projects. With only a few banks active in Dutch healthcare, healthcare organizations were left with little choice than to accept the banks' new terms.

The practices between health insurers and healthcare organizations that changed after Solvency II mainly concerned their financial transactions. The continuous flow of pre-payments, invoices, reimbursements, and repayments exchanged between health insurers and healthcare organizations results in a tangled web of mutual debts between the two entities. Solvency II dictated that health insurers needed to reserve capital for delays in debt settlements between them and healthcare organizations (i.e., the risk that healthcare organizations cannot repay their debts to health insurers). Health insurers, therefore, worked towards a better overview of mutual debts so that they could anticipate financial risks and reduce the amount of solvency capital. This overview also provided health insurers the opportunity to periodically adjust the amount of prepayments and intervene when healthcare organizations exceeded the agreed-upon care services. Consequently, health insurers started to expedite their payments and urged healthcare organizations to speed up their invoicing.

Chapter two also showed that, in response to the changing demands and stricter financial processes stemming from banks and health insurers, healthcare organizations were forced to professionalize their financial management. Healthcare organizations introduced or grew their financial departments, adapted their internal processes and hired new types of professionals with financial knowledge and negotiating skills. As a result, healthcare organizations found themselves increasingly focused on risk management and mitigation.

The emerging practices between banks, health insurers and healthcare organizations resulting from the healthcare reform and amplified by the implementation of the Basel III and Solvency II frameworks, underscore two noteworthy trends. First, the actions and interactions between banks, health insurers and healthcare organizations are increasingly motivated by managing and minimizing financial risks and a constant search for certainty. Banks search for financial securities on their investments, health insurers want certainty on provided care to fulfill their "duty of care" and healthcare organizations seek continuity of their existence through financial stability. With the implementation of Basel III and Solvency II, risk-thinking became even more engrained in the mindset of banking and health insurance representatives and a standardized practice in their organizations. Healthcare organizations were increasingly seen as risk objects, and the larger the organization, the bigger the financial risks. Chapter two illustrated how banks, and to a lesser extend health insurers, attempted to shift their own financial risks onto healthcare organizations through newly implemented practices, which included closer relationship management, stricter loan procedures and tighter monitoring of mutual dets. Minimizing risks as much as possible is typical for modern societies. However, in attempts to control risk, we often relocate risks or inadvertently produce new ones (Beck, 1992). The actions of banks and health insurers are examples of such attempts, highlighting that while Basel III and Solvency II try to mitigate financial risks, they actually redistribute them further downstream, onto healthcare organizations. A practice that the financial regulators who set these rules do not seem to take into consideration, nor are they held accountable for the far-reaching consequences of their rules.

Second, while the intent of Basel III and Solvency II is to affect the banking and insurance sector, the regulatory frameworks also have an unexpected and unanticipated effect on Dutch healthcare. This thesis makes us therefore aware of how intricate and multi-layered the effects of regulatory frameworks are. Many European countries experienced a direct impact from the global financial crisis on the provision of healthcare through governmental austerity measurements (Cylus et al., 2012; Clemens et al., 2014b; Letho et al., 2015; Morgan and Astolfi, 2015; Saltman, 2018). Dutch healthcare, however, felt the effects of the crisis indirectly through the Basel III and Solvency II regulatory frameworks that affected the capital provision by banks and purchasing practices of health insurers. The Basel and Solvency regulatory frameworks are living documents, in constant development and being adapted and finetuned by regulatory agencies. Then further translated to European, national and organizational rules and interpreted by regulators, banks and insurers. Decisions on new rules and their implementation take up many years and require constant alertness to possible effects on the capital and income availability of healthcare organizations. A new set of adaptations to the Basel III framework[22] is underway, aiming to promote the use of standardized risk models for determining the height of capital buffers that banks must reserve. The new rules seek to minimize the reliance on internal banking models, ensuring consistent and comparable procedures across the board. Under the adapted Basel III framework, banks utilizing internal risk models must adhere to a capital floor, set at no less than 72.5% of the buffer derived from the standardized risk model. Concerns have been raised that these changes will significantly impact many European banks, as they heavily rely on internal risk models and have lower risk exposures. Consequently, this will necessitate banks to hold larger capital buffers under the new set of rules (Feridun and Özün, 2020). For Dutch healthcare, this implies that access to capital may become even more challenging and potentially costlier. The mechanisms outlined earlier, whereby banks altered their practices towards healthcare organizations, have the potential to exacerbate existing challenges or instigate new effects. A development that the healthcare sector

[22] The new set of Basel measurements is also referred to as Basel IV, Basel 3.1 or CRR3 in European context.

should better consider when making plans for the future of healthcare (chapter five).

## Relations under pressure

Despite national and international efforts to structure the relationship and interactions between healthcare organizations and financial stakeholders, their roles and dynamics are also continuously (re)shaped through ongoing micro-level interactions among banks, health insurers and healthcare organizations. Especially in times of changing existential circumstances, healthcare organizations rely heavily on the personal relationships they have built over time with financial stakeholders. To answer the third research question on how banks, health insurers and healthcare organizations interact under pressure, I will first focus on the power imbalances, interdependencies, and relational dimensions of the dynamics between healthcare organizations and their financial stakeholders in times of financial distress. Dimensions that are often implicit and therefore difficult to grasp but have fundamental consequences for access to care. Then I elaborate on how decision-making processes surrounding financial distress consider the interests of local residents, patients and employees. I will end with some reflections on two developments that have the potential to redistribute current interdependencies among healthcare organizations and their financial stakeholders.

In times of financial distress, individual healthcare organizations are confronted with an unstable financial situation and face difficulty in fulfilling its obligations towards banks and health insurers. In chapter four, I demonstrated that in such a situation, healthcare organizations are subjected to the rules and demands of financial stakeholders, thereby limiting the executives' power considerably. Determining the future of the healthcare organization in times of financial distress necessitates urgent decision-making and primarily involves executives and representatives from specialized teams within the bank and health insurance company. These representatives act first and foremost to protect the financial interests of banks and health insurers as they are endangered with the potential downfall of the healthcare organizations. For banks, it is important to assess the long-term sustainability of the healthcare organization and receive commitment from health insurers to help the healthcare organization. Health insurers, on the other hand, want to ascertain whether the healthcare organization is necessary to fulfill the insurers' "duty of care". The outcome of such analyses determines the attitude of financial stakeholders and their initial willingness to cooperate in rescuing the organization.

Moreover, in times of financial distress, the interactions among banks, health insurers and healthcare organizations are characterized by hard negotiations. Banks and health insurers often exert pressure on the healthcare organization to implement turnaround measures, such as layoffs, budget cuts and transformations in care services. However, financial stakeholders not only value hard data, qualitative measures, and financial numbers, but also seek predictability through financial transparency and reassurance on "soft" signals (Kok et al., 2020), such as the competencies of managers and executives and trust. Decisions are not only rationally informed, but are more often based on feelings, perceptions of the other, and mutual understandings. The most striking example of this was when representatives of a bank decided not to accept a deal to save a mental healthcare organization based on a quick calculation during lunch (chapter four). When both rational and relational requirements are met, banks, health insurers and healthcare organizations can work strategically together to save the healthcare organization. In chapter four, I illustrated how such collaborations between financial stakeholders and healthcare executives can fluidize initial role perceptions. One case involved the health insurer transcending its traditional role as a purchaser of care to serve as capital provider, enabling the hospital with funding for transformation plans. It is also possible that during financial distress, the financial interests of banks, health insurers and healthcare organizations diverge, trust falters and they find no common ground. This can ultimately culminate in the bankruptcy of the healthcare organization.

The findings presented in chapter four also highlight how banks and health insurers take public interests into account when deciding to aid healthcare organizations in financial distress. Public interests are supposed to be ensured through the legal "duty of care" of health insurers. However, even if the insurer is able to show that care can be continued by other providers, oftentimes societal upheaval still emerges. This indicates that the "duty of care" seems limited in its incorporation of public interests due to its narrow focus on continued care, overlooking that patients, employees and local residents attach importance to the places they work and receive care. A healthcare organization is not merely viewed as a collection of bricks, but rather as a place of security, care and community spirit. The organization also serves as employer and a status symbol for the region (Holmes et al., 2006; Kirouac-Fram, 2010; Moon and Brown, 2001; Stewart, 2019). Furthermore, the stakeholder that is supposed to represent public interests through the "duty of care" – the health insurer – is not perceived as a trustworthy and legitimate party by most healthcare providers and the public. This makes it even more difficult for patients, employees and local residents to trust health insurers' decisions regarding (potential) closures of healthcare organizations and whether continued care is guaranteed. This thesis shows that it is important to consider how to better safeguard public interests in decision-making processes during financial distress in such a way that the concerns of those involved are heard and accommodated. After all, these decisions affect public services and concern public money.

Finally, as we turn towards the future, two other developments are relevant to discuss. The first concerns the apparent deteriorating financial position of healthcare organizations, with numerous organizations, especially in youth care, mental healthcare and long-term care, struggling to stay afloat (EY, 2023; WfZ, 2024). As a result, healthcare organizations will increasingly depend on financial stakeholders to help alleviate financial pressure. The second development revolves around the impending scarcity of care, due to rising demand and growing staff shortages. In times of scarcity, health insurers will encounter difficulty in meeting their "duty of care" and will increasingly rely on healthcare organizations to deliver care services with fewer staff. Preventing bankruptcies will become imperative, requiring health insurers to support healthcare organizations during periods of financial distress. The combination of these developments – on the one hand the deteriorating financial positions of healthcare organizations and on the other hand the growing demand for care while staff shortages are increasing – will continue to shift interdependencies between banks, health insurers and healthcare organizations. This can bring health insurers and healthcare organizations closer together in helping to find solutions for systemic issues such as waiting lists and staff shortages, while it can also pressure them into their respective responsibilities and increase interdependencies.

## Implications for practice and theory

In the following paragraphs, I will first discuss the practical implications of this thesis for policymakers, researchers, and other healthcare actors. Followed by a discussion on the theoretical contribution of this thesis.

### Practical implications

The dynamics between banks, health insurers and healthcare organizations displayed in this thesis, show a complex web of interactions that are shaped by varying role perceptions, struggles for power and legitimacy and evolving interdependencies between financial stakeholders and healthcare organization. These dynamics are influenced by and, in turn, influence the changing institutional contexts. This thesis serves, in the first place, as a wake-up call to many policymakers, governmental organizations, regulatory agencies, researchers, executives and managers working in the healthcare sector. They are often unaware that financial stakeholders have gained substantial influence in healthcare as a consequence of policy decisions aimed at implementing regulated competition and the side-effects of financial regulation for banks and health insurers, adjusted after the global financial crisis. As a result, healthcare organizations increasingly depend on financial stakeholders to survive (i.e., financialization). And for long, stakeholders in healthcare have paid little attention to the pivotal role of banks and their importance for capitalizing the sector. Health insurers, on the other hand, have always been approached from an economic perspective in research and policymaking, thereby overlooking the complex reality these organizations and their employees operate in. With this thesis, knowledge about the roles, interactions and practices of banks, health insurers and healthcare organizations has been made visible. In this section, I will reflect on the practical implications of my findings for policymakers, researchers, and other healthcare actors, focusing first on banks and then on health insurers.

The changing role of banks in healthcare and vis-à-vis healthcare organizations, leads me to consider two practical implications. First, banks have played an important role in enhancing the financial professionalization of healthcare organizations. They demand and critically assess business plans, financial ratios and future scenarios before capital is provided. This has led to greater operational and financial efficiency, as well as more substantiated investments and critical reflections on the necessity of spending by healthcare organizations. The second conclusion links to the first; the banks' focus on efficient capital spending also necessitates vigilance. This thesis demonstrates that the banking sector's main focus is on financial management and risk mitigation, which does not always align with the public values also present in healthcare. Research on the financialization of healthcare warns us for the foregrounding of a financial logic at the expense of public or communal values (Cordilha, 2021; Lavinas, 2018). In this thesis, examples showcasing the prioritization of financial interests include banks redirecting financial risks deriving from Basel III onto healthcare organizations or banks demanding financial ratios from healthcare organizations (e.g., 20-25% solvability and 15% equity), which results in capital being tied up in the balance sheets of organizations, preventing them from investing in innovations, sustainability, renovations, or increasing salaries. On the other hand, healthcare organizations, the Ministry of Health, umbrella and representative organizations, care associations, and other relevant healthcare parties barley take developments in financial markets into consideration when designing policies or planning for the future of healthcare.

Drawing from the findings of this research, I recommend that the government, health purchasers and those in charge of healthcare organizations involve the banking sector as an equal participant in decision-making and policymaking processes. More importantly, they should do so by appealing to the banking sector's societal role. Banks make societally relevant infrastructures possible through their financial services. They stimulate economic activity and manage capital safely. A robust banking sector is, therefore, in the public interest and contributes to the stability of countries. In healthcare, banks approve investment plans for buildings, renovations, and large-scale innovation projects before providing capital. By actively involving banks as partners in decision-making processes and future policy directions on both organizational and national levels, they can contribute to accelerating sustainability, fostering innovation, future-proofing care facilities, and collaborating on solutions for other challenges facing the Dutch healthcare sector. Given the mutual dependencies and intertwinement of banks, health insurers and healthcare organizations, durable solutions can only be found when all perspectives are brought together.

The results of this research also shed light on the complex role that health insurers play and their relationship with healthcare organizations. Practical implications for solving the lack of legitimacy assigned to health insurers and the distrust between insurers and healthcare organizations are not easily formulated. However, health insurers and healthcare organizations need each other, and their interdependency is strong. It must become a priority for both parties to work on their mutual relationship. This requires them to set aside their negative perceptions of each other, their own interests, and find a common purpose to work towards. While this thesis has shown that prejudices, power imbalances and a lack of legitimacy are obstructing a good relationship between health insurers and healthcare organizations, the growing narrative and policy change towards collaboration as new steering mechanism indicates that it is the right time to work towards a closer relationship and transcend issues from the past. This research has shown that financial and operational transparency are important in building trust and a good relationship. Examples of such efforts can be observed in the form of multi-annual contracts, where health insurers and healthcare organizations demonstrate long-term commitment, as well as with the creation of regional transformation plans, aimed at setting and achieving common goals. However, it should not stop with financial and operational transparency, but also include relational transparency, meaning that health insurers and healthcare organizations should open-up about their interests, intentions and the mechanism and regulations that steer them. This is especially relevant for health insurers, given the perceptions in society about their (legitimate) role and functioning.

We can conclude that the interactions between banks, health insurers and healthcare organizations are impactful and require more attention and effort than they have received so far. Each actor has a legitimate role based on its own power base, founded in their legal task as financer (banks), purchaser and orchestrator (health insurer) or providers of healthcare services (healthcare organizations), and influenced by international, national or regional market conditions. The dynamics in the financial arena of Dutch healthcare have consequences for healthcare practices and require hard work to harmonize. Investing in good relationships is necessary, as is understanding the viewpoint and motives of others, and finding common goals by moving from individual interests to shared interests.

## Theoretical implications

Traditionally, research into the financial arena of Dutch healthcare takes a rational economic perspective. This perspective often explores how markets work or how they could be improved (Frankel et al., 2019), or, more specifically, examines the contribution of health insurers to improving efficiency and reducing healthcare costs (e.g., Schut et al., 2023; Stadhouders et al., 2023; Douven, 2020; Gaspar et al., 2020; Croes et al., 2018; Krabbe-Alkemade et al., 2017; Schut and Van de Ven, 2011; Duijmelinck et al., 2015; Varkevisser and Van der Geest, 2002). Such studies are less attentive of the social and institutional contexts in and through which market mechanisms operate and their consequences. This thesis, however, took a different direction and foregrounded the complex dynamics between financial stakeholders and healthcare organizations in the context of regulated competition. We used literature on the financialization of healthcare to highlight how financial stakeholders increasingly influence healthcare policy and practice, and its consequences for the provision of care services (Engelen, 2008; Hunter and Murray, 2009; Van der Zwan, 2014; Cordilha, 2021). However, much research on the financialization of healthcare has, so far, provided explanations in broad and macro-level terms, looking for answers in major societal developments and discussing new financial actors and financially driven policy changes. As valuable as this is, they have stayed clear of the everyday dynamics, practices, and experiences of financial parties and healthcare organizations that have to work together, negotiate, explore, assert authority, and exercise power.

This thesis has contributed to research on the financial arena of healthcare and the concept of financialization in two ways. First, by relating financialization and the financial arena of Dutch healthcare (Engelen, 2008; Hunter and Murray, 2009; Van der Zwan, 2014; Bayliss, 2016; Lavinas, 2018; Mawdsley, 2018; Storm, 2018; Cordilha, 2021) to practice-based and relational perspectives (Schatzki, 2018; Callon, 1986; Muniesa et al., 2007; Mitchell, 2008; Wilsford, 2010; Lawrence and Suddaby, 2006; Mahoney and Thelen, 2010), I have been able to unravel *how* financial parties influence care practices and why they want to do so in the first place. A focus on the micro-processes of financialization, has resulted in a deeper understanding of how financial parties give meaning to their roles, rules and environment and the mechanisms that shape their behavior in a context of regulated competition. More specifically, the adoption of translation (Callon, 1986; Freeman, 2009; Wæraas and Nielsen, 2016) and stakeholder theory (Mitchell et al., 1997; Parent and Deephouse, 2007; Magness, 2008; Neville et al., 2011) enabled me to show how financial stakeholders enact their financial roles in everyday activities and vis-à-vis other healthcare actors. With translation theory, I was able to dissect all negotiations, efforts and acts of persuasion that actors employ to forge a network with others to accomplish a certain goal. By following the development of relationships and how actors seek to move others, I was able to draw attention to the perceptions, strategic and emotional dispositions and interactions of actors under political, societal and temporal pressure (Callon, 1986; Freeman, 2009; Wæraas and Nielsen, 2016).

Second, with institutional theory (Hall and Taylor, 1996; March and Olsen, 1995; Mahoney and Thelen, 2010), I was able to demonstrate that banks, health insurers and healthcare organizations are embedded within a broader context of (international) rules, norms, values and regulatory frameworks that both inform and regulate their behavior, and which they also help shape themselves (Hall and Taylor, 1996; March and Olsen, 1995). The incremental policy change towards regulated competition has opened the door for interactions with other, unexpected, regulatory regimes (Basel III and Solvency II). As a result, the institutional environment of financial parties and healthcare organizations has changed and continues to evolve, leading to a layered and complex financial arena (Van de Bovenkamp et al., 2014) in which processes of financialization with significant consequences for care practices have remained largely unnoticed. Institutional theory has made visible how macro-level developments are translated into the (micro) daily practices of banks, health insurers and healthcare organizations.

## Reflections and recommendations for future research

To further develop our knowledge on the role of and relations between banks, health insurers and healthcare organizations, I propose three directions for future research. First, this research is based on interviews, document analysis and in-depth case studies, providing us with the opportunity to better understand the *how* and *why* of the financial arena of Dutch healthcare. However, I did not directly observe the behavior of and interactions among banks, health insurers and healthcare organizations in their day-to-day practices. The main reason for this is that banks and health insurers are reluctant and cautious to participate in observational research. They do so to protect financial and other sensitive information, especially when it concerns their negotiations with healthcare organizations or their special account teams. Nonetheless, I believe that ethnographic research would provide further insights into the motives, practices and interactions of banks and health insurers. Such insights can help policymakers, healthcare executives and managers to better understand the behavior of financial stakeholders in healthcare and oversee the consequences of their own decisions and policies on the broader financial arena of Dutch healthcare; and help executives to better deal with potential situations of financial distress.

Second, this thesis has focused on health insurers as main financer of healthcare activities. However, many healthcare organizations also deal with other purchasing parties, such as municipalities and regional care offices. These organizations each have their own specific dynamics, and particularly in municipalities, the politically charged context might provide an interesting role to further investigate. Moreover, there are additional actors, such as accountants, supervisory boards, regulatory bodies and credit commissions of banks, that play an important role in the financial stability of healthcare (organizations). Their roles have not been examined in this research but warrant further investigation.

Another line of research that has been given little attention in this thesis, is the financial arena of other countries. By focusing on the Netherlands, which is a rather unique case with a banking sector that providers capital, I was able to dive deeper into the dynamics between financial parties and healthcare organizations. It would be interesting to compare our findings to countries in which banks and/or health insurers are active or expand the scope of research to different types of (private) financial parties, such as private equity investors (Gupta et al., 2023; Rechel et al., 2023; EY, 2024) or financing through public-private initiatives (Vecchi, Hellowell and Gatt, 2013). In light of financialization processes, other researchers have already shown that the influence of financial parties in healthcare is not limited to healthcare systems that have been privatized, but also takes place in more publicly oriented healthcare sectors (Cordilha, 2021; Horton, 2022; Vural, 2017). If we want to understand how financial parties penetrate and influence healthcare practices on a wider global scale, we should also follow-up on different types of healthcare systems.

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# Appendices

# Appendix I. Beleidsoverzicht bouw en tarieven zorginstellingen 1950-2006 [I]

## 1950: Rijksfinancierings- en garantieregeling

Na de Tweede Wereldoorlog is er een gebrek aan arbeidskracht en bouwmaterialen terwijl de vraag om grootschalige en moderne zorgfaciliteiten toeneemt. De overheid stelt een bouwvolume in en voorziet tegelijkertijd in de financiering van nieuwbouw. Met de Rijksfinancieringsregeling financiert de overheid tot maximaal 3/7de deel van de investeringskosten van zorgvastgoed en garandeert via de Rijksgarantieregeling voor het overige deel de rente en aflossing (tot max. ƒ 40 miljoen). Deze regeling is alleen voor instellingen die de kosten niet uit eigen exploitatie kunnen opbrengen en is verbonden aan een vergunningsplicht. In 1957 schaft men de Rijksfinancieringsregeling af. In 1958 gaat de 'Garantieregeling inrichtingen voor gezondheidszorg' in. Deze regelt dat instellingen een beroep kunnen doen op borgstelling van de overheid als ze vreemd vermogen aantrekken. De kapitaallasten (rente en afschrijvingen) worden nagecalculeerd in de verpleegdagtarieven en zijn 'gegarandeerd'. Ook als een gebouw niet meer bestaat, blijven de kapitaallasten tot het einde van de wettelijke vastgelegde afschrijftermijnen gegarandeerd vergoed. Deze regeling wordt in 1988 opgeheven.

## 1964: Ziekenfondswet (ZfW)

Met de invoering van de Ziekenfondswet worden werknemers die minder dan een jaarlijks vast te stellen bedrag verdienen verplicht om zich te verzekeren tegen ziektekosten. De ZfW wordt in 2006 vervangen door de Zorgverzekeringswet (Zvw).

## 1965: Wet Ziekenhuistarieven (WZt)

Met de Wet Ziekenhuistarieven regelt de overheid de regulering van de ziekenhuistarieven. Een ziekenhuis mag een tarief alleen in rekening brengen na goedkeuring door het Centraal Orgaan Ziekenhuistarieven (COZ)[II] en als de Minister geen bezwaar maakt. In 1982 trekt de overheid de

Wet Ziekenhuistarieven in 1982 en vervangt deze door de Wet Tarieven Gezondheidszorg (WTG). Daarmee verdwijnt ook het COZ.

## 1968: Algemene Wet Bijzondere Ziektekosten (AWBZ)

Met de invoering van de Algemene Wet Bijzondere Ziektekosten is iedere inwoner verzekerd voor langdurige zorg en ondersteuning als gevolg van ziekte of beperking. In 2015 heft de overheid de AWBZ op en hevelt de zorg over naar andere wetten (Wlz, Zvw, Wmo en Jeugdwet).

## 1971: Wet Ziekenhuisvoorzieningen (WZV)

Met de introductie van de Wet Ziekenhuisvoorzieningen reguleert de overheid de planning, capaciteit en bouw van de ziekenhuiszorg, geestelijke gezondheidszorg en verpleeghuiszorg. Het doel van deze wet is om tot een doelmatig, toegankelijk en kwalitatief aanbod van voorzieningen te komen, waarvan de omvang afgestemd is op de behoefte aan zorg. Pas in 1979 wordt de wet integraal van kracht, met enkele wijzigingen en de oprichting van het College voor Ziekenhuisvoorzieningen (CVZ)[III]. Het CVZ stelt standaarden op voor het gemiddeld aantal toegestane bedden, specialisten en bijzondere verrichtingen in een bepaalde regio, als ook de maximale omvang en kosten van bouw- en investeringskosten voor zorgvoorzieningen. Provincies zijn vervolgens verantwoordelijk voor het opstellen van een plan voor hun regio waarin onder andere de huidige capaciteit, benodigde capaciteit en bouwvoorstellen worden opgenomen. Dit plan wordt ter goedkeuring aan het Ministerie voorgelegd, waarbij het CVZ een adviserende rol heeft.

Zorginstellingen moeten voor nieuwbouw of verbouw een aanvraag indienen bij het College voor Ziekenhuisvoorzieningen. Hiervoor wordt een gedetailleerd plan ingediend, dat getoetst wordt aan het regionale plan van de provincie en de standaarden van het CVZ. Na het advies van het CVZ kan de minister goedkeuring verlenen. Met deze goedkeuring ontvangt de instelling een vergunning, die automatisch toegang biedt tot bekostiging vanuit de ZfW en AWBZ. Ziekenfondsen zijn verplicht instellingen met een vergunning te contracteren. Daarnaast biedt een vergunning ook integrale en gegarandeerde vergoeding van rente op leningen en afschrijvingen op gebouwen. Omdat investeringen en financiering min of meer gelijk oplopen, levert dit voor financiers een impliciete garantie op. Ondanks de introductie van functiegerichte budgettering in de jaren ’80, waarmee bekostiging wordt gestandaardiseerd, worden rente en afschrijven nog steeds vergoed op basis van nacalculatie.

In de jaren ’90 ontstaat onvrede over het tot dan toe gevoerde beleid. Men vindt de wet te aanbod gestuurd, wat leidt tot een ingewikkeld, bureaucratisch en langdurig goedkeuringsproces voor nieuw- en verbouwplannen. Daarnaast leidt het beleid tot een maximalisatie van vierkante meters en bouwkosten, in plaats van tot een efficiënte bouw en een afweging tussen investeringen en exploitatiekosten. De WZV wordt daarom hervormd en gedereguleerd, waarbij enkele regels worden afgeschaft en procedures verkort. Zo wordt de reikwijdte van de wet beperkt tot nieuwbouw, verkleining en sluiting van instellingen. De instandhouding van gebouwen wordt de verantwoordelijkheid van instellingen zelf. Ook vervangt de overheid de planningssystematiek door een bouwplafond, waarbij een plafondbedrag wordt vastgesteld voor de gezamenlijke investeringskosten en exploitatiekosten van alle voorzieningen. Toestemming voor nieuw- en verbouw wordt pas verleend als er financiële ruimte voor is.

In 2006 vervangt de Wet toelating zorginstellingen (Wtzi) de Wet Ziekenhuisvoorzieningen.

## 1982: Wet Tarieven Gezondheidszorg (WTG)

In 1982 vervangt de Wet Tarieven Gezondheidszorg de Wet Ziekenhuistarieven (WZt) en regelt de totstandkoming van de tarieven voor inrichtingen, instellingen en individuele beroepsbeoefenaren in de gezondheidszorg. Het Centraal Orgaan Tarieven Gezondheidszorg (COTG)[IV] stelt richtlijnen vast voor de hoogte, opbouw en berekeningswijze van de tarieven. Zo stelt het COTG bijvoorbeeld tarieven voor locatie kosten, vaste kosten en semi-vaste kosten van instellingen vast. Daarnaast moet het COTG ook goedkeuring verlenen aan tarieven die tot stand komen in onderhandelingen tussen instellingen en ziektekostenverzekeraars (variabele kosten die gerelateerd zijn aan het volume en de productie van de instelling). Het COTG stelt tenslotte ook het tarief voor de kapitaallasten vast, waarop nacalculatie van toepassing is. Het COTG bepaalt dus in belangrijke mate het jaarlijks budget van een zorginstelling.

In 2006 vervangt Wet marktordening gezondheidszorg de WTG en de Nederlandse Zorgautoriteit het COTG.

## Vanaf 2006: Invoering gereguleerde concurrentie

Vanaf 2006 introduceert de overheid elementen van de markt in de zorg. De invoering van de Zorgverzekeringswet, de Wet toelating zorginstellingen en de Wet marktordening gezondheidszorg in 2006 markeert het officiële beginpunt. Daarmee komt geleidelijk een einde aan de overheidsregulering voor de bouw, planning en tariefstelling van zorginstellingen. Dit betekent onder andere dat de kapitaallasten (rente en aflossing) niet langer door de overheid worden vergoed op basis van nacalculatie, maar onderdeel worden van het integrale tarief van zorginstellingen, waarover met zorgverzekeraars wordt onderhandeld. Voor de ziekenhuizen geldt dit vanaf 2008, met een overgangsperiode tot en met 2012. In de langdurige zorg vindt de afbouw plaats van 2012 tot en met 2017.

I De informatie in deze bijlage is gebaseerd op:

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II Ook wel het College Ziekenhuistarieven (CZ) genoemd.

III In 2000 wordt het College voor Ziekenhuisvoorzieningen (CVZ) omgedoopt tot het College Bouw Ziekenhuisinstellingen. Het belangrijkste verschil tussen deze twee is dat het College Bouw Ziekenhuisvoorzieningen geen adviesorgaan is, maar een uitvoeringsorgaan waardoor het zelfstandig besluiten kan nemen. De procedures blijven hetzelfde, maar er is niet langer goedkeuring van de Minister nodig. Vanaf 2006 spreken we met de invoering van de Wtzi van het College Bouw Zorginstellingen, die in 2010 wordt opgeheven.

IV Ook wel het College Tarieven Gezondheidszorg (CTG) genoemd.

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# Summary

Banks and health insurers play a crucial role in Dutch healthcare. Banks provide capital through long-term loans and short-term credit, enabling healthcare organizations to build, invest and innovate. Health insurers reimburse healthcare organizations for care delivered to their insured, based on contractual agreements regarding the quantity, cost and quality of care. The financial commitment between banks, health insurers and healthcare organizations enables the delivery of care services, ensures the financial stability of both individual organizations and the healthcare sector as a whole, and contributes to the accessibility and affordability of healthcare.

Despite the significant role of banks and health insurers in Dutch healthcare, the relationships and daily interactions between them and healthcare organizations receive little attention in research and policy. This is striking as financial dependencies appear to be increasing. This thesis aims to uncover the intricate web of social relations and activities between banks, health insurers and healthcare organizations, which are continually shaped and reshaped by the work of individuals, as well as the broader context of regulated competition in which they are embedded. I refer to this web of social relations and activities as the *financial arena of Dutch healthcare*. The main question that guides this thesis is:

**How can we understand the dynamics between banks, health insurers and healthcare organizations in the context of regulated competition?**

The **introductory chapter** of this thesis begins with the research aim, followed by a description of the formal roles of banks and health insurers in Dutch healthcare, an exploration of how these roles came to be, and an explanation of the theoretical framework and research design.

In **chapter II**, I describe the constantly evolving institutional context of banks, health insurers and healthcare organizations. I focus on a reform in Dutch healthcare and international regulations introduced after the 2007 global financial crisis. Both developments have influenced each other and have become intertwined, with major and unexpected consequences for the relationships and practices among banks, health insurers and healthcare organizations.

The reform introduced *regulated competition* as the main governance regime and made healthcare organizations responsible for their own financial stability, exposing them to the risk of bankruptcy without government intervention. Consequently, banks no longer viewed healthcare organizations as risk-free investments and began to intensify relationship management. This meant, for instance, that banks demanded detailed business plans from healthcare organizations before providing capital and paid closer attention to the competencies of healthcare executives. Banks became more proactive and sought ways to exert greater control over healthcare organizations. Additionally, the reform made health insurers responsible for purchasing care for their insured at the best price, volume, and quality. Simultaneously, health insurers were expected to reduce total healthcare costs – a multifaceted role they struggled with for a long time.

The global financial crisis in 2007 led to stricter international regulations – Basel III for banks and Solvency II for insurers. As a consequence, banks reduced lending, increased risk premiums, and shortened loan durations. This shifted financial risks to healthcare organizations, placing them in precarious refinancing structures. The international regulations also resulted in banks operating solely in consortia for larger healthcare investments. Consequently, healthcare organizations have no alternative financing options and must accept stricter conditions imposed on them. Under Solvency II, health insurers began closely monitoring debts, adjusting prepayments, and intervening in contract deviations. This resulted in faster payments and a pressing demand for healthcare organizations to accelerate their invoicing processes.

In particular, this chapter illustrates how regulated competition and international interventions aimed at securing financial systems have drastically and unexpectedly shifted risk perceptions. This has ingrained (financial) risk thinking and risk management within the healthcare sector. On the one hand, it has prompted healthcare organizations to professionalize their financial departments and adapt their internal processes. On the other hand, it has opened the door for banks and health insurers to further redistribute financial risks downstream to healthcare organizations.

In **chapter III**, I shift perspective from banks and health insurers to healthcare executives – as representatives of their healthcare organizations. I explore how they perceive their financial stakeholders in light of the changing roles and practices discussed in chapter II. The findings illustrate that, despite the growing influence of banks in healthcare, healthcare executives generally view them as legitimate and valued stakeholders. I attribute this to banks' apparent focus on financial topics and their thorough knowledge of financial issues, which is often lacking in healthcare organizations.

In contrast, I also show how healthcare executives hold a more critical view of health insurers. Executives question the legitimacy of health insurers, while simultaneously feeling significant pressure from them on both financial and care-related issues. Interactions with insurers are frequently experienced as challenging and can quickly escalate, particularly during annual negotiations. The perceived lack of legitimacy attributed to health insurers is especially concerning as it results in frustrating contracting processes, hinders collaborative efforts, and complicates insurers' roles in managing care and costs.

Building on chapters II and III, where I illustrate how the dynamics within the financial arena of Dutch healthcare are (re-)structured by the healthcare reform and financial crisis, **chapter IV** highlights another key aspect. It reveals that the dynamics between banks, health insurers and healthcare organizations are also continuously (re-)shaped through ongoing micro-level interactions. These micro-level interactions become especially apparent and significant during times of financial distress. This chapter focuses on two cases: a hospital and a mental healthcare organization, both facing financial pressure and the threat of bankruptcy. As their financial situation worsens, they become increasingly dependent on the willingness of banks and health insurers to provide financial support.

This chapter shows that in situations of financial distress, healthcare organizations seek survival, while banks aim for long-term financial stability for both the healthcare organizations and themselves. Banks partly achieve this by securing commitment from health insurers, who, in turn, focus on fulfilling their “duty of care”. Through tough negotiations and by applying strategic pressure, banks, health insurers and healthcare executives work to advance their own interests and gain leverage over one another. Although banks and health insurers claim that their decisions on whether to aid healthcare organizations are based solely on rational analysis, this chapter demonstrates that feelings, perceptions and the ability to build trust are equally important. I also show that in situations of financial distress, only a few key individuals hold the power to determine the fate of the healthcare organization. They often prioritize financial interests over public, societal, or other considerations. This underscores the need to better safeguard public and societal interests in the decision-making process. This is particularly important now, as power balances may be shifting once again amid the worsening financial state of healthcare organizations, rising staff shortages, and increasing demand for care.

In **chapter V**, I explore how policymakers within the healthcare sector are increasingly viewing collaboration, rather than competition, as a solution to systemic challenges. These challenges, including staff shortages, growing waiting lists, and increasing demand for care, are especially acute in mental healthcare, where they significantly impact accessibility. I demonstrate that despite a strong willingness within the sector to cooperate, in practice, collaboration initiatives – particularly between mental healthcare organizations and health insurers – succeed only sporadically. Deep-seated prejudices, a lack of legitimacy, and entrenched routines – remnants from the era of *regulated competition* – make it difficult to build trust and foster effective partnerships. I argue that overcoming these barriers is in the best interest of both health insurers and mental healthcare organizations, which will require ongoing work to align interests and a focus on relationship management.

In the **concluding chapter**, I combine insights from the different chapters and draw three conclusions. First, the role and influence of banks have grown over the past decades, while health insurers continue to face legitimacy issues and strained relations with healthcare organizations. Second, the unexpected influence of international regulations, combined with national policy reforms, has significantly (re)shaped the financial arena of Dutch healthcare. This has embedded risk management within the sector and enabled risk-shifting behavior from banks to healthcare organizations. Finally, situations of financial pressure reveal underlying motivations and power dynamics between banks, health insurers and healthcare organizations, which ultimately determine where care is delivered and under what conditions.

By examining both large-scale developments and micro-level interactions within the financial arena of Dutch healthcare, I unraveled the intricate connections between the worlds of finance and healthcare. I emphasize the importance of involving financial stakeholders in healthcare policy, practice and research, as collaborating with them will be crucial for addressing future challenges in the healthcare sector.

# Samenvatting

Banken en zorgverzekeraars spelen een cruciale rol in de Nederlandse gezondheidszorg. Banken verstrekken kapitaal via langlopende leningen en kortlopende kredieten. Hierdoor worden zorgorganisaties in staat gesteld om te bouwen, te investeren en te innoveren. Daarnaast vergoeden zorgverzekeraars zorgorganisaties voor de geleverde zorg aan hun verzekerden. Dit doen zij op basis van contractuele afspraken over het volume, de kosten en de kwaliteit van zorg. Deze financiële verbintenissen die banken, zorgverzekeraars en zorgorganisaties met elkaar aangaan, maken de levering van zorg mogelijk. Daarnaast waarborgen ze de financiële stabiliteit van individuele zorgorganisaties en de zorgsector in zijn geheel en dragen ze bij aan de toegankelijkheid en betaalbaarheid van zorg.

Ondanks de belangrijke rol van banken en zorgverzekeraars in de Nederlandse gezondheidszorg, is er weinig aandacht voor de relaties en dagelijkse interacties tussen hen en zorgorganisaties in onderzoek en beleid. Dit is opvallend omdat financiële afhankelijkheden toe lijken te nemen. Het doel van dit proefschrift is om het complexe web aan sociale relaties en activiteiten tussen banken, zorgverzekeraars en zorgorganisaties bloot te leggen. Deze relaties en activiteiten worden voortdurend (en opnieuw) vormgegeven door het werk van individuen, evenals de bredere context van gereguleerde concurrentie waarin ze zijn ingebed. Ik verwijs naar dit geheel als *de financiële arena van de Nederlandse gezondheidszorg*. De vraag die daarom centraal staat in dit proefschrift is als volgt:

**Hoe kunnen we de dynamiek tussen banken, zorgverzekeraars en zorgorganisaties begrijpen in de context van gereguleerde concurrentie?**

De **inleiding** van dit proefschrift begint met het onderzoeksdoel, gevolgd door een beschrijving van de formele rollen van banken en zorgverzekeraars in de Nederlandse gezondheidszorg, een verkenning van hoe deze rollen zijn ontstaan en een uitleg van het theoretische kader en de methoden.

In **hoofdstuk II** beschrijf ik de steeds veranderende institutionele context van banken, zorgverzekeraars en zorgorganisaties. Ik richt me daarbij op een stelselwijziging in de Nederlandse gezondheidszorg en internationale regels die zijn ingevoerd na de wereldwijde financiële crisis van 2007. Beide ontwikkelingen hebben elkaar beïnvloed en zijn met elkaar verstrengeld geraakt met ingrijpende en onverwachte gevolgen voor de relaties en praktijken tussen banken, zorgverzekeraars en zorgorganisaties.

Met de stelselwijziging werd *gereguleerde concurrentie* de belangrijkste sturingsorde in de Nederlandse gezondheidszorg. Zorgorganisaties werden zelf verantwoordelijk voor hun financiële bedrijfsvoering en konden failliet gaan zonder dat de overheid zou ingrijpen. Als gevolg hiervan beschouwden banken zorgorganisaties niet langer als risicoloze investeringen en begonnen hun relatiebeheer te intensiveren. Dit betekende bijvoorbeeld dat banken gedetailleerde bedrijfsplannen van zorgorganisaties eisten voordat zij kapitaal verstrekten en steeds meer aandacht hadden voor de leiderschapskwaliteiten van zorgbestuurders. Banken werden dus pro-actiever en zochten manieren om meer controle over zorgorganisaties uit te oefenen. Daarnaast werden zorgverzekeraars met de stelselwijziging verantwoordelijk voor het inkopen van zorg voor hun verzekerden tegen de beste prijs, volume en kwaliteit. Tegelijkertijd werden ze ook geacht de totale zorgkosten te reduceren – een combinatie van rollen waar ze lange tijd mee worstelden.

De wereldwijde financiële crisis van 2007 leidde tot strengere internationale regels – Basel III voor banken en Solvency II voor verzekeraars. Hierdoor verstrekten banken minder leningen, verhoogden risico-opslagen en verkortten de looptijden van leningen. Financiële risico's werden hiermee doorgeschoven naar zorgorganisaties die in risicovolle herfinancierings-structuren terecht kwamen. De internationale regelgeving leidde er ook toe dat banken bij grotere investeringen alleen nog maar in consortia opereerden. Zorgorganisaties hadden hierdoor geen alternatief meer en konden niet anders dan de strengere voorwaarden die werden gesteld, accepteren. Als gevolg van Solvency II begonnen zorgverzekeraars met het monitoren van onderling schulden, het aanpassen van de bevoorschotting en in te grijpen bij contractafwijkingen. Dit resulteerde in snellere uitbetalingen en een dringende oproep aan zorgorganisaties om factureringsprocessen te versnellen.

Dit hoofdstuk toont vooral aan hoe gereguleerde concurrentie en internationale interventies om financiële systemen veiliger te maken, risicopercepties drastisch en onverwacht hebben verschoven. Hierdoor is het denken in financiële risico’s en het willen managen van deze risico’s ook in de zorgsector ingebed. Enerzijds heeft dit zorgorganisaties ertoe aangezet hun financiële afdelingen te professionaliseren en interne processen aan te passen. Anderzijds heeft het ook de deur geopend voor banken en zorgverzekeraars om financiële risico's verder door te schuiven naar zorgorganisaties.

In **hoofdstuk III** verschuif ik de focus van banken en zorgverzekeraars naar zorgbestuurders – als vertegenwoordigers van zorgorganisaties. Ik onderzoek hoe zij hun financiële stakeholders percipiëren in het licht van de veranderende rollen en praktijken die in hoofdstuk II zijn besproken. De resultaten tonen aan hoe, ondanks de toenemende invloed van banken in de gezondheidszorg, zorgbestuurders hen over het algemeen als legitieme en gewaardeerde stakeholders beschouwen. Ik schrijf dit toe aan de schijnbare focus van banken op financiële onderwerpen en hun grondige kennis van financiële kwesties, die vaak ontbreekt binnen zorgorganisaties.

Daarentegen laat ik ook zien hoe zorgbestuurders kritischer zijn ten opzichte van zorgverzekeraars. Bestuurders trekken de legitimiteit van zorgverzekeraars in twijfel en ervaren tegelijkertijd aanzienlijke druk van hen met betrekking tot financiële en zorginhoudelijke onderwerpen. Interacties met zorgverzekeraars worden vaak als uitdagend ervaren en kunnen snel escaleren, vooral tijdens jaarlijkse onderhandelingen. Het waargenomen gebrek aan legitimiteit dat aan zorgverzekeraars wordt toegeschreven, is zorgwekkend omdat het resulteert in een frustrerend contracteerproces, samenwerkingsinspanningen belemmert en de rol van zorgverzekeraars in het aansturen van zorg en het beheersen van zorgkosten bemoeilijkt.

Voortbouwend op hoofdstukken II en III, waarin ik laat zien hoe de dynamiek binnen de financiële arena van de Nederlandse gezondheidszorg veranderd door de stelselwijziging en de financiële crisis, benadrukt

**hoofdstuk IV** een ander belangrijk aspect. Het laat namelijk zien dat die dynamiek tussen banken, zorgverzekeraars en zorgorganisaties ook veranderd door continue micro-level interacties. Deze micro-level interacties worden met name zichtbaar en belangrijk in tijden van financiële druk. Dit hoofdstuk richt zich daarom op twee casussen: een ziekenhuis en een organisatie voor geestelijke gezondheidszorg, die beiden te maken hebben met financiële problemen en dreigen failliet te gaan. Naarmate de financiële situatie verslechterd, worden deze organisaties steeds afhankelijker van de bereidheid van banken en zorgverzekeraars om financiële steun te bieden.

Het hoofdstuk toont aan dat in situaties van financiële druk, zorgorganisaties er alles aan doen om te overleven, terwijl banken zich richten op de lange-termijn financiële stabiliteit van zowel de zorgorganisaties als henzelf. Dit bereiken ze deels door commitment van zorgverzekeraars te waarborgen, terwijl zorgverzekeraars zich richten op het voldoen aan hun *zorgplicht*. Door middel van harde onderhandelingen en het uitoefenen van strategische druk proberen banken, zorgverzekeraars en zorgbestuurders hun eigen belangen te bevorderen en elkaar te beïnvloeden. Hoewel banken en zorgverzekeraars beweren dat hun beslissingen over het al dan niet steunen van zorgorganisaties uitsluitend zijn gebaseerd op rationele analyses, toont dit hoofdstuk aan dat gevoelens, percepties en het vermogen om vertrouwen op te bouwen even belangrijk zijn voor die afweging. Ik laat ook zien dat in tijden van financiële druk, slechts een paar sleutelfiguren de macht hebben om het lot van de zorgorganisatie te bepalen. Ze stellen daarbij vaak financiële belangen boven publieke, maatschappelijke of andere belangen. Dit laat zien dat het noodzakelijk is om publieke en maatschappelijke belangen beter te waarborgen gedurende het besluitvormingsproces, vooral nu machtsverhoudingen mogelijk weer verschuiven in het licht van de verslechterende financiële positie van zorgorganisaties, toenemende personeelstekorten en een groeiende vraag naar zorg.

In **hoofdstuk V** onderzoek ik hoe beleidsmakers binnen de zorgsector steeds vaker samenwerking in plaats van concurrentie zien als oplossing voor systemische uitdagingen. Deze uitdagingen, waaronder personeelstekorten, groeiende wachtlijsten en een toenemende vraag naar zorg, zijn vooral acuut in de geestelijke gezondheidszorg, waar ze een aanzienlijke impact hebben op de toegankelijkheid van zorg. Ik laat zien dat ondanks een sterke bereidheid binnen de sector om samen te werken, samenwerkingsinitiatieven – vooral tussen organisaties voor geestelijke gezondheidszorg en zorgverzekeraars – in de praktijk slechts sporadisch succesvol zijn. Diepgewortelde vooroordelen, een gebrek aan legitimiteit en vastgeroeste routines – voortkomend uit het tijdperk van gereguleerde concurrentie – vormen een obstakel voor het opbouwen van vertrouwen en het bevorderen van effectieve partnerschappen. Ik betoog dat het overwinnen van deze barrières in het beste belang is van zowel zorgverzekeraars als organisaties voor geestelijke gezondheidszorg. Dit vereist echter voortdurende inspanningen om belangen op elkaar af te stemmen en een focus op relatiemanagement.

In de **discussie** combineer ik inzichten uit de verschillende hoofdstukken en trek ik drie conclusies. Ten eerste is de rol en invloed van banken de afgelopen decennia toegenomen, terwijl zorgverzekeraars te maken hebben met een legitimiteitsprobleem en gespannen relaties met zorgorganisaties. Ten tweede heeft de onverwachte invloed van internationale regelgeving, in combinatie met nationale stelselwijzigingen, de financiële arena van de Nederlandse gezondheidszorg aanzienlijk veranderd. Hierdoor is het denken in (financiële) risico's en het willen managen van deze risico's ook in de zorgsector ingebed. Ten slotte leggen situaties van financiële druk de onderliggende motieven van en machtsdynamieken tussen banken, zorgverzekeraars en zorgorganisaties bloot. Deze bepalen uiteindelijk waar zorg wordt geleverd en onder welke voorwaarden.

Door zowel de grootschalige ontwikkelingen als ook de micro-level interacties binnen de financiële arena van de Nederlandse gezondheidszorg te onderzoeken, ontrafel ik de complexe verbanden tussen de financiële wereld en de wereld van de gezondheidszorg. Ik benadruk daarbij dat het belangrijk is om financiële stakeholders te betrekken bij zorgbeleid, -praktijk en -onderzoek omdat samenwerking met hen cruciaal zal zijn voor het aanpakken van toekomstige uitdagingen in de zorgsector.

# Dankwoord

Dit proefschrift had niet tot stand kunnen komen zonder de hulp van zoveel anderen.

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Een speciaal dankwoord gaat uit naar een aantal oud-collega's die inmiddels veel meer zijn dan dat. *Jolien*, we hebben dit promotietraject samen doorstaan en ik ben dankbaar voor de vriendschap die hieruit is ontstaan. Jij was altijd te porren voor een "korte" pauze, een etentje en andere uitjes. Je luisterend oor en onze eindeloze gesprekken hebben me de afgelopen jaren steeds weer geholpen om door te gaan. Daarom ben ik blij dat je tijdens de verdediging naast me staat, zodat we dit hoofdstuk samen kunnen afsluiten. Dank dat ik altijd bij je terecht kan! *Warsha*, jouw support en onze open en eerlijke gesprekken waardeer ik enorm. Tegenwoordig vinden die niet meer plaats op kantoor, maar onder het genot van een cocktail in de stad. Die omgeving vind ik een hele verbetering. En ja, we gaan hierna echt samen sporten, beloofd! *Dara* & *Wouter*, mijn ex-collega en ex-buurtjes, ik mis jullie zo dichtbij. Dank voor alle leuke momenten, de goede gesprekken, Dara's fantastische vertelkunst en Wouters' hilarische accenten. Met jullie is het altijd gezellig. *Oemar*, ik ben blij dat we elkaar nog steeds regelmatig spreken in ons groepje van vier. Dank voor de fijne gesprekken en je gezelligheid, maar vooral ook voor je gekke kant die af en toe boven komt drijven (ik zal niet snel vergeten hoe je op een serveerwagentje door het PhD-hok vloog). *Janine*, je dochter vond het misschien een beetje vreemd dat je een vriendin van midden-twintig had, maar ik heb daar nooit iets van gemerkt. Ik ben dankbaar voor alles wat we gedeeld hebben en hoop dat we elkaar weer wat vaker gaan zien. *Sabrina*, wat was het fijn om samen met jou – vaak onder het genot van een wijntje – alle ontwikkelingen in ons promotietraject en persoonlijke leven te bespreken. *Iris* en *Renée*, dank voor jullie optimisme en humor (en je letterlijke neusje voor kantoorroddels, Renée). De fijne schrijfweekenden in Frankrijk en Zeeland zullen me nog lang bijblijven.

Tijdens de afronding van dit proefschrift kreeg ik ook nieuwe collega's. Inmiddels meer dan anderhalf jaar geleden stapte ik voor het eerst als ambtenaar door de poortjes van De Resident. Een beslissing waar ik nog geen moment spijt van heb gehad. Dat kwam mede door het warme welkom van *Sandra*, *Eva*, *Gerben*, *Angela*, *Madeleine*, *Elia*, *Tessel*, *Rogier*, *Nadia*, *Warsha*, *Marieke*, *Danny*, *Henriëtte* en *Fred*, evenals alle andere collega's die bij de *Directie Patiënt en Zorgordening* werken. Dank jullie wel voor de fijne werkomgeving die jullie creëren! Ook de mensen van het *Waarborgfonds voor de Zorgsector* wil ik hier niet ongenoemd laten, en in het bijzonder wil ik *Frans* bedanken voor zijn bijdrage aan de historische context van dit boekje.

Terugkijkend op dit traject, besef ik me steeds meer hoe belangrijk vrienden en familie zijn geweest. *Eva-Maria*, jij was de afgelopen jaren een onmisbare vriendin. Ik waardeer het enorm hoe je, ondanks onze drukke levens, om de zoveel weken weer eens appte voor een koffie. Dank voor die stabiele factor, je oprechte interesse, loyaliteit en eerlijkheid. Ik hoop dat we onze vriendschap nog vele jaren mogen voortzetten. *Elise*, mijn langstdurende vriendschap. We zijn samen opgegroeid, van giebelende pubermeisjes op de middelbare school tot huisgenoten tijdens onze studententijd, en nu als volwassenen met alle grote mensen verantwoordelijkheden die daarbij komen kijken. Ik ben dankbaar voor al die mooie herinneringen samen en de vriendschap die daaruit is ontstaan. En ik hoop nog lang een beroep op je te kunnen doen als mijn externe geheugen.

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*Deo omnis gloria*

# Curriculum Vitae

# Portfolio

| | |
|---|---|
| Name: | Tessa van Dijk |
| Department: | Erasmus School of Health Policy & Management (ESHPM) |
| PhD period: | 2018-2024 |
| Promoters: | Prof.dr. Richard Janssen and Prof.dr. Wilma van der Scheer |
| Co-promotor: | Dr. Martijn Felder |

**Peer-reviewed academic publications**

Van Dijk, T.S., Van der Scheer, W.K. and Janssen, R.T.J.M. (2021). Power, legitimacy and urgency: Unravelling the relationship between healthcare organizations and their financial stakeholders. *Health Policy* 125(8), 1077-1084.

Van Dijk, T.S., Van der Scheer, W.K., Felder, M. and Janssen, R.T.J.M. (2023). Healthcare reform and financial crisis in the Netherlands: Consequences for the financial arena of healthcare organizations. *Health Economics, Policy and Law* 18(3), 305-320.

Van Dijk, T.S., Felder, M., Janssen, R.T.J.M. and Van der Scheer, W.K. (2023). For better or worse: Governing healthcare organizations in times of financial distress. *Sociology of Health & Illness*, 1-22.

**Other publication**

Van Dijk, T.S., Van der Scheer, W.K. en Janssen, R.T.J.M. (2021). Zorgbestuurders vinden de eisen van verzekeraars niet altijd wenselijk en passend. *Economisch Statistische Berichten* 106(4794), 76-78.

De Koning, C., Van Dijk, T.S. en Janssen, R.T.J.M. (2024). De ggz in relatie tot zorgverzekeraars; een verkenning. *Tijdschrift voor Psychiatrie* 66(1), 24-29.

**Courses**

| | | |
|---|---|---|
| Netherlands Institute of Governance (NIG) | Classics in public administration and political science | 2019 |
| | Formulating and answering research questions | 2019 |
| | Getting it published | 2019 |
| | Integrity and responsibility in research and advice | 2019 |
| | Making science on politics and governance matters | 2022 |
| Erasmus Graduate School for Social Sciences and the Humanities (EGSH) | Digital research methods for textual data | 2018 |
| | Responsible data management | 2018 |
| | Qualitative coding with Atlas.ti | 2018 |
| | Searching, finding and managing your literature | 2019 |
| | Qualitative interviewing | 2019 |
| | English academic writing for PhD candidates | 2020 |
| | Qualitative data analysis with grounded theory | 2020 |
| RISBO | Basic didactics | 2018 |

**Teaching activities**

| | | |
|---|---|---|
| BSc Gezondheids-wetenschappen | Beleid- en bestuurswetenschappen | 2017-2018 |
| | Afstudeerproject | 2019-2020<br>2020-2021 |
| MSc Health Economics Policy and Law | Comparative health policy | 2018-2019<br>2019-2020<br>2020-2021 |
| | Advanced research methods | 2021-2022 |

### Contributions to conferences, seminars and webinars

| | |
|---|---|
| Presentation board NVZD | 2017 |
| ESHPM Research Seminar | 2017 |
| Presentation Honours Class | 2018 |
| Presentation Conference ‘Zorg & Financieringsvormen’ | 2019 |
| Poster presentation at EHMA Conference | 2019 |
| Paper presentation at NIG Annual Work Conference | 2019 |
| Presentation focusgroup NVZD | 2019 |
| Presentation board NVZD | 2019 |
| Presentation Academic Workplace Healthcare Governance | 2021 |

### Ancillary activities

Member Activity Committee ESHPM
Member Academic Workplace Healthcare Governance

### Award

Best poster award at EHMA Conference 2019, Espoo, Finland

# About the author

Tessa van Dijk was born on August 5th, 1995, in Soest, the Netherlands. She developed an interest in healthcare while working at a nursing home, and later in a specialized ward for people with dementia.

Tessa obtained her Bachelor's degree in Health Sciences and a Master's degree in Health Economics, Policy and Law with a specialization in Health Economics at Erasmus University Rotterdam. After completing her master's in 2017, she began her PhD journey at the Erasmus School of Health Policy & Management. Her PhD research focused on the financing of healthcare, in particular the changing roles of banks and health insurers in Dutch healthcare and their interactions with healthcare organizations. The findings of her work were shared at both national and international conferences and published in international peer-reviewed journals. In addition to her research, Tessa graduated from the Netherlands Institute of Governance (NIG) and has taught various bachelor's and master's courses and supervised thesis students.

Tessa currently works as a policy advisor at the Ministry of Health, Welfare and Sport, where she can apply her research into practice. She is involved in promoting good governance in healthcare and addressing issues related to the financial sustainability of healthcare organizations.

Now that she has some free time again, Tessa enjoys spending it with family and friends, watching movies and American football with her boyfriend, visiting museums, and taking on creative hobbies.

*ts.v.dijk@minvws.nl*