Purchasing professional component services in the healthcare sector buyer-seller relationships in the dental sector

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Purchasing professional component services in the healthcare sector:

Buyer-seller relationships
in the dental sector

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Preface

After years of practice, the all-deciding game is played. As with volleyball there is no way to win this game without the help of others, your teammates. I would therefore like to take this opportunity to thank everyone who has helped me in realizing this Master Thesis as part of the Graduation Project, which is the completion of the Master Program Innovation Management at Eindhoven University of Technology.

First of all I would like to thank my first supervisor at the TU/e Dr. Ir. Wendy van der Valk for her coaching throughout this project. At the start you never exactly know what you are up against, but the regular meetings we held helped me overcome the challenges I experienced during the project. Moreover, her suggestions and constructive reflections have helped me improve my game and get the most out of this project. Also, I would like to express my gratitude towards my second supervisor Dr. Ir. Ad Kleingeld for his critical feedback and the valuable suggestions coming from his field of research.

Furthermore, I would like to thank VGZ for giving me the opportunity to conduct a case study in the dental care sector. Special thanks go out to Marc Janssen, for his suggestions and supportive attitude. Moreover, I would like to thank him and Jeroen van Spengen, as company supervisors, for the time and effort they have put into my project. I would, furthermore, like to thank all other VGZ employees who have made it possible to accomplish this project, either by providing me the necessary documentation, or by actively participating in the study. I would especially like to thank Bart Thielen for regularly teaching me about the dental care sector, and Louis Enneking for his support throughout the project, particularly in organizing the brainstorm meeting. Of course I would also like to thank all professionals in the field for giving me the opportunity to talk to them.

However, besides the players in the field, the game would be nothing without the support of my family and friends. Their support throughout the whole project, especially during tough times, gave me the strength to go on and complete this final part of my study. I am immensely grateful for their faith in me.

Ingrid Hovens

Eindhoven, September 2012

Management Summary

Ever since the advice of *'Commissie* Dekker' in 1987 plans for a fundamental reform of the healthcare sector have been presented (Van der Lugt, 2005; Varkevisser and Schut, 2010). At this moment the Dutch healthcare sector can be visualized as a triad with three parties involved; the health insurers, the care providers and the patients. Since the introduction of the Health Insurance Law (*Zorgverzekeringswet)* the government expects health insurers to purchase care on behalf of their customers (the insured); a buyer-seller relationship between health insurer and are provider is thus necessary; the healthcare market. However, overall purchasing services is thought to be quite complex (Smeltzer and Ogden, 2002). Given the fact that a health insurer is trying to buy care services from professionals that deliver the service directly to the patients, almost without any interference by the health insurer, makes it even more difficult to specify and manage the service bought.

Research question

Literature has, however, not extensively studied how to purchase such care, especially since the services bought in the *Healthcare market* are found to be services that are a combination of the previously defined *professional* service (Silvestro et al., 1992) and the *component* service (Van der Valk et al., 2009). The following research question was therefore formulated:

"How can buyer-seller relationships in the healthcare market best be established and strengthened when buying professional component services, in order to secure high quality, affordable, and accessible services for consumers?"

Establishing and strengthening relationships can be a difficult and time consuming project. Not only the formal aspects such as contracts and the clauses they include are under consideration, also the actual (personal) relationship can be an important facet for a buyer-seller relationship to succeed. Even the best specifications and the right type of contract can break and fall with, for example, the wrong approach or a lack of trust from either side. The other way around, unsuitable contractual agreements can destroy a good relationship. This study therefore considered both contractual and relational aspects in the buyer-seller relationship in the healthcare market.

Theoretical background

Evaluating the services typical for the healthcare market revealed that the services provided by the care providers can be considered *professional* services according to a service classification by Silvestro et al. (1992), and because the care is directly delivered to the patient (the insured) it is also a *component* service. The conducted literature review thus led to the *ProCo* service type to be defined. According to Axelsson and Wynstra (2002) the nature of the specific service and the specific situation determine the way in which the purchasing process should be handled. Considering existing literature several things can be said about contract types, specifying services, and performance management and measurement. For one Performance-based contracts (PBC's) are considered preferable over Behavior-based contracts. However, for PBC's to work contract incentives should be carefully designed and it should be able to verify performance. Performance indicators used for this verification of performance are, however, not yet used throughout the whole healthcare sector, making studies on contract type very difficult for

some care sectors. In the future more knowledge is, however, expected to be gained on this issue. For now the focus is therefore on contract incentives and possibilities to govern the relationship.

There are two types of governance: contractual and relational. Recent studies suggest that these two governance types should be considered as complementary mechanisms (Poppo and Zenger, 2002; Ferguson et al, 2005). According to Ferguson et al. (2005) contractual governance can be advantageous for relationships in a business-to-business environment as the negotiation process can help structure expectations and obligations. Furthermore, the negotiations can serve as a foundation for social governance mechanisms as they promote expectations of cooperation (Poppo and Zenger, 2002). Relational governance is associated with trust, which is found to improve the performance of interorganizational exchanges (Poppo and Zenger, 2002). Moreover, the social and organizational mechanisms that control the exchange are considered to have these norms and values that promote flexibility, solidarity (commitment) and information exchange (Poppo and Zenger, 2002) Relational governance can therefore be seen as a mechanism helping in establishing a successful buyer-seller relationship. Literature suggests that for established exchanges relational governance should become predominant. Figure I shows the mechanisms found in literature that are expected to influence the success of the buyer-seller relationship. The conducted study looks at the results on this in the healthcare setting.

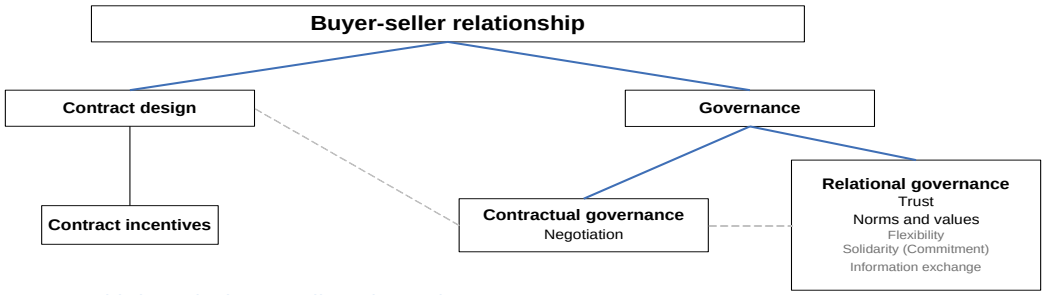

Figure I: Establishing the buyer-seller relationship

Research approach

To study the object of interest, the buyer-seller relationship in the healthcare market, a multiple case study was conducted facilitated by health insurer VGZ. As the company was struggling with establishing profound relationships with dental care providers, especially the general dentists, the object of study was quickly chosen. Contractual incentives and governance were considered thoroughly. Because of the lack of performance indicators in this dental sector the contract type was not further evaluated.

Data triangulation, the use and combination of different methods to study the same phenomenon (Yin, 2009) was taken care of by using documentation, conducting (exploratory) interviews, and the use of a brainstorm meeting. This data triangulation enhances the reliability of findings. As stated several interviews were conducted (see Figure II), which were transcribed and then coded using NVivo software. Both the buyer and the seller were represented in this study, with three cases being studied on the seller's side; core + contract, core + no contract, and non-core + contract. Using the coding as a starting point the data was analyzed by conducting within-case and cross-case analyses.

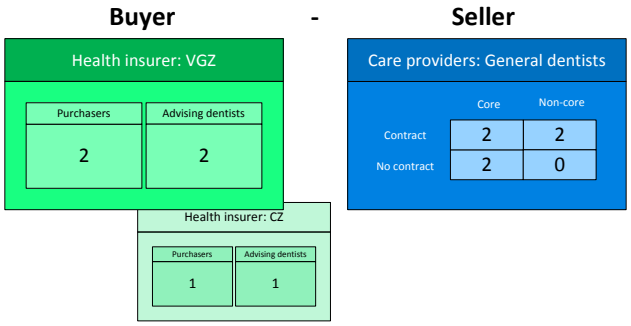

Figure II: Case study design

	Managers & dentists in the field
Relational	
Negotiation	
Negotiation: current perception	
Approach	
Mailing	
Telephone	
Personal contact	
Meetings	
Trust	
Trust: current perception	
Publicity	
Publicity: current perception	

Figure III: Current perceptions and important factors

Findings

Looking at the three cases it was found that, although in general the contract incentives of administrative advantages are acknowledged, other factors play an important role in the decision not to contract. These factors even overrule the possible significant (financial) advantages for the parties in the core area, with generally over 30% of patients insured with VGZ. Moreover, even those having signed a contract feel that there is still room for improvement on these factors. It was found that these improvements can be considered to lie in the governance mechanisms executed by the health insurer. As Figure III shows, negotiation possibilities are considered important to the relationship, but at the moment the care providers feel that there is room for improvement here, as the current perception of these possibilities is mediocre. Also the health insurer should question whether it is necessary to even try to include all these requirements for everyone. Moreover, there somewhat appears to be a lack of trust toward the health insurer, partly caused by bad publicity. One has indicated that a more personal approach and more information exchange (e.g. through meetings) could enhance the level of trust.

In order to state more specifically what the dental care providers need in terms of governance, a brainstorm meeting was organized with a representative for both 'core'-cases and representatives from the health insurer VGZ (e.g. a purchaser and an advising dentist). Letting both 'sides' of the relationship participate, enables finding suggestions for improvement that can also be considered applicable. Moreover, the general brainstorm design enables to prioritize ideas and to thoroughly discuss the most important ones; leading to quite extensive action plans. Trust stood at the centre of the discussion, and was closely linked to approach and information exchange. It was found that it would be wise to hold meetings to facilitate more information exchange (e.g. on the health insurer's policy and struggles) and to simultaneously offer a chance for personal contact. Furthermore, these mechanisms should be continuously used throughout the pre-contractual stage. It was considered acceptable for the health insurer to segment the market of dentists, on for example the percentage of VGZ insured, in order to enable a more personal approach in the (pre-contractual) purchasing process. As long as the need for information exchange was satisfied in this by providing the other health insurers with information that they would be contacted later. Keeping this promise is important in terms of trust.

Conclusion & Theoretical contribution

This study has shown that trust is a very important factor in the buyer-seller relationships evaluated. Without the parties trusting each other it will be almost impossible to establish a relationship at all (aside from the relationship imposed by the government as a result of the triad in the Dutch healthcare system). It was found that trust can be build by being transparent about policies and by communicating in a personal way. For this to work the care provider should, however, also be committed to this relationship by being transparent as well and by being open to constructive discussions. The information exchange thus plays a key role in creating a good relationship.

Once a basis of trust has been established the pre-contractual relationship can be strengthened further by continuing the information exchange and by enabling negotiation (e.g on prices and requirements), thereby continuing the personal approach. Trust, however, appears to be a prerequisite for establishing buyer-seller relationships in the healthcare market. Thereby it was found that both social processes and information exchange are mechanisms to influence the factor of trust. Previous literature stated that contractual governance with the mechanisms of negotiation can serve as a foundation for social governance (Poppo and Zenger, 2002), this study, however, shows that relational governance is necessary for negotiation to take place at all.

So although planned incentives for contracting are evaluated as interesting by care providers, governance (especially relational governance) can make or break the chances of a contractual relationship in the healthcare market. Previous literature has, however, not explicitly stated such an influence to be present. Figure IV visualizes the factors that have been found to influence the success of (contractual) buyer-seller relationships. Moreover, the green line suggests the relationship between governance mechanisms and contract incentives; where bad governance mechanisms can possibly inhibit any chance of a good relationship, even with the best contract incentives provided.

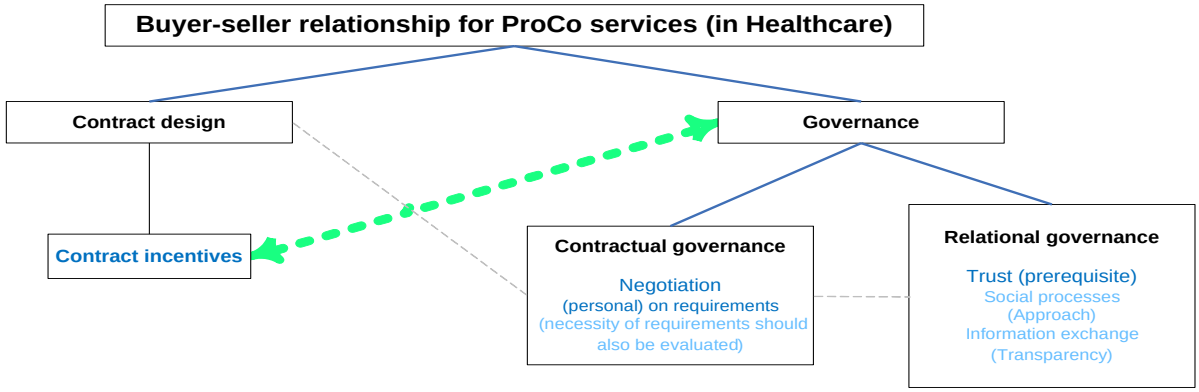

Figure IV: Factors influencing the success of buyer-seller relationships in the healthcare market.

Managerial implications

Professionals should strive for profound social processes in their purchasing process and the necessary information exchange. Brainstorm meetings, as the one held in this study, appear to be an appropriate tool to activate these relational mechanisms. Moreover, they can provide new insights. The general design of a brainstorm meeting can thus be used as a tool by other professionals. Professionals should think thoroughly about whether to include all phases of a brainstorm and about who should participate.

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1. Introduction

The Dutch healthcare system is a system that is positively evaluated in international comparison and has thousands of satisfied 'customers', but still asks for a lot of attention as the government tries to create a system that provides a better grip on the sector (Van der Lugt, 2005). Ever since the advice of '*commissie Dekker*' in 1987 plans for a fundamental reform of the healthcare sector have been presented (Van der Lugt, 2005; Varkevisser and Schut, 2010). Eventually, the Health Insurance Law (*Zorgverzekeringswet* or Zvw) was introduced in 2006. This law implies that health insurers have to purchase care on behalf of their customers (the insured). The Dutch Minister of Health, Edith Schippers, wants the health insurers to be critical when purchasing care. They should not buy care everywhere they can, but select only the best care against a competitive price. This statement underlines the importance of active and selective purchasing of care by health insurers.

Over the last couple of years the government has been creating more room for health insurers and care providers to negotiate on price and quality of care by withdrawing the fixed prices they had set in several care sectors, creating more of a free market. This development has led to health insurers more actively trying to find the best way to purchase care (Varkevisser and Schut, 2010). How care can best be purchased is, however, something that is not entirely clear yet, given the special features of the healthcare sector. We do know that care is a service and, overall, purchasing services is thought to be more complex than purchasing goods (Smeltzer and Ogden, 2002). A service is, for example, overall quite hard to specify (Ellram et al., 2004; Van der Valk and Rozemeijer, 2009). Specifying most care services is even harder since the service purchased is a very knowledge intensive *professional service*; without some knowledge of what the service entails a buyer can hardly specify it. Moreover, the fact that there is not much reliable information available on the quality of care makes it difficult to specify performance. Secondly, health insurers operate in a triad with both the care providers and the insured/patients. The health insurer is thus purchasing the service on behalf of their insured; buying these so called *component services* has implications on how to specify the service (Axelsson and Wynstra, 2002). Furthermore, it will also have implications on how to contract, and manage the relationship, as the service delivered to the customers (insured) is delivered by a third party, the service provider, and therefore not under the complete control of the focal (buying) company. The focal company (health insurer) would, however, want to have some insight in the performance of the service provider in order to make sure that high quality care is delivered to their customers. Focus should thus be put on how these so called professional component services (ProCo services; Hovens, 2012) could be contracted, and how the buyer-seller relationships for this service type could best be managed.

So far literature has not extensively studied the combination of professional and component services. Actually, a literature review by Hovens (2012) is the first step in looking at these ProCo services. Furthermore, purchasing literature looking at the healthcare sector mainly focused on purchasing *for* healthcare instead of purchasing *of* healthcare. Now that the government is withdrawing from its controlling function and focus is put on keeping costs within limits, purchasing in this sector becomes more and more important. The goal of this study is, therefore, to increase knowledge in the field of purchasing professional services in the healthcare triad. Especially on how to specify and contract ProCo services and how to further manage the buyer-seller relationship for this type of services.

Overall knowledge on buyer-seller relationships within the healthcare sector is thus still very limited. Knowledge of this relationship is, however, very relevant with the changes the sector is currently going through. The following research question is therefore formulated in order to extend knowledge on buyer-supplier relationships in the healthcare sector.

"How can buyer-seller relationships in the healthcare market best be established and strengthened when buying professional component services, in order to secure high quality, affordable, and accessible services for consumers?"

Establishing and strengthening relationships can be a difficult and time consuming project. Not only the formal aspects such as contracts and the clauses they include are under consideration also the actual (personal) relationship can be an important facet for a buyer-seller relationship to succeed. Even the best specifications and the right type of contract can break and fall with, for example, the wrong approach or a lack of trust from either side. The other way around, unsuitable contractual agreements can destroy a good relationship. This study will therefore consider both contractual and relational aspects in the buyer-seller relationship under consideration. One part is thereby focusing on finding an answer to how to design the contract in this healthcare context. The other part focuses more on the approaches and manners that are necessary in order for the (formal) buyer-seller relationship to be established and to keep it functioning over time.

This report is structured as follows: Chapter 1 gives a general introduction into the study. Chapter 2 discusses the theoretical background. In Chapter 3 the research approach that is used as a basis for this study is outlined. Chapter 4 will elaborate on the data gathered, of which the analysis will be discussed in chapter 5. In chapter 6 the study's redesign, based on the previous findings, will be explained and resulting data will be shown. Chapter 7 will then formulate conclusions based on the results found. Eventually this report will be concluded with a discussion, limitations and directions for future research.

2. Theoretical background

As a starting point for this study a literature study (Hovens, 2012) was conducted with the leading question: "*How can the buyer-seller relationship best be designed for a free market within the healthcare sector?"* This literature study was conducted in order to gain a better insight into the current knowledge on the purchasing process for services and managing the buyer-seller relationship. Specific aspects of the healthcare sector were taken along in order to critically evaluate the findings. Based on this literature study this chapter explains what service type is under consideration considering dental services, what to do when contracting these types of services in terms of the contract design, and how to further govern the relationship between buyer and seller. More general purchasing literature is used as a basis for investigating the purchasing *of* healthcare as scientific literature is mostly focusing on purchasing *for* healthcare.

2.1 Purchasing healthcare services

The healthcare sector is often visualized as a triad. Triads consist of three entities in this case, the health insurer, care provider, and consumer (insured/patient). Within the healthcare sector different types of services occur. Some services are directed at the company itself or its employees, whereas other services are directed at the end customers. In the situation in which the health insurers purchase some sort of care from the care providers that the insured eventually consume, which is situation at which this study focuses, several service type definitions can still be applicable. The main focus of this study is the dental sector. In this section the right service type definition will be sought for this dental sector. The specific service type dealt with will affect the purchasing process to pursue.

2.1.1 Defining the service type

Just as with products there are many different types of services, researchers have therefore tried to make service classification schemes. Literature shows that researchers have come up with different classifications (Cook et al., 1999). As they use different dimensions for differentiating services these classifications can easily exist next to each other, one not necessarily being better than the other (Van Weele, 2010).

Considering the service classification by Silvestro et al. (1992), rating organizations on six service characteristics, one could state that the health insurance companies are trying to purchase *professional services* from the dental care providers. Care can come in different forms, but in case of for example dental services, involves a relatively long direct interaction between care provider and patient. Furthermore, the service has to be highly customized as no person is the same. Also, as the service has to be adjusted for every person there are no mass transactions.

> *"**Professional services**: organizations with relatively few transactions, highly customized, process-oriented, with relatively long contact time, with most value added in the front office, where considerable judgment is applied in meeting customer needs."*
>
> (Silvestro et al., 1992, p.73)

Fitzsimmons et al. (1998) use the dimensions 'importance of the service' and 'focus of the service' to classify a service. These authors name advertising as an example of a professional service. Such services

are very knowledge intensive and the way in which such services are designed is not transparent; the same goes for many health services. For a health insurance company procuring care on behalf of their insured is very important to their core business activity. The focus of the service procured is often on the care process that the care providers are able to give to the clients of the health insurer. The service procured by health insurers seems very different from the advertising example, especially as it is meant for the insurer's clients, not for the buying company itself, but the importance to the core business of the buying company is very high. According to the classification of Fitzsimmons et al. (1998) it can therefore also be stated that the health insurer purchasing dental services is buying *professional services*.

From the viewpoint of Wynstra et al. (2006) and Van der Valk et al. (2009), who focus on business services, it could be stated that the health insurer is buying *component services*. Component services have a high impact on downstream customers, which are those outside the buying company, in this case the insured. The insurance company is not looking to change the bought service or to interfere with the actual delivery of the service by the care provider.

> *"**Component services**: are passed on to end-customers without being transformed by the buying company."*
>
> (Van der Valk et al., 2009, p.810)

As a health insurer is thus trying to buy professional services for their customers, they can be seen as buying *professional component services* (ProCo services). When purchasing services one should consider what type of services are bought as this will have its influence on the purchasing process. Dependent on the criticality of the service the DMU (Decision Making Unit) needs a different composition (Van Weele, 2010). Furthermore, each type of service process requires a different service strategy, control and performance measurement system (Silvestro et al., 1992). So, in discussing how component services should be bought the one should not forget the underlying type of service that is actually delivered to the customer; a professional service. For a professional service the substantive knowledge lies almost completely with the service provider and the exact service to be delivered depends on each specific situation (high customization) and can therefore hardly be defined in advance. Mass services, on the other hand, can be defined quite exactly and can more easily be translated to service level agreements. Although health insurers also purchase more mass-like services, for example a pharmacy spreading medicines, the focus is now on the professional services, such as dental services. The next section will elaborate further on how to purchase these ProCo services, with special attention to how to contract them.

2.2 Contract design for ProCo services

The purchasing process for services in general is being perceived as being different and more complex than for goods (Smeltzer and Ogden, 2002). Furthermore, the nature of the specific service and the specific situation determines the way in which this process should be handled (Axelsson and Wynstra, 2002). Not only is it difficult to formulate the right service level agreements and contracts for business services, developing the right specifications is what primarily defines the success of the service purchasing process (Ellram et al., 2004; Van der Valk and Rozemeijer, 2009).

2.2.1 Specifying ProCo services

In order to secure the quality and content of the desired service the service should be defined quite precisely, however, as the service does not exist yet this is quite difficult. Moreover, defining the service requires some fundamental understanding of the business process (Axelsson and Wynstra, 2002). When defining the content of a service one could focus on input, process/throughput, output or outcome. Although a combination of focuses can be used a specific service will often be dominated by one of the four methods. Considering ProCo services, striving for either output or outcome specifications would be wise. Because of the professional part of ProCo services it can be stated that these services are very knowledge intensive, as a professional service involves a high degree of expertise from the service provider. Letting the buyer, usually not an expert on the service, tell the service provider what to do exactly would therefore not be useful. According to Van Weele (2010), preferably one should always strive for an output or outcome specification, since these allow the suppliers more degrees of freedom in their work. The service providers are then able to perform the service in the way they prefer and see as the best way possible. This freedom also allows the supplier to be innovative, and innovation by care providers should be stimulated (Porter and Teisberg, 2004).

Furthermore, for component services the buyer should be able to identify and communicate end customer demands as the service is without alteration passed on to end customers. Marketing people of the buying company are often involved in the sourcing process of these types of services, since they are knowledgeable about the requirements of the end customers (Van der Valk, 2007). The difficulty lies in translating these requirements to precisely formulated specifications. Gelderman and Albronda (2007) name five types of requirements to consider when formulating a service specification: functional, technical, logistical, qualitative and commercial requirements. Within a service specification a differentiation is often made between primary requirements, secondary requirements and whishes as not all specifications have the same level of importance to the buyer and there is only a very small probability that service providers are able to live up to all requirements (Gelderman and Albronda, 2007). In healthcare, for example considering the dental sector, it is often not a matter of contracting only the best care provider; the selection process is a bit different from other instances. In all instances not living up to the primary requirements should be a reason not to contract the service provider. Primary requirements can thus be considered order qualifiers. Normally, standing out in certain secondary requirements or living up to certain whishes can be order winners, however, care providers living up to the primary requirements, but not fully living up to the secondary requirements might all be very suitable to contract. Moreover, the secondary requirements might still be negotiable.

2.2.2 Contract type

Having found service providers considered suitable to deliver the service, contracting is the following step. Although Porter and Teisberg (2006) discourage selective contracting as they are of the opinion that the consumers must be able to make their own choices without restrictions imposed by others, contracting care providers is still considered an important aspect within the Dutch healthcare system. This, one can easily understand when considering the fact that in this system the health insurers are paying most of the costs involved with a care treatment. The health insurers, thus, logically prefer the insured to go to qualitatively good care providers.

As parties want to safeguard against the hazard of opportunism legal contracts are often used (Poppo and Zenger, 2002). In the contract agreements can be made on several aspects, such as performance, prices and payments. When considering professional services Tate et al. (2010) differentiate between outcome-based and behavior-based contracts. Outcome-based contracts focus on the actual performance and are therefore also often called performance-based contracts (PBC's). Behavior-based contracts, however, focus on processes, activities and tasks that will accomplish the desired results (Eisenhardt, 1989a; Tate et al., 2010). It can thus be stated that in general there are two types of contracts, those focusing on the realized service output and those that do not. Several authors have looked at these two contract types and looked into their pros and cons for sourcing services. Moreover, within literature there seems to be disagreement regarding the success of performance-based contracting, some show the positive results in terms of service delivery and cost efficiency, others put focus on the pitfalls and unintended consequences of this contracting approach. A third group states that performance-based contracting can have mixed results and states that positive results greatly depend on whether contract incentives are properly designed and carefully managed (Heinrich and Choi, 2007; McBeath and Meezan, 2009). What contract type can best be used for dental ProCo services should thus be carefully figured out by investigating the pros and cons for this service type. Moreover, contract incentives appear to have a decisive influence on the suitability of PBC's.

Contracts or Service Level Agreements (SLAs) increase a buying company's control over service delivery. The buying company wants the service provider to at least meet agreed upon service levels, and the service provider wants to be fairly rewarded for his efforts (Logan, 2000). The performance delivered by a service provider will, however, often be hard to evaluate, especially as the service is not delivered within the physical premise of the buying company. The buyer might thus be unable to effectively verify the service provider's performance (Eisenhardt, 1989a). The ease with which outcomes can be measured is, however, one of the factors making a performance-based contract favorable over a behavior-based contract (Tate et al*.,* 2010). "*In general, the more difficult it is to specify the outcome and output of the service, the more difficult it is to arrange for a performance-based contract."* (Van Weele, 2010, p. 97).

Furthermore, it is stated that behavior-based contracts are considered most appropriate when the behavior of the service provider can be monitored and measured, but monitoring behavior is often costly for professional services and it will not always be possible to establish a clear link between certain behavior and outcomes. Moreover, because of the measurement challenges little incentive will exist for suppliers to improve their cost management (Tate et al*.,* 2010). Incentives to provide high quality care can also be considered absent because of these challenges (except for the more moral incentives that care providers might have). For behavior-based contracts the risks are thus lower for the service provider as he only has to display the specified contractual behaviors and cannot be blamed for poor results. The outcome-based contract, however, will hold the service provider fully responsible for attaining the agreed result (Tate et al*.,* 2010).

It should be noted that it is almost impossible to foresee all problems and misunderstandings that might arise in the relationship between buyer and service provider. For some situations clauses might be

included in the contract to deal with certain situations, but it is considered impossible to include all possible situations; there is no such thing as complete contracting. One of the assumptions of Agency theory with regard to human nature is that the actors will show opportunistic behavior by acting in their own self-interest in case of unanticipated events (Tate *et al*., 2010). Service providers will focus on the aspects that are most easily measured as these will probably be used to evaluate performance. When focusing on what is measured one is not always showing the behavior that the buyer is interested in. For example, a dentist treating a large number of patients a day does not automatically imply that they are treated correctly; quality deterioration could take place. In the case of the healthcare sector one cannot discard this self-interest, but it might apply to a lesser extent as social (moral) responsibility also plays a role, as the actors might be intrinsically motivated to deliver high quality care for the population. However, contracts should be designed very carefully.

All in all both behavior-based and performance-based contracts have their benefits and downsides. However with the focus on keeping the cost of healthcare within limits, as is currently of importance in the Dutch healthcare market, performance-based contracting appear to have an advantage over behavior-based contracting. Furthermore, this type of contract gives the professional more freedom in doing his job which might lead to better quality. However, when working with this type of contract it is very important that the right performance measures are set. In the contractual stage it is therefore important to agree on what criteria to use for assessing the quality of the provided service. Key performance indicators should be set up (as part of the Service Level Agreements) on which both parties agree. Considering the dental sector one is working hard on defining such performance indicators, but one is still struggling with these indicators. For this sector PBC's can, for now, almost be considered impossible to use, because of this lack of performance indicators. In the future, however, this contract type might become very suitable, especially since behavior is also very hard to specify and control for ProCo services. Contracts currently used in this sector are, therefore, often considered payment contracts, as either of the two discussed contract types are currently hard to implement in full.

2.2.3 Performance measurement and management

In order for health insurers to ensure that the care provided to their end customers is of high quality they should manage and measure the performance of the care providers. The use of performance indicators is currently strongly emerging in the healthcare sector (Campbell et al., 2000; Van der Geer et al., 2009). In many countries more and more focus is put on assessing quality, moving away from assessing costs and activity. Especially efficient use of resources and effectiveness of healthcare are under consideration (Campbell et al., 2000). The Dutch healthcare sector is following this global trend of healthcare reform towards free market conditions (Van der Geer et al*.,* 2009).

In healthcare, performance management systems appear to focus mainly on final treatment results. Referring back to the way that services could be specified one could say that the focus is thus on outcomes (Van der Geer et al*.,* 2009). According to Campbell et al. (2000) the outcome is a consequence of care, not a component of care, and knows two principal domains; health status and user evaluation. Furthermore, the outcome is actually only one of the three categories involved in defining quality of care. Another category, the process of care is the actual delivery and receipt of care and can be divided

in clinical and inter-personal care processes. The clinical process focuses more on whether the care is appropriate and necessary, whereas the inter-personal care is about the interaction of health care professionals and users or their caretakers (Campbell et al., 2000). The third category is the structure of health care, which involves the physical characteristics and staff characteristics that define the health system under which care is provided. Structural features of healthcare thus provide the opportunity to be able to give care but do not guarantee it. These structural features can have a direct impact on processes and outcomes. As the outcome of care is not only dependent on the structure of health care, but also on the processes of care (Campbell et al., 2000), it could be considered wise to include process measures in a performance measurement system. As Campbell et al. (2000) state process measures are, generally speaking, better indicators of quality of care, as outcomes are often rare, often only measurable after a long time, and may be dependent on factors that the health professional does not have control of. However, suitable process measures should be linked to evidence of improved outcomes (Campbell et al., 2000). Furthermore, feedback on performance measures could generate a higher performance in the future. Feedback should, however, be limited to task elements that are controllable by the care provider (Van der Geer et al., 2009).

2.3 Governance: Contractual vs. Relational

There is more to interorganizational exchanges than what has been discussed in the previous section. The steps discussed above focus on the contract design, but the exchanges should be governed as well. For one the contract should be managed; contractual governance. Furthermore, as transactions between buyers and suppliers are embedded within a wider social context, some form of relational governance is considered to be important in order for the relationship to succeed.

2.3.1 Contractual governance

Transaction cost economics scholars state that managers look at the known exchange hazards and adjust the governance features of interorganizational relationships to match these hazards. Focus is thereby put on hazards in terms of specialized asset investments, difficult performance measurement, or uncertainty (Williamson, 1985; Williamson, 1991). Mangers therefore often compose contracts to hedge these foreseeable hazards.

Since it is almost impossible to foresee all problems and misunderstandings (Poppo and Zenger, 2002) it is impossible to draft complete contracts. Contracts can therefore not include all the necessary safeguards to reduce transactional ambiguity and mitigate opportunistic behavior (Lui and Ngo, 2004). However, as exchange hazards rise so must contractual safeguards (Williamson, 1985). Considering the healthcare sector, most hazard probably lies in the fact that performance is difficult to measure. As performance can hardly be measured parties might limit their efforts towards fulfilling the agreement. Mangers can then choose between realizing lower performance or improving performance measurement by expanding resources in order to create more complex contracts (Poppo and Zenger, 2002). The complex contracts that are needed in these instances are costly to craft. Parties are only willing to bear these cost as the consequences of contractual breach are considerable (Poppo and Zenger, 2002).

Completer contracts more abundantly detail roles and responsibilities to be performed, explicitly specify procedures for monitoring and penalties for underperformance, and determine the outputs or outcomes to be delivered (Poppo and Zenger, 2002). Contracts extensively including all the above may, however, provide for a very rigid relationship as almost no room is left for flexibility. The supplier could see the rigorous application of a formal contract as the buyer taking advantage of his power (Ferguson et al., 2005). Excessively detailed contracts are, furthermore, hard to monitor ex-post. Less extensive contracts, on the other hand, are often seen as a poor governance mechanism as they might introduce ex-post problems when unforeseen and undefined events occur. However, these contracts can be favorable as they give room for more flexibility. Especially within the healthcare sector with its complex professional services one could never stipulate every potential contingency and should not strive for it either. It would be wise to leave some room for the professional service-provider to deliver the service in the way he prefers and sees as the best way possible.

2.3.2 Relational governance

Many scholars agree that the governance of interorganizational exchanges involves more than formal contracts (Poppo and Zenger, 2002). Relational governance mechanisms refer broadly to mechanisms based largely on trust and social identification. Empirical work shows that relational governance is associated with *trust*, which is found to improve the performance of interorganizational exchanges (Poppo and Zenger, 2002). Relational governance is thus seen as a mechanism that can enhance the exchange performance (Ferguson et al., 2005); it can thus be expected that it helps in establishing a successful buyer-supplier relationship.

Performance is expected to be enhanced as the exchange is embedded in public and private information flows that commence by the social ties. Certain behavioral guidelines are derived from the shared norms and values and are further developed during the socialization process (Ferguson et al., 2005). Having these shared norms is likely to reduce the chances of opportunistic behavior as a 'trustworthy' exchange partner does not want to jeopardize the relationship established.

Furthermore, the social and organizational mechanisms that control the exchange have these norms and values that promote flexibility, solidarity (commitment), and information exchange (Poppo and Zenger, 2002) at their basis. These norms help circumvent the potentially high costs of exchange hazards, as *flexibility* provides adaptability in case of unforeseeable events, *solidarity* takes care of a certain commitment to joint action when problems need to be solved, and *information sharing* further facilitates problem solving and adaptation (Poppo and Zenger, 2002). However, the development and maintenance of the mechanisms within the dense network of social ties might involve considerable costs in terms of time and resource allocation (Poppo and Zenger, 2002). Furthermore, parties should take care of not losing themselves in these dense social ties, making them blind to new information and new opportunities.

2.3.3 Contractual and relational governance: substitutes or complements?

Research has generally viewed relational governance and contractual governance as substitutes. However, several recent studies suggest that contractual and relational governance need to be considered as complementary mechanisms (Poppo and Zenger, 2002; Ferguson et al., 2005).

One of the arguments for using the two governance types as substitutes is the statement that there is simply little need for contractually specifying actions if one party trusts the other. Furthermore, relational governance enables adaptive responses and lowers transaction costs. So, informal social controls push contractual governance to the background (Poppo and Zenger, 2002). Another argument stating that both governance types should not be used simultaneously is the argument that contracts may signal distrust in the eyes of the supplier. Undermining trust might encourage opportunistic behavior instead of discouraging it (Ghoshal and Moran, 1996; Poppo and Zenger, 2002), and thereby hinder the development of relational behavior. Contractual governance is then thus seen as undermining the formation of relational governance. The arguments indeed appear to be indicating that relational governance and contractual governance are indeed substitutes. Moreover, the feeling is given that relational governance is placed above contractual governance. This feeling is further endorsed when considering the basic fact that contracts are in fact costly to write, monitor and enforce. Furthermore, Cannon et al. (2000) demonstrate that detailed contracts and not well developed norms reduce exchange performance. Another interesting statement by these authors is that relational governance enhances performance under conditions of both high and low environmental uncertainty (Cannon et al., 2000), whereas one could imagine that in an environment of high uncertainty good formal agreements will be hard to make.

Empirical research in business services has, however, disconfirmed the substitution view (Poppo and Zenger, 2002), but has not disconfirmed the view of complementarity of contracts and relational governance.

It is stated that in isolation contractual mechanisms may lack enforcement capabilities as for these relationally-governed exchanges the enforcement of contracts relies less on third parties, such as the court (Ferguson et al., 2005). For these interorganizational exchanges enforcement occurs through social processes that build trust; relational mechanisms are thus of importance for these exchanges to succeed.

Another aspect is that higher levels of relational governance can moderate contract enforcement in conflict situations as the social ties result in strong norms, and build trust and commitment that makes the involved parties less reliant on the formal contract (Gundlach and Achrol, 1993). Roxenhall and Ghauri (2004), however, claim that contracts are hardly ever established to prove what was agreed upon or to enforce the agreement. These authors do demonstrate that contracts are mostly drawn up to establish business relationships; confirming the willingness of both parties to engage in the exchange.

According to Ferguson et al. (2005) contractual governance can be advantageous for relationships in a business-to-business environment as the negotiation process can help structure expectations and obligations. Furthermore, the negotiations can serve as a foundation for social governance mechanisms

as it promotes expectations of cooperation (Poppo and Zenger, 2002) and in that manner function complementary to relational governance. *'Thus, the process of developing complex contracts in response to exchange hazards positively affects future exchange performance through the development of social relations (i.e., relational governance) as well as complements relational governance through the formal specification of limits and expectations.'* (Poppo and Zenger, 2002, p.713).

Furthermore, the refinement (increased complexity) of formal contracts may be promoted by relational governance. As a close relationship is established and sustained parties can evaluate on lessons learned and revise their contracts accordingly. *'Exchange experience, patterns of information sharing, and evolving performance measurement and monitoring may all enable greater specificity (and complexity) in contractual provision.*' (Poppo and Zenger, 2002, p.713). Relational exchanges may thus gradually develop more complex formal contracts.

Formal contracts help ensure that the early, more vulnerable stages of exchange are successful (Poppo and Zenger, 2002), because of the negotiations necessary to craft a contract. Formal contracts promote relational governance in exchange settings. On the other hand relational governance enables refinement of contracts and promotes stability in interorganizational exchanges. It seems, however, that for established exchanges relational governance should become predominant as empirical evidence shows that, in various contexts, established exchanges are characterized by relational governance, which positively influences performance (Ferguson et al., 2005).

2.4 Conclusion

According to purchasing literature, PBC's are considered most suitable as these hold the service provider more responsible for attaining the agreed result. This preference is further confirmed as it is not only hard to describe specifically what behavior is expected. Moreover, displaying the specified behavior does not automatically result in the expected results, but the care provider cannot be held responsible for this. Contract incentives should, however, be carefully designed for PBC's to work. This will also apply to other contract types.

Furthermore, the notion should be made that PBC's can only properly work as performance can be verified and for this it is necessary to come up with profound performance indicators. The dental sector, however, has not implemented such indicators, making performance-based contracting impossible for now. Recently, some indicators have been defined, but these are currently being tested and therefore cannot yet be used. Considering literature it is, however, considered wise to include both outcome and process indicators once they get implemented.

PBC's being not possible yet, behavior-based contracts are not automatically the contract type to use. Monitoring behavior is hard for professional services, and will only get more difficult and expensive for ProCo services such as the dental care services, since the component part means that the service interaction does not directly involve the buying company. However, considering the necessary outcome and process indicators for performance-based contracting, one should also still keep in mind the feasibility of monitoring the different measures and the costs coming along with measuring them.

Furthermore, the relationship between buyer and seller should be governed, also when considering ProCo services. In general, it seems that formal contracts are important in the early stages of the exchange, whereas relational governance is becoming more and more important once the exchange is established. The development of relational governance is, however, considered a necessity for exchange relationships, in general, to succeed.

Given the lack of performance indicators to be applied in the dental sector the contract type will not be further studied in this study. The role of contract incentives will, however, be studied further. Whether the concepts on governance proposed by literature are indeed applicable to the buyer-seller relationships in the healthcare sector considering ProCo services will also be studied. Figure 1 shows the factors that according to literature will influence the establishment of the buyer-seller relationship, and that will be further discussed in this study.

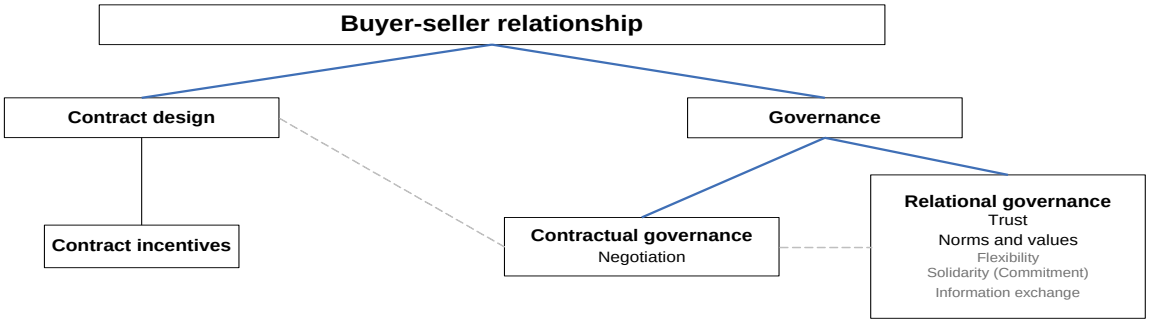

Figure 1: Factors influencing the establishment of the buyer-seller relationship

3. Research approach

As introduced, this study is focusing on purchasing ProCo services and how this should be done in the healthcare sector in order to establish and strengthen the buyer-seller relationship. The theoretical background outlined in the previous chapter gave some insight in what academic literature states on purchasing services and buyer-seller relationships. This theory is used as a background for this study, however, in order to provide a clear and founded conclusion to the central research question for this study several stages have to be passed through. The three major stages that this study consists of being: 1) defining a research methodology, 2) gathering and analyzing data, and 3) reporting the conducted study and formulating conclusions. The first two stages will be described in the following sections. The fourth stage consists of this report.

3.1 Stage 1: Research methodology

In order to find an answer to the research question a certain research methodology had to be chosen. Because of the generally complex social phenomena in healthcare, especially with the new situation of a free market for dental care that is under consideration, case study research appeared to be the most suitable research method for this project since it allows the study of real-life events without disturbing the holistic and meaningful characteristics of these events (Yin, 2009). According to Yin (2009) and Dul and Hak (2008) one of the distinctive characteristics of a case study is the fact that the object of study or its environment are not manipulated (*real-life context)*. Scores obtained from the case(s) are then analyzed in a qualitative manner.

Furthermore, as Yin (2009) states, research questions starting with 'how' are more exploratory in nature and likely lead to the use of case studies. In this study we try to explore what aspects can establish or strengthen a relationship in the healthcare sector. For VGZ specific we, however, also try to explain the underlying reason of why relationships are not always present or well established and what can be done about this. According to Dul and Hak (2008) we can furthermore make a distinction between practice-oriented and theory-oriented research, in this project both are combined. Based on the real life context a contribution to the knowledge of VGZ was sought, however, based on existing literature and the specific characteristics of professional healthcare services a contribution to theory development was also sought.

Within case study research there is the possibility to do a single-case study or a multiple-case study. The first one is very useful when considering unusual or rare cases (Yin, 2009). Multiple-case designs are often seen as more robust because evidence from multiple cases is considered to be more compelling. Within this study multiple cases were investigated in order to provide an answer to the research question. Section 3.2 will further elaborate on the cases chosen.

3.2 Stage 2: Data collection and analysis

As discussed before the Dutch healthcare sector involves health insurers, care providers and the insured. These three parties together form a triad that has three different relational links (Figure 2). As can be seen from the research question the buyer-seller relationship is the relationship to be further studied, as it appeared from literature that not much was known on how to build such a relationship in

the healthcare context when considering ProCo services. The health insurer VGZ was found as a suitable facilitator for conducting a case study in this area as it is one of two parties (the buying party) involved in the relationship to be studied. This chapter will introduce the case company and the specific sector to be studied, as well as explain the followed design of the study; defined cases, gathered data and analyzing approach.

3.2.1 The case company: VGZ

The study described in this document was conducted at a Dutch health insurance company called Cooperation VGZ. Up until 2011 this company was part of the Univé-VGZ-IZA-Trias (UVIT) cooperation, but in 2012 privatization followed. Cooperation VGZ not only consists of the 'brand' VGZ, but also Univé Zorg, IZZ, IZA, UMC, and Cares Gouda fall under the responsibility of Cooperation VGZ. The cooperation has an estimated 4.1 million clients and VGZ itself has grown to one of the largest Dutch health insurers with about 1.2 million clients in 2012. VGZ has many individually insured clients in the south of the Netherlands; overall the number of insured of Cooperation VGZ is highest there. Furthermore, the cooperation has a strong position in the business market, mostly in the top 50 companies, government, and educational sector.

The slogan of VGZ is *'Voor goede zorg zorg je samen'* (translation: for good healthcare you care together). In order to secure good healthcare the cooperation between customer, caregiver and the insurance company is getting ever more important. The relatively new Health Insurance Law imposed by the Dutch government in 2006 got these three parties closer together, which is necessary to assure high quality healthcare that is accessible and affordable.
As shown in Figure 2, the health sector is made up out of three closely related markets; the care market, insurance market and healthcare market. A health insurance company such as Cooperation VGZ offers different insurance packages (basic and supplementary) that the customers (the Dutch population) can choose from. The insurance packages for example compensate for hospital care, dental care, pharmaceutics, contact lenses, physiotherapy, etc. A client pays a certain insurance rate, depending on the insurance package desired. Furthermore, a client has an own risk (Dutch: *eigen risico)*; a pre-specified amount for which he will not be compensated. For example, in 2012 the mandatory own risk is €220, this means that you have to pay yourself for the first part of care that you receive (the first €220). With many insurance companies it is possible to chose for a higher own risk in return for a lower insurance rate; meaning you have to pay a larger part of the care you receive yourself. Some types of care are, however, excluded from this own risk, such as the general practitioner, maternity care, and the care covered by your supplementary insurance. Furthermore, depending on the (supplementary) insurance package the client will be compensated up until a certain amount for a certain type of care; a supplementary package can for example include a compensation of €150 for contact lenses every 2 years, if the lenses cost more the remaining costs are for the insured's own account.

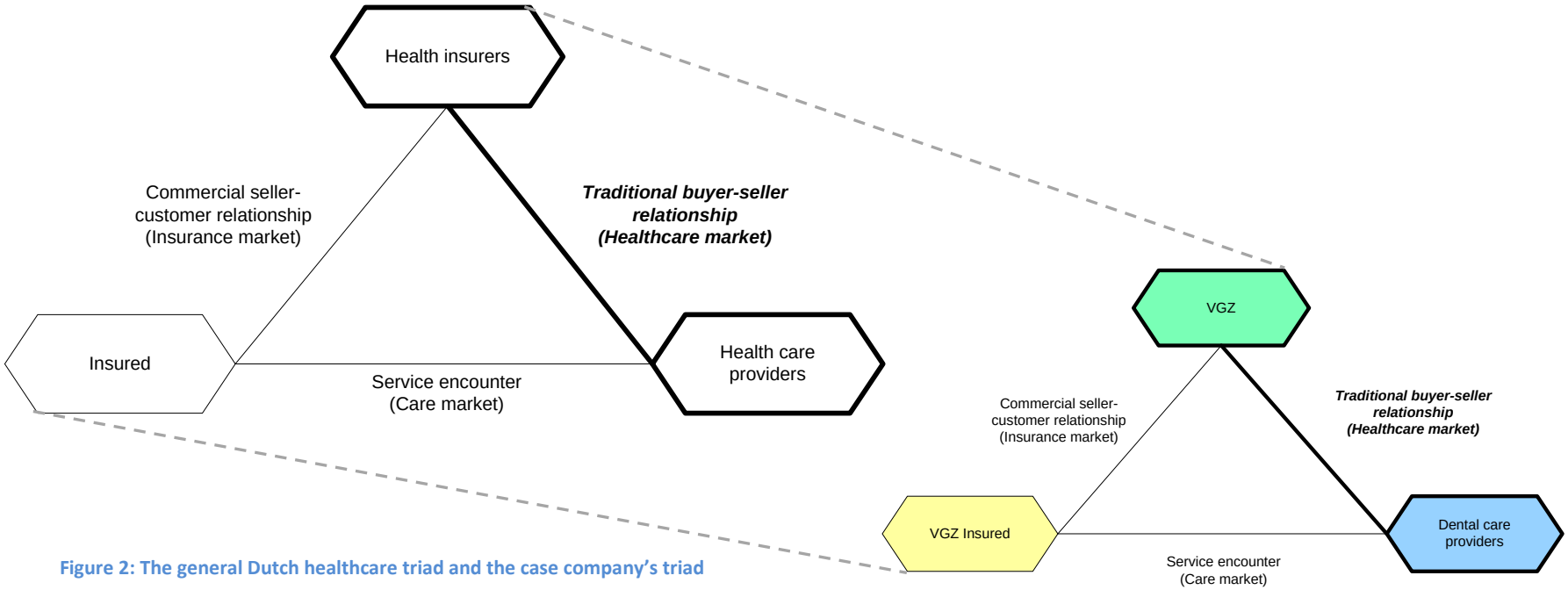

Figure 2: The general Dutch healthcare triad and the case company's triad

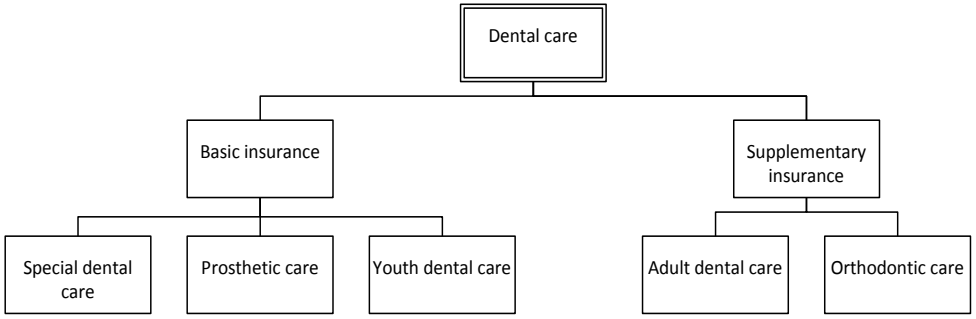

Figure 3: Division of dental care types

When a client has signed the contract for a certain insurance package he can just visit the dentist, general practitioner, physiotherapist, etc. It should be noted that refunds can differ depending on the exact insurance package chosen. Often the insurance company has made certain (administrative) agreements with the care provider, leaving the client completely out of the payment process. Sometimes the client has to ask for compensation by sending the invoice to the insurance company. The care providers thus take care of the treatment, medicines or other products towards the patient/consumer and most of the times get paid by the insurance company of which the patient is a client.

The insurance company tries to make certain agreements with care providers in terms of quality, prices and volume. Furthermore, it sets up some incentives (e.g. a lower insurance rate when taking the basic insurance type '*natura*' instead of '*restitutie*') in order for the insured to visit contracted care providers as this will give them a better refund. The insurance company knows better what to expect from these care providers in terms of costs and quality and therefore prefer doing business with them.

3.2.2 The dental care sector: a problem definition

Several types of care that a health insurer is concerned with could be used as a case. One could, for example, think of physiotherapy or dental care, which are both professional services that the health insurer wants to purchase in order to offer the insured accessible, high quality and affordable care. Eventually, dental care was chosen as the specific sector in this context to study, not only because it lived up to the specifications of the researcher to study a ProCo service, but because this sector was, and still is, going through lots of developments that would make the state of the buyer-seller relationship even more important. The sector's triad and the exact relationship under consideration within this case study are also shown in Figure 2.

The research at VGZ was conducted at the department of Dental Care. This department takes care of the purchasing of several types of dental care. Within the basic insurance package special dental care (e.g. special orthodontic care and implant care), prosthetic care, and youth dental care (for those under 18) are included. In supplementary packages adult dental care (for those above 18) and orthodontic care are included (Figure 3).

Setting up care agreements is very important for VGZ, since they are meant to control for several aspects important for their clients, being: high quality care, affordability, and accessibility. In the dental care market in 2011, however, almost no care agreements have been signed between the dental care provider and the health insurer (with the exception of implantologists and dental prostheticians, with whom care agreements exist more often). For most other dental care providers only general terms and conditions apply.

Incentives thus seem to be lacking for dentists to sign contracts with VGZ. Moreover, the imbalance in the relationship between dental care provider and health insurer does not improve the situation. Looking at the dentist density in the Netherlands this greatly varies throughout the country, with some problematic areas, such as Overijssel and Zeeland where there are about or more than 2400 people per dentist. If most dentists do not have much capacity left at their dental practice there is not much room

to move insured around to other dentists (the 'preferred provider system'). As dentists do not really have to be afraid to lose a lot of their patients, they are not expected to feel the need to sign a contract in order to become a preferred provider.

Furthermore, dentists might feel that contracts will take away the freedom of performing their service tasks as they prefer, and what they see as the best possible way. Performance levels are hard to define for services, but almost certainly will, in one way or another, be included in a contract causing dentists to feel threatened in doing work their way and rejecting contracts.

For general dentists the contracting rate is very low. For this large group, of about 8000 dentists, care agreements are thus not abundantly present, making it hard to control for the factors: quality, affordability and accessibility. Up until 2011 affordability was largely controlled for by the maximum prices the Dutch Healthcare authority (*NZa*) set for dental care. However, from the 1st of January 2012 onwards a lot has changed within the dental healthcare market. A new performance structure came into effect and the government allowed free pricing for dental care providers. The imbalance in the relationship between health insurer and dental care provider becomes more of an issue in this situation, because of the retreating role of the government. After all, as dental care providers are allowed to set their own prices, affordability might become an issue as the expected rising cost prices for health insurers might have their effect on the insurance rates if no action is undertaken. From 2012 onwards suitable care agreements thus became more of a necessity for all types of dental care to keep control of the situation.

VGZ also felt that it should focus more on the purchasing opportunities in this sector and therefore was interested in further investigating how to establish and strengthen this specific buyer-seller relationship.

3.2.3 Gathering data

Within the dental sector there are thus several different types of care providers such as the general dentists, implantologists, and orthodontists. Investigating all the different buyer-seller relationships within this sector would not be feasible within the time span of this study. Furthermore, VGZ was especially interested in the buyer-seller relationship with the general dentist as it was especially hard to come to contractual agreements with this relatively large group of dental care providers. The implantologists, which are general dentists specialized in implantology, are most similar to this group and were therefore considered as a group to compare with. Moreover, this group was considered interesting as the contracting rate was much higher and sufficient for VGZ. To find out whether it was indeed smart to take along the implantologist group in this study, exploratory interviews with two advising dentists of VGZ were conducted. The interviews revealed that the situation for implantologists, and thereby the incentives to enter a relationship with the health insurer, was actually so different from the general dentists that taking this group along would not really add to the study. A check with a dentist-implantologist further confirmed this; therefore this group was not further examined.
The orientating interviews with two advising dentists as well as interviews with two purchasers of VGZ were meant to gain more internal VGZ knowledge on the general dentists and VGZ's relationship with them. These orientating interviews, furthermore, considered how to form a representative 'sample' of

the Dutch general dentists market. Eventually this led to the determination of four different sub-groups of general dentists to be investigated.

A matrix was set up in which a distinction is made between 'contract' or 'no contract' on one side and 'core' or 'non-core' on the other side. The necessity of the distinction between contract and no contract is quite straightforward as one group will be able to give a clear indication of why they decided to contract, whereas the other group will clarify why they did not. It was, furthermore, expected that the incentives for dental practitioners in the core area of the health insurer (Appendix I) might be different than for those in non-core areas. In the core area a relatively high percentage of the population is VGZ insured, which is expected to be reflected in the percentage of VGZ insured patients in the patient database of dental practices located in this area. As can also be seen in Appendix I, the top 25 of Dutch municipalities for VGZ have over 40% VGZ insured. VGZ considers municipalities with over 33.3% VGZ insured as very interesting. Translating this to dental practices, a typical dental practice in the core area can be expected to have well over 30% VGZ insured.

Although this study is done from the business situation of VGZ, exploratory interviews with another health insurer further contributed to the establishment of the four cases. These two extra interviews indicate that the market situation seems to be comparable for other health insurers as well; they thus gave some further indications that choosing these four cases was logical. The complete design for this study is visualized in Figure 4, where the numbers indicate the number of interviews. It should be noted that reliability will increase if multiple sources of data on the same phenomenon are used (Voss, 2002). As both internal purchasers and advising dentists are interviewed as well as people with those functions in a similar company, and the perspective of the seller is also taken along reliability of the findings thus increases.

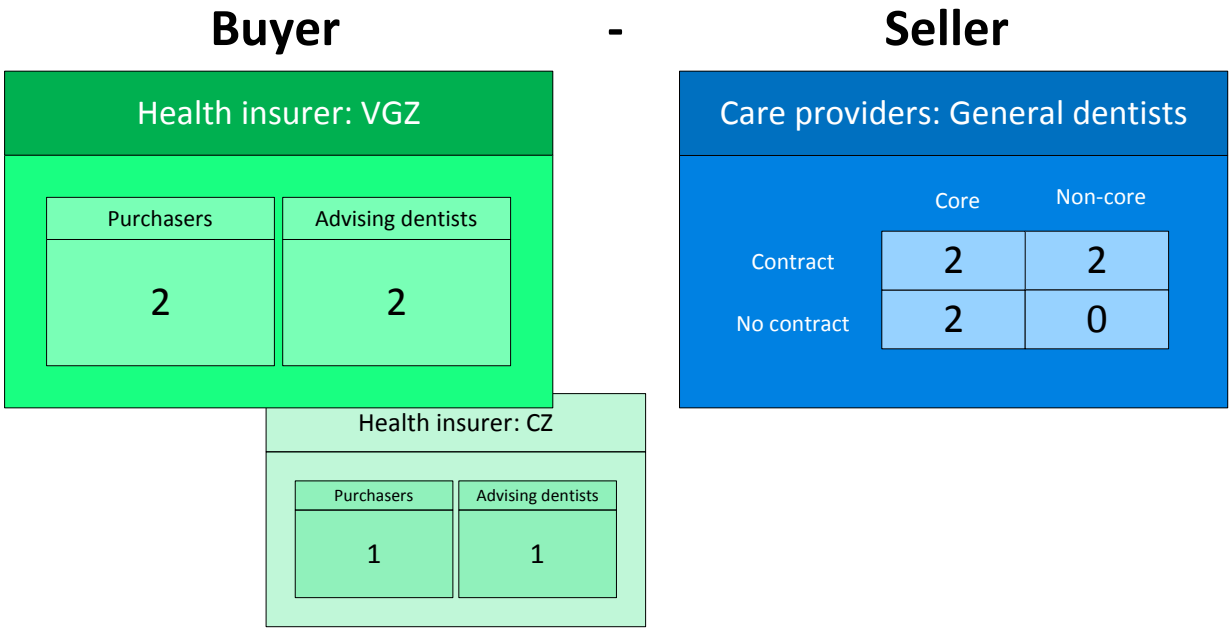

Figure 4: Case study design

Based on the VGZ list of approached dentists and their list of contracted parties, dentists were divided in one of the four groups defined and several were contacted by telephone and asked to contribute to the study by means of an interview. For the list of interviewed parties and the telephone script see Appendices II and III. Face-to-face interviews were held with the dentists or dental practice managers that accepted for the cases defined. Face-to-face interviews were chosen because the context is complex, especially for an outsider. These types of interviews are suitable for asking open and complex questions (Baarda and De Goede, 2006); by using these open questions more knowledge can be gained. The interviews were semi-structured. Some leading questions were prepared (see Appendix IV) which were revised by advising dentists and purchasers in order to make sure that all relevant leading questions were included and correctly formulated. The leading questions formed a certain basis necessary in order to be able to compare the cases, but when crossing an interesting topic further questions were asked. A high proportion of the questions were open questions, although this makes the processing of data more difficult and time consuming, these questions are most informative in this complex situation where knowledge is limited.

It should, however, be noted that the 'non-core/no contract'-case shows 0 interviews. This case was not further investigated as no completely new insights had to be expected after the other three cases had been investigated. Taking this case along would only take a lot of (travelling) time which would not weigh up as no new information was expected. Moreover, the primary interest of VGZ is the core area and therefore time was rather put in a redesign of the study. With the interviews having given several suggestions and directions for improvement it would be interesting to see what aspects are considered most important and, moreover, to see what actions and purchasing process changes are needed to make these improvements. Both care providers and the health insurer will have ideas on how to improve, but together they can best come to a feasible action plan, which is why they were both involved. A meeting was therefore planned for which both employees of VGZ as well as care providers were invited. With a brainstorm session and room for discussion the opportunity was given to come up with suitable action plans. The report on this meeting was verified by one of the participants of VGZ.

Data triangulation, the use and combination of different methods to study the same phenomenon (Yin, 2009), will enhance the reliability of finding. Besides interviews and a brainstorm-meeting further knowledge about the market situation and processes was gained in several ways. Documentation was reviewed, such as the care agreements used and policy plans for dental care. Furthermore, VGZ had decided to hire a strategic consultant (BCG) to help them with entering the new situation of a free dental market from January 2012 onwards. The documents and presentations that BCG made, while conducting their project aimed at finding a good strategy for VGZ to approach the new situation in the dental market and providing the necessary tools for analyzing dentists in terms of prices and volumes, were also reviewed. Several meetings (*Werkgroep vrije tarieven Mondzorg* and *Teamoverleg Mondzorg*) were attended as well in order to gain more background knowledge. Furthermore, having a workplace in the same office as the advising dentists and purchasers enables closely following the processes and issues. As interviews were not the only way in which data was collected the concept of data triangulation was met. Data triangulation is one of the tactics to assure construct validity (Yin, 2009). The others used in this study are verifying the interviews with the interviewees in order to assure that

their input was processed correctly. Also the report on the meeting was verified by a participant. Moreover, the progress of the study and the (final) report were reviewed by the supervisors of this project at VGZ.

3.2.4 Analyzing data

In order to analyze the qualitative data from the interviews the interviews were recorded and transcripts were made that were sent back for verification to the interviewees. In order to analyze the data three concurrent flows of activities, as defined by Miles and Huberman (1994), are passed through, being: data reduction, data display, and conclusion drawing/verification. Together with data collection these three types of analysis activities form a cyclical process as shown in Figure 5.

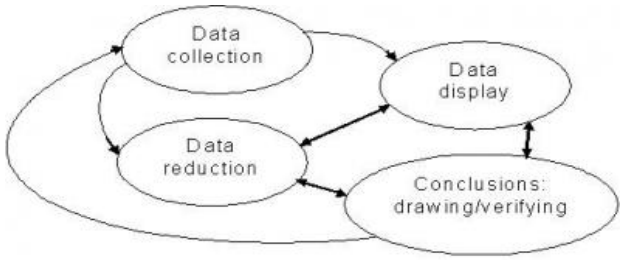

Figure 5: Components of data analysis: Interactive model **[Source: Miles and Huberman, 1994]**

As transcripts of interviews form an enormous amount of data that is quite unstructured, even though the interview were structured around a fixed set of questions, the data has to be reduced in order to be able to analyze it in a profound way. Burnand (1991) and Miles and Huberman (1994) describe several stages for analyzing interview transcripts in qualitative research. Coding the data is one of the most important steps in analyzing this type of date. In this study it was chosen to use the software Nvivo to help in coding all the data. This is not only easy as coding itself goes quicker, but it also enables easily taking together sections of the same code from different transcripts that enables analyzing categories separately and writing-up the concluding findings for each of these categories.

As case studies in general involve a staggering volume of data (Eisenhardt, 1989b) several analyzing steps have to be conducted in order to be able to draw substantiated conclusions. A within-case analysis allows us to become familiar with each of the three cases as a stand-alone entity, which will eventually allow the unique patterns of each case to emerge (Eisenhardt, 1989b). After this a cross-case analysis can look at the similarities between cases and search for intergroup differences (Eisenhardt, 1989b). For this study a comparison of the cases consisting of contracted parties will be made as well as a comparison of the cases with parties in the core area of VGZ.

3.3 Conclusion

This chapter has described the case company and its specific problem. Moreover, the chapter has described exactly what research steps are taken. By describing these in a way that makes them repeatable by other researchers enables them to draw similar conclusions; improving the reliability of the study. Chapter 4 will now specifically discuss the gathered data from several of the sources described above: care agreement documentation, exploratory interviews, and data gathered from the three cases studied.

4. Data: perspectives on the buyer-seller relationship

The goal of this study is to find the best way to commit health providers to the insurance company. This commitment was sought in the possibilities of setting up care agreements with the dentists, but also possibilities to create commitment by strengthening relational aspects were not overlooked. In order to find an answer to the research question one should evaluate the current buyer-seller situation, how the different parties involved experience this situation, and what possibilities they see in changing this situation for the better. This chapter provides an overview and explanation of the data that was gathered from both sides of the buyer-seller relationship. Documentation as well as interviews and meetings provide an insight into the relationship from the perspective of the health insurer. Interviews with dental care providers for each of the three cases investigated provide data from the supplier's side.

4.1 Care agreements: recent developments

With the changes in the dental care market VGZ decided to make some changes in their policy. Up until 2011 VGZ (then still called UVIT) offered all dental care providers some general terms and conditions, mainly focused on direct invoicing, but as of the 1st of January 2012 these were terminated. With the termination of these general terms and conditions the content of the care agreements was changed somewhat in order to keep all important aspects included when a formal relationship went into effect. These new care agreements, for example, now had to include clauses on direct invoicing as these were previously part of the general terms and conditions.

4.1.1 General terms and conditions 2011

The general terms and conditions were actually focused on direct invoicing of the dental care operations. For all UVIT clients with a basic insurance from UVIT the dental care providers could invoice directly to UVIT. It did not matter whether the insured did or did not have a supplementary insurance with UVIT. Only if they had such a supplementary insurance with another health insurer, dental care operations falling under this insurance should not be invoiced with UVIT. Wrongly submitted invoices were returned to the care provider.

The care provider should provide a direct invoice to the health insurer for the care provided in a certain month before the end of the next month. If this was done the care provider could (with some exception such as invoices for missing an appointment and invoices of more than €1650) expect a payment of 100% of this invoice within 21 days after the invoice was received by the health insurer. The health insurer would then take on the task to acquire the uninsured parts with the insured client. If the client did not pay UVIT would ask third parties, such as a collection agency, to help obtain these back payments. UVIT thus took over the default risk as it would in no instance ask back the part of the invoice that the patient did not pay from the dental care provider. If a patient has complaints the health insurer can reverse the payment made to the care provider. If the complaint has been resolved the care provider has to send the invoice to the patient, who can then file it with the health insurer.

Besides conditions focused on the actual invoicing, the document included one other important aspect stating that the health insurer is allowed to control the activities, for example in terms of overtreatment, performed by the care provider. The patient registration station is thereby accessible only to employees

who belong to the functional unit of the medical adviser of the health insurer. Furthermore, the care provider himself should be enabled to be present during this control.

4.1.2 Care agreement general dentist 2012

As of 2012 the general terms and conditions were terminated, the possibility for direct invoicing was thereby completely cancelled for care not falling under the Health Insurance Law (Zvw) as long as no care agreement had been signed by the care provider. Moreover, when a care agreement is signed direct invoicing for care not covered by this law is only possible if the patient has a supplementary dental insurance with one of the 'brands' of cooperation VGZ. Equal to the year before the care provider should provide a direct invoice to the health insurer for the care provided in a certain month before the end of the next month. Invoices for missing appointments are still not part of this system. If the invoice has been delivered on time the health insurer pays 100% of the invoice within 21 days after the invoice has been received (there is no monetary limit for invoices). If, for some reason, VGZ cannot make this payment within those 21 days they will make an advance payment of 90% of the invoice within this time period. Part of the agreement is that VGZ will take over the default risk under the same conditions proposed in the former terms and conditions.

Besides the clauses on invoicing this care agreement includes some further clauses. One of these clauses is focused on controls. This clause states that health insurers are allowed to control for compliance to the conditions included in the care agreement. One of these conditions is that the care provider should have the right expertise and deliver quality. Besides performing according to standards and being registered in the '*Kwaliteitsregister Tandartsen*' or '*Stichting Garantiefonds Mondzorg*' there are no specific quality requirements stated in the agreement. The health insurer is, moreover, still allowed to perform a physical check within the dental practice.

An important difference between the former terms and conditions and this care agreement is that this agreement involves price arrangements. VGZ wanted to include these prices in order to keep grip on the new situation in which no fixed prices are set by the government anymore.

4.1.3 Contracting

As prices were fixed before and VGZ was not expecting general dentists to suddenly start signing these care agreements, especially when these included price arrangements, they were looking for incentives for general dentists to sign. A decision that was thus already made by VGZ is that taking over the default risk of the dentist is only done when a care agreement is signed. This can create an incentive for the dental care provider to sign a care agreement, although a factoring company such as Fa-med could also take over this job for a small fee per invoice. The contracting rate went from 0% in 2011 to about 10% in 2012. Whether this was caused by the termination of terms and conditions and the fact that the default risk was taken over only with an agreement, or whether this was caused by other factors, cannot be stated based on this documentation. Interviews were held to provide more data on this and other related topics.

4.2 A health insurer's perspective

Several exploratory interviews were held in order to obtain an understanding of the dental care sector, but also to gain an insight into the state of affairs with the buyer-seller relationship, the expectations of the health insurer, and VGZ's processes in terms of purchasing dental care.

4.2.1 Purchasing process

Exploratory interviews with the *Team manager generic care purchasing* and a *Dental care purchaser* of VGZ have given an insight in how VGZ has organized the purchasing process for dental care. First of all one purchaser and one assistant purchaser, in total 1,5 FTE are responsible for the entire dental care sector which is composed of well over 8000 dental practices and hundreds of other dental care providers. These care providers are mostly contacted through mailings/e-mail, as "*For this amount of care providers there is actually really no good alternative."* (Team manager). So only occasionally dental care providers are contacted by telephone, and only in exceptional cases face-to-face.

In Figure 6 the general purchasing process for the most recent contracting period is shown in order to give an overview of the steps that were made. *"The way contracting is approached legitimizes the choice for a standard approach towards dentists. We are not going to individually negotiate conditions with every dentist."* (Team manager). The care agreement offered is thus standardized for every care provider. The prices agreed upon can, however, be different and depend on what the care provider is offering. Of course not all offerings are automatically accepted, a tool is testing the offered prices together with the treatment volumes the dentist has shown in the previous years. Even if overall prices are lower or only marginally above the prices set by VGZ a higher price, for a certain treatment executed very often by that dentist, can dramatically increase dental care costs. Only if the outcome of the tool is within certain boundaries the care agreement is finalized. Sometimes outcomes are just above limits and negotiation on prices follows, which normally goes through e-mail.

In the first few months of the year the purchasing department has, furthermore, actively sought for big dental practices in VGZ's core area. Large parties such as '*Kies Mondzorg'* and '*Samenwerkende Tandartsen',* which include many dental practices, have been approached in a more active manner. These parties have many VGZ insured and one care agreement can be made for all dental practices belonging to such a party. The time effort put in because a more personal approach is chosen is quickly earned back as one can simultaneously contract several dental practices. A more active approach was also pursued for some strategically chosen parties, such as parties with relatively many VGZ insured close to dental practices that were considered not performing to the desired standards. The results were, however, somewhat disappointing.

Meetings with regionally formed groups of dentists were previously visited as these visits were part of VGZ's policy, however, with the corporate mergers of the last years these meetings with regional dental associations, have been almost completely terminated. Only the contact with the NMT (*Nederlandse Maatschappij tot bevordering der Tandheelkunde*) has remained. As the Team manager states: "*We hear signals that dentists would appreciate having these regular meetings, but these signals are given by contracted parties. … but this leaves us guessing what the dentist population more generally thinks of*

these meetings." It is thought that these meetings could possibly help in creating more trust as they could give more transparency in VGZ's actions, something which the company is aiming for.

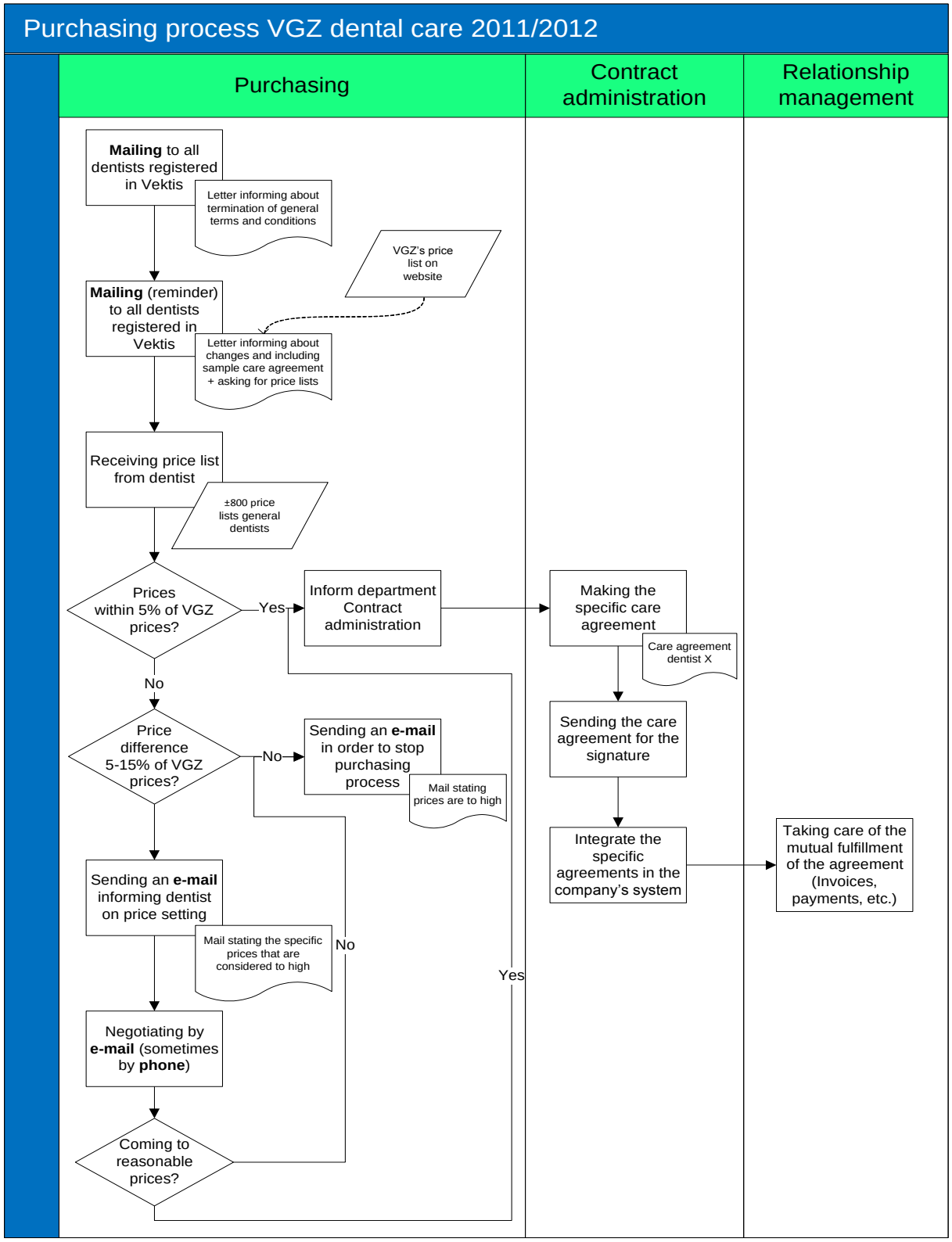

Figure 6: Purchasing process at VGZ

4.2.2 Contract VGZ

The interviews with the *Team manager* and *Purchaser*, together with the interviews with two *Advising dentists* show the perspective of VGZ towards the contract they offer and what they expect to be incentives or impediments for the general dentist to sign this contract.

The interviewees all see the administrative advantages of direct invoicing and taking over the default risk as the greatest incentive for dentists to sign the contract. As one of the advising dentists states: *"The advantage of the contract that the dentist is now going to sign is that of VGZ taking over the default risk and the possibility for direct invoicing. You then take over a large part of the administrative burden of the dentist."* There is an automatic system VECOZO through which the invoices can be handed over to the health insurer who then pays the invoice and takes care of the process of retrieving the part that the patient is not insured for. This is said to be time saving for the dentist as he does not have to search how much of the total invoice the patient has to pay himself and he does not have to send separate invoices to his patients, or put extra effort in receiving the money from these patients. Furthermore, the risk of patients not paying is hereby transferred to the health insurer.

On the other hand, the advising dentists expect the dentists to be less enamored of several of the requirements that VGZ has put into the contract. *"A contract with VGZ is nice…, but the insurer expects something in return."* Dentists are considered less willing to sign as clauses of quality measurement are included. It is, however, stated by the advising dentists that if these quality measurements are composed in collaboration with the dentists, or are part of the quality requirements professional associations such as NMT poses, they will be more neutral in including these requirements in the contract. It is expected that those who deliver good care want to show this. However, if such measurements are enforced by the health insurer the dentists might experience this as undesired interference as they are the professionals. Dentists are furthermore, often talking about *"The power of the health insurer. But what power is that? And then they fall silent."* The care provider cannot really define this 'power'. Controls the health insurer incidentally performs might be seen as giving the health insurer a certain power. On the other hand if the care provider does his work properly there is nothing to be afraid of according to the health insurer; care providers are expected to realize this.

The prices that the health insurer wants to agree upon are also seen as something that might cause friction. As one advising dentist states: *"They get a certain price and everyone reacts on it by stating 'there are free prices and I only get that price from you'. The treatment is, however, not different this year compared to last year … so below the line care should not cost more."* The experiment is about free prices, but VGZ thus tries to pose fixed prices to keep costs within limits. At first instance (this aspect was reversed after a few months) VGZ even set maximum compensation prices for the insured, if the care provider asked higher prices the patient had to pay the extra part. An incentive for care providers to sign the care agreement at that moment might have been the fact that *"I do not want to burden a patient with financial barriers."* Furthermore, as patients would get compensated in the extent expected, given their insurance policy, they would not come to the dentist with questions why they had to pay extra and why the dentist set higher prices than what the health insurer set as maximum. If the

price list the dentist had in mind did not differ too much from the prices set by VGZ he might sign the contract for this reason.

According to the interviewed advising dentists, another reason to sign, also related to the relationship between dentist and patient, might be the fact that the patient never received the invoices from the dentist, and the dentist does not want to change this situation, and thus wants to be able to send invoices directly to the health insurer.

4.2.3 Relationship VGZ-dentist

The interviews with the advising dentists have, furthermore, given an insight in what is thought about the relationship VGZ has with the dentists.

There is too little room for negotiation according to the interviewees, as one advising dentist states: *"Looking at contracting, we send a letter with 'sign here' and then we're done. But that is not how it works, if you want an agreement you'll have to negotiate."* As stated before the purchasing staff capacity at VGZ is too small to actively negotiate with dentists at a larger scale, but it is definitely seen as something that VGZ should change if they want more care agreements to be signed.

As the former quote as well as the purchasing process in Figure 6 show, VGZ is often relying on letters. This approach is considered very impersonal and the advising dentists expect that a more personal approach would be better, especially to create trust. One advising dentists explicitly expresses this feeling as he states: *"I think, that is what we see now, that the people calling get more done than what we would get done by sending a letter. A letter is just a piece of paper. If there is a name or a face then there is more trust, then VGZ has a face and things are more personal. That just works better than a piece of paper, that piece of paper is what they all do."* When the dentist links a certain person to VGZ he is thus expected to be more likely to put more trust in the relationship then when he sees VGZ as one big organization without a face.

Talking about trust the fact that VGZ has openly sought publicity with statements on prices being too high is not something that gains trust from the care providers, as one advising dentist states: *"Or there are dentists that have sent their price list and on the 6th of January a press release states that dentists' prices are 10% too high. That doesn't build trust to say the least. I'm not stating who is right or wrong, but it doesn't build trust."* Furthermore, publicity like this shows that VGZ does not fully trust the care providers either. This publicity shows that the health insurer thinks dentists require too high a price for a treatment. There is thus mutual distrust in this relationship.

Last, but not least, one advising dentist thinks it would be wise to put more effort in the relationship with the care providers by joining or even self-organizing meetings with dentists in order to be more transparent toward the care providers and to find out what thoughts and feelings there are on the sector's development and the plans the health insurer has. He states: *"We (advising dentists) are the ones maintaining the informal relationship. We should actually do that much more, but there is simply no time for that. In the past we would go to regional meetings, but it has been years since I've last been there. There is just no time to go there. … We are too formal and that creates a distance."* As stated in

the section on the purchasing process, the Team manager is also wondering whether it would be wise to join or organize such meetings.

4.2.4 Conclusion health insurer's perspectives

Interviews with purchasers from VGZ have explained how the purchasing process at VGZ is designed and have given an insight in what aspects they think makes a care agreement interesting for a dentist; the administrative advantages. Thoughts on how the dentists see the contract offered and how they might experience the relationship with the health insurer were gained from two advising dentists of VGZ. Their thoughts are summarized in Table 1. Green indicating that the specific aspect would have a positive influence on the willingness to contract or the view on the relationship. Yellow indicating a more neutral view and red boxed indicating that including these conditions or actions could have a negative influence. Non-colored boxes indicate that no specific statement was made on these aspects. There are relatively many non-colored boxes for interviewee B as the intention of this exploratory interview was especially to gain insight into the activities of the Dutch *Capaciteitsorgaan,* which is monitoring and giving advice on for example dental care providers, in which the interviewee was also involved.

Table 1: Advising dentists' perspective on contract and relation

	Advising dentists			Advising dentists	
	A	B		A	B
Contract			**Relational**		
Administrative			Negotiation		
Direct invoicing			Approach		
Default risk			Mailing		
Requirements			Telephone		
Quality measurement			Personal contact		
Prices			Meetings		
Controls			Trust		
Patients			Publicity		

Overall it can thus be concluded that the advising dentists acknowledge the view of the purchasers on the administrative advantages. Requirements are thought to be more problematic for contracting, especially price requirements in the situation of free pricing. Negotiation possibilities and more personal contact, also through meetings, are considered important. Moreover, personal contact is expected to create more trust; which is often seen as a pitfall for contracting possibilities.

As discussed in chapter 3 another health insurer was also approached in order to further increase the reliability of these findings. The interviews with a purchaser and advising dentist from CZ showed that they approach the market likewise and that in general their thoughts on the aspects discussed above are the same. The situation is thus not typical for only VGZ.

4.3 A care provider's perspective

With the insights gained from the exploratory interviews with purchasers and advising dentists of VGZ some leading questions were formulated to ask the general dentists (Appendix IV). Three cases have been defined which were investigated by interviewing for each case two parties (Appendix II). This

section will first shortly discuss each of the parties interviewed in terms of location and situation. In the next part we will further elaborate on the most important or specific properties and statements. This information will be linked to one of three aspects, being the contract, the relationship with the health insurer, and the possibilities for extending the relationship.

4.3.1 Introduction to interviewed parties

Case I: Core + Contract

1) This dental practice is run by two general dentists who were interviewed simultaneously. With its location in *Dordrecht* this party belongs to the core area of VGZ and indeed about half of the patients are VGZ insured. As stated by the dentists the average social-economic status of their patients is not very high, which poses a risk in terms of receiving payments for treatments.
2) This interview was with the managing director, also still working as dentist-implantologist, of a consortium of 14 dental practices throughout the province of *Limburg*. Especially in the northern part of this province there are a lot of VGZ insured, so it is stated that in total for the 14 dental practices about 50-55% of patients are VGZ insured. They absolutely experience the risk of non-payment, especially with the lower social-economic status in the south of the province, which poses a risk on the organization.

Case II: Core + No contract

3) This sole dental practitioner located in *Eindhoven,* part of VGZ's core area, is located in a district where quite some people receive a minimum wage or receive a payment by the government. The risk that patients will not pay the invoice is therefore also felt, but not in a very high degree. About 40% of the patients in this dental practice are VGZ insured.
4) This dental practice located in *Rotterdam* employs several general dentists. The interview was held with the manager, who stated that they experience a high risk of patients not paying. Again this situation is caused by a low social-economic status. It turned out that this dental practice has not that many VGZ insured, actually most (about 40%) are from health insurer Zilveren Kruis, although it is situated in the core operating area of VGZ.

Case III: Non-core + Contract

5) A sole dental practice located in *Nunspeet* was also visited to interview the manager (wife of the general dentist). This practice does not have many VGZ insured; no more than 10%. This party is one of the few parties in this part of the Netherlands that has signed a contract with VGZ. As stated by the interviewee the practice is located in a very traditional environment in which they do not really experience the default risk, although every practice, of course, comes into contact with some non-payers.
6) This dental practice is run by a general dentist, with a part-time general dentist, and some other assistants as employees. This practice is located in *Emmeloord*, also part of the area where only a few dentists have signed a contract with VGZ. With about 10% of patients insured at VGZ this is only a small group. Furthermore, the dentist states not to experience a high default risk so far, although payments might sometimes take a bit longer.

4.3.2 Contract health insurer

One of the goals for interviewing several dentists was to find out more about their perspective on contracts offered by health insurers. What aspects of a contract are interesting for dentists, and what aspects are thresholds for these care providers to sign a contract. Table 2 gives an overview of how the six interviewees introduced in the previous section, and numbered accordingly, see the contract. Green indicates that the specific aspect is considered a good thing to be included in a contract, whereas red indicates that this aspect could form a reason not to sign. Yellow represents a more neutral view. Not every dentist made an explicit statement on each aspect, and therefore some boxes are non-colored. Each aspect will be shortly discussed and where relevant supplemented with some typical statements. New codes (i.e. codes that were not explained when discussing the health insurer's perspective) will be briefly explained. A complete explanation of all the codes can be found in Appendix V.

Table 2: Care providers' perspective on the contract

		Core + Contract			**Core + No contract**		**Non core + Contract**	
		Dentists		Managing director	Dentist	Manager	Manager	Dentist
		1a	1b	2	3	4	5	6
		Dordrecht		Limburg	Eindhoven	Rotterdam	Nunspeet	Emmeloord
Contract								
1	Administrative							
	Direct invoicing							
	Default risk							
	Payment							
2	Requirements							
	Volume (patient) control							
	Quality measurement							
	Prices							
	Controls							
	Technical costs							
	Website							
3	Patient database							
	Patients							
	Patient % per insurer							

1) Administrative

Administrative aspects appeared to form quite an important part of a contract. As is shown by Table 2, the possibility of direct invoicing is never really seen as something bad, moreover, three parties (1,2,6) explicitly stated that this was one of the reasons for signing a contract. As the dentist from Emmeloord stated: *"My idea was where possible I would realize direct invoicing, eventually through a payment contract. My big advantage is that I can deliver a bulk of invoices and get payed 3-4 weeks later, and I don't have to separately process all those invoices. It's just convenience, it's that simple."* This statement shows that an administrative advantage is seen in direct invoicing, other parties (3,5), however, somewhat undo this advantage as is shown by the statement of the dentist in Eindhoven: *"I send all my invoices via a factoring company. Relatively speaking that costs me less work than when I would invoice directly via the health insurer, because there I would have to separate the invoices per health insurer,*

and get it back per health insurer if something is wrong. … I do think that it could be cheaper to invoice directly via the health insurer, I pay 90 cents per invoice now."
As seen in the introduction quite some parties also really experienced the default risk. A dentist in Dordrecht responded to the question whether they specifically chose for a contract with VGZ because that would take away the default risk, with: *"Yes, and because invoicing is easier."* They and several other dentists (1,2,3,6) see it as an advantage that the health insurer is taking over this risk. Moreover, it saves them from having to send separate invoices to the patients, which is administratively advantageous. Furthermore, it might save them from having to put more effort in trying to receive the patient's money. Related to this default risk is the payment the health insurer makes, as the same dentist from Dordrecht states about VGZ: *"I am satisfied that they pay 100%, that they also pay the part that the patient is supposed to pay to us."* Some dentists (1,6) find it very important that the health insurer pays 100% of the invoice and by this fully takes over the default risk. Some other health insurers, however, transfer back this risk to the care provider after a certain time if they have not yet received the money from the patient, and this does not give the same administrative advantage.

2) Requirements

Another aspect influencing the willingness of dentists to sign a contract are the requirements posed by the health insurer. *"If I sign a contract I oblige myself to a lot of things; requirements of the health insurer that you should meet."* (Dentist in Eindhoven). Health insurers often have the idea that when a care provider signs the contract they must also be willing to take on new patients from that specific insurer. Contracts do not yet include explicit statements that they are obliged to take these patients, but VGZ for example is thinking about including such a clause in order to effectuate a certain volume (patient) control. Some health insurers do have lists of contracted parties, and they refer patients who are looking for another care provider to such lists; VGZ uses the '*Zorggids*' for this. As can be seen in Table 2 the ideas about patient control are very different, some (2) find it great as this could bring new patients, others definitely do not want to see such a clause in the contract (1,3,5,6). *"We don't want more patients. … Another dentist might love to be in a Zorggids as that might make him better known."* (Manager in Nunspeet). The interviewee from Rotterdam is more neutral and states that it would be interesting, but *"then Zilveren Kruis and DSW also come with this volume control and then we have to see what is most interesting for us."* Furthermore this interviewee notes that patients can also look in Google to find another dentist, they do not necessarily need the insurer for a reference.

Another requirement on which some have a positive and others a negative view is quality measurement. A view shared by all interviewees is that it is still very hard to measure quality, that is a point that cannot be overlooked, as one interviewee states on for example including in a contract that in a defined percentage of the cases a filling must stay in for the minimum of time defined: *"I think that's very good, but that is something you can measure. But how does the filling stay in? If it is leaking, then it is still not out. That still does not say anything about the real quality."* (Managing director of the consortium in Limburg). A dentist in Dordrecht is of the opinion that these type of requirements are too far away from the basic agreements that should be made, although they "*…understand that they want to measure quality…"* Most interviewees acknowledge that this is the direction in which dental care is going, but do not really feel that it is the job of the health insurer to define these. *"I can imagine that when quality*

indicators are introduced by professional organizations that the health insurer requires that they are applied." (Dentist in Emmeloord).

As a free market is entered some interviewees (4,5) are of the opinion that price requirements should not be part of a contract. *"If they say this is our maximum price, then you can define your own price, but well what's the point in that. That's what I think is wrong."* (Manager in Nunspeet). Moreover, the dentist in Eindhoven thinks that the maximum prices defined are really on the low side. The interviewed dentists in Dordrecht and Emmeloord are considered to have a more neutral view as prices were discussed, but the most important aspect of these prices were that there were no fixed prices forced upon them. As the dentist from Emmeloord states: *"…they should not want to get the most out of it by undermining all prices set by a dentist."* The interviewee of the consortium in Limburg has made a price agreement, but states now: *"I don't want to commit myself to prices at this moment because it does not outweigh the administrative benefits."* He explained that this was primarily due to the fact that the contract at that moment did not offer him an advantage over other care providers anymore, as all care providers were paid the price they asked, a price concession would thus not have been necessary. So, even though a contract offers administrative advantages, having to make price concession without market benefits makes contracting less interesting for this care provider.

When asking further about agreements in the contract a few other aspects were addressed as well. For as far as control, such as quality controls, are concerned dentists have very different opinions, even when working in the same dental practice as is the case with the interviewees in Dordrecht, as can be seen in Table 2. One dentist states: *"Let them come.",* whereas the other states: *"Well, that's unmentionable for me. I just don't want that."* In the extensive discussion with the dentist in Limburg on controls it became clear that he is of the opinion that there should be much more control. *"The sad thing is that there is no control at all, I really hope that changes."* This dentist sees this as an important aspect in order to be able to find out whether the quality of the treatments provided is good enough. Another requirement, being the determination of fixed technical costs, was seen by the party in Dordrecht as a reason not to sign a contract with a certain insurer even though they had an agreement before the situation of free pricing. So, for this party, determining prices for treatments was alright, but definitely not for technical costs. Furthermore, the manager in Nunspeet stated that requiring a website was an example of why they had chosen only to sign payment agreements and not any care agreements with their whole bulk of requirements.

3) Patient database

Taken along in the discussion on why one would or would not choose to sign a contract were the patients of the care provider. The underlying reason of why parties 2, 5, and 6 signed contracts was because they wanted to act in the interest of their patients. For dentists 5 and 6 the reason lies in the fact that *"this is easy for the patient as he doesn't get the invoice"* (Dentists in Emmeloord), moreover, *"Patients are used to everything directly being arranged with the health insurer"* (Manager in Nunspeet). The care provider in Limburg is currently looking into the effects contracting could have on patients, if without contracts patients are lost, contracting could become an option even if a contract is not interesting in any other aspect. *"Then you start looking at other things, does that insurer have additional*

value that enables treating patients better or giving a better service, then this is important value as well." The dentist in Eindhoven chose not to sign any contracts at all in order to be consistent towards patients, however, if terms would change for the worse she would want to sign a contract with every health insurer, *"but that is purely for the sake of my patients."* Consistency, and thereby creating transparency towards the patients, is also what made the interviewed party in Rotterdam decide not to sign any contracts with health insurers at all, but to work with a factoring company.

A last statement on the patient database is the patient percentage per insurer. It appears that a higher percentage of patients insured with a certain health insurer often make it more interesting to sign a contract. Some (1,2) are really aiming for the big insurers percentagewise as these give them huge administrative advantages, others (5,6) are aiming also for somewhat smaller parties as well, mainly because they also have other, more patient related, reasons to sign. The interviewed parties in Eindhoven and Rotterdam are not influenced by the percentage, although the dentist in Eindhoven states: *"I keep an eye on what they are doing, because 40% of my patients are insured with them so that makes me dependent on them."*

4.3.3. Relationship health insurer-dentist

Another reason for conducting interviews with dental care providers was to find out more about how the relationship with the health insurer is perceived and what could possibly be done to strengthen this relationship. Data on the aspects discussed has been visualized in Tables 3 and 4;
Table 3 indicates how the current relationship is perceived, whereas Table 4 focuses on visualizing what would influence the relationship for the better and what is not considered beneficial for the relationship. Non-colored boxes again indicate that the interviewee has not given any specific data on the aspect concerned. For Table 3 a red box means that the specific aspect is poorly perceived, yellow is neutral and green means that it is experienced as being good. For Table 4 color coding is more in line with Table 2, meaning that a green box is indicating that the specific aspect is seen as being important for the relationship, red means that it is seen as degrading the relationship and yellow poses that the interviewees are more indifferent about that aspect.

1) Negotiation

One thing really arising from the interviews is that negotiation is an important aspect of a relationship. Looking at Table 3 it can be seen that half of the parties (3,5,6) feel that negotiation is not really enabled in the current situation; *"So it's basically take it or leave it."* as the dentist from Eindhoven states it. The party in Dordrecht did feel that limited negotiation was possible, in any case with VGZ, as they stated: *"Prices. I've tried to negotiate on other things as well, but these couldn't be discussed."* The managing director of the consortium in Limburg stated that he was really satisfied with how negotiations went; *"Well, I showed my vulnerabilities and they have given theirs and we have found each other."* When looking at whether negotiation is also seen as something that could really influence the relationship, Table 4 shows that some (1,2,3) find it important that there is room for negotiation and that one looks at *"…why my prices are the way they are…"* (Dentist in Eindhoven), whereas some (5,6) find that it does not really influence their perception of the relationship.

Table 3: Care providers' current perception of relational aspects

		Core + Contract			Core + No contract		Non core + Contract	
		Dentists		Managing director	Dentist	Manager	Manager	Dentist
		1a	1b	2	3	4	5	6
		Dordrecht		Limburg	Eindhoven	Rotterdam	Nunspeet	Emmeloord
Relational								
1	Negotiation							
4	Contacting health insurer							
	Accessibility							
	Knowledge							
5	Trust							
6	Publicity							

Table 4: Care providers' ideas on changing the relationship

		Core + Contract			Core + No contract		Non core + Contract	
		Dentists		Managing director	Dentist	Manager	Manager	Dentist
		1a	1b	2	3	4	5	6
		Dordrecht		Limburg	Eindhoven	Rotterdam	Nunspeet	Emmeloord
Relational								
1	Negotiation							
2	Approach							
	Mailing							
	Telephone							
	Personal contact							
3	Meetings							
4	Contacting health insurer							
	Contact (person)							
6	Publicity							

2) Approach

This part focuses on the way health insurers should approach their dental care providers, especially considering the purchasing process. As can be seen in the Table 4 opinions vary quite a bit, some state that *"if it goes well by mail, then that's fine with me"* (Dentist in Dordrecht), whereas the Managing director in Limburg states: *"If you just send me a standard mail with 'we're unavailable at this moment' then I think that's annoying."* However, the dentist in Emmeloord is more of the opinion that *"It really did not play a role how they approached me or not…"* Others see it as a good first initiative (3), or something that is always worth trying (4). If health insurers would work more with personal contact or phone this is never seen as something bad. *"Telephone and sometimes seeing each other face-to-face is something that I think you should do anyway when you have agreements"* (Managing director of the consortium in Limburg), and *"I think that if an insurer is really interested, I would appreciate it to sit around the table and talk."* (Dentist in Eindhoven) are statements that should that a more personal approach would be appreciated. The dentist in Emmeloord has a critical view on the approach and makes an interesting statement indicating that the type of approach favorable might depend on the insurance of the patients, as he states: *"It has its advantages, although I can imagine that if you only*

have 200 patients of a certain health insurer it is questionable whether it is really worth the effort as it is only a small group."

3) Meetings

In the past health insurers would often join regional meetings of dentists, but this happens less and less. VGZ even does not join any of these meetings because, as an advising dentist said, there is no time to do this. Some dentists, however, show the need for such meetings as the dentist in Eindhoven states: *"I would like to occasionally have contact with the insurers. I would also quite like it if a meeting would occasionally be organized to talk without immediately making it contract negotiations."* Furthermore, when insurers are involved the remark is made that *"The way they do this is really one-way traffic; the opinion of the dentists is not being heard. It should come with more consultation."* (Dentist in Dordrecht).

4) Contacting the health insurer

Of course it is not only a matter of the health insurer contacting the dentist, the dentist should also be able to turn to the health insurer when having questions. As can be seen in Table 3 the accessibility of the health insurer is somewhat questionable, some state that *"Whatever it is, if there is something and I call it is quickly resolved."* (Dentist in Nunspeet). Whereas others (3,4) state that it takes two weeks to get an answer, or *"The accessibility is bad if you're put 20 minutes on hold. And then you can also still only call between 9 and 11."* (Dentist in Dordrecht). Moreover, even when the health insurer is reached one is not always satisfied with the knowledge the employees appear to have, as the manager in Rotterdam states: *"Sometimes I get the right answers, sometimes I get answers that just aren't right, but I think that's mainly because the people of the 'call centre' just don't know that much of the matters discussed. Or you get called back 2 weeks later and then you still don't get an answer."* The dentist in Eindhoven experiences the same problems as *"…it is hard to get the person on the line that knows what it is about."*, however, she can imagine that not everybody has the knowledge, but *"…it is complicated."* Some (1,6) state that it would be nice to have your own contact whom to approach when questions arise. *"…then you have an entrance and that can be easier…"* (Dentist in Emmeloord), although he might not know all the answers, *"…as long as you get help or if they know who you should talk to."* (Dentist in Dordrecht).

5) Trust

It is hard to put your finger on the aspect of trust; interviewees did not explicitly say this word, but it appears to be a difficult issue for some (1,3,4). An example of a statement by the dentist in Eindhoven, showing that there is some distrust is: *"And further there is also the fact that I as a professional on my own feel very small and powerless towards such a large health insurer."* The dentist in Emmeloord on the other hand states that he *"…really did not experience any problems with an insurer in those 20 years."*, and the Managing director in Limburg feels that they can be very open to each other as the statement in the part on negotiations already showed that they show each other their vulnerabilities.

6) Publicity

Health insurers have sought publicity at the start of the free market to inform about the rising prices for dental care. This could not bear the approval of several dentists (1,3) as *"…the health insurers have pictured us as big thieves that are only filling their pockets. That is very negative."* (Dentist in Dordrecht). Such general publicity that depicts the whole dental market in such a way can deteriorate the relationship. The Managing director of the consortium is focusing more on the possibilities of using publicity to change a certain relationship for the better, as he states: *"But maybe they can use more social media, they can express their pride on the website. There is nothing wrong with that."*

4.3.4 Possibilities for extending the relationship

One of the possibilities for extending the relationship health insurer VGZ was thinking about was looking for possibilities to centralize the purchasing of materials. As VGZ could possibly attain better purchasing benefits compared to dental practices purchasing individually. When bringing this idea under the attention of the interviewees the reactions were overall that this might not be the best idea. Although *"this could be interesting, it depends on whether I get the freedom to use the materials I'd like to work with or that I only get to use certain materials"* (Dentist in Eindhoven). This freedom is important to all dentists, and as the Managing director in Limburg states *"If I say that we already use 3 different filling materials. A health insurer should not interfere with how something is done, with what drill for example."* This last statement shows that it would be very hard to meet everybody's needs and they *"…question whether this is the job of the insurer to pick up on such things."* (Dentist in Emmeloord). For patient quality surveys all interviewees are of the opinion that this is not something the insurer should be concerned with and that this is something the care providers should do themselves, and might be required by the professional organizations such as the NMT.

Dentists do seem to feel the need to receive more feedback from the health insurers, for example showing the specificities of their dental practice compared to the benchmark (2,3). Furthermore, the dentist in Emmeloord stated that he would like to hear which patients have not paid their invoice, *"such feedback would not be wrong. … That would be interesting for them as well as I can point it out to the people concerned."* Another thing this dentist points at is looking at which children under 5 do not visit the dentist, send their parents a letter stating that they can go do the dentist for free the first time as it is important that to start at a young age. As focus is on prevention such actions from insurers would be interesting. The Managing director in Limburg stated that in order for health insurers to gain more insight in the quality of work they could also look at whether they could be assisted by some dental practitioners in order to be able to call up more patients for controlling the quality of the treatment.

4.4 Conclusion

This chapter has given an overview of the data gathered during the study. Documentation was reviewed and both interviews with employees of the insurer, as well as with dental care providers, were discussed point wise. Quotes were used in order to illustrate the points made. Now that the general findings have been discussed for all cases it is important to find out whether cases are comparable and internally valid. For this within-case and a cross-case analysis should be conducted.

5. Data analysis and results

In the previous chapter the data gathered has been discussed. There are different ways to analyze this data by making different cross sections that can each bring along several insights. In this chapter each case will be evaluated in order to gain insights on the consistency of findings within a case. Moreover, cases will be compared in order to reveal similarities and differences between the cases. Eventually, a comparison of the perceptions of the buyer (health insurer) and seller (dental care provider) will be given.

5.1 Within-case analysis

This section includes a within-case analysis for each of the three cases investigated in order to find the unique aspects for each case. As there are two parties investigated for each case, similarities and differences might occur. Similarities indicate that these findings can possibly be generalized to the entire case. Differences can be caused by other factors playing a role; this type of analysis will help in identifying what these factors are and what consequences they bring along for the perception of the care provider.

5.1.1 Case I: Core + Contract

Considering Case I several case specific and interviewee specific properties have been summarized in Table 5. Moreover, this table shows what similarities and differences there are between the interviewed parties. Together these properties and perceptions will feed the discussion in this section in order to find unique case patterns.

It appears that the possibilities of direct invoicing and taking over the default risk that VGZ offers, in combination with the high percentage of VGZ insured, form an incentive to sign a contract with VGZ as the administrative benefits are considerable. Furthermore, the possibility to negotiate is important for these parties. Negotiation on prices should at least be possible, especially since price agreements are considered somewhat problematic, otherwise the administrative incentive to sign might be outweighed. Moreover, meetings with these core parties would add to the buyer-seller relationship.

In terms of possible requirements of volume control, quality measurement, and controls the parties have different opinions. The explanation for these differences appears to lie mostly in the fact that the parties are very different in terms of size and entrepreneurship. A growing party can be very in favor of gaining new patients to fill the patient database, whereas smaller parties will probably be more limited in their possibility to do this. Obliging these smaller parties to such requirements might not be wise. When contracting, negotiation on such an aspect would be recommended. Furthermore, larger parties might be operating at a high level and put a relatively large effort in realizing this by means of using quality materials and trainings. Of course this costs time and money and such parties might therefore like to see results in public, as this would benchmark their quality with others and would put their name in the market. This benchmarking would become possible if quality is measured consistently and controls are executed on a regular basis. Smaller parties might, however, just do what is necessary to stay up-to-date and since doing this is already part of what is required by professional organizations such as the NMT, they might feel that health insurers should not interfere. The contracting process

should include considering what type of party is involved and act accordingly. This does not mean automatically skipping these requirements as there are reasons for a health insurer to include these (i.e. to keep dental care affordable, accessible and of a high quality), but one should look at the level at which these requirements should be included and put into effect. Are quality requirements set by bodies such as the NMT enough or should additional requirements be set in this particular situation; for example in order to temper more unwanted behavior a party has shown before, or to be able to state more about the quality.

Table 5: Characteristics Case I: Core + Contract

Case I: Core + Contract [Dordrecht (1) + Consortium in Limburg (2)]	
Case specific properties	✓ Core area: > 30% VGZ insured ✓ Contract signed with VGZ
Interviewees' properties	* Medium to lower social-economic status * Dentists vs. Managing director * Only signed a contract with VGZ
Perceptions on contract and relationship	**Similarities** ❖ Patient % of VGZ insured makes contracting interesting because of the administrative advantages (direct invoicing and default risk) ❖ Negotiation possibilities are important ❖ Organizing meetings would add to the relationship ❖ Having to agree on prices is difficult **Differences** ❖ View on requirements such as volume control, quality measurement, and controls put in a contract ❖ Using publicity ❖ The approach favored

Larger parties with big business plans might even like a health insurer to openly publish on their relationship to show that they are satisfied with what the care provider is doing in terms of obtained quality. For a smaller party with a smaller working area and patient database such publicity can be considered less worthwhile. Publishing more general articles, for example on rising prices, should be considered carefully as a quick generalization will definitely not be appreciated when negative issues are concerned.

The preferred approach seems to be influenced by the attitude of the care providers. One will want to minimize contact with the health insurer to the much needed to operate efficiently and see mailings and e-mail contact as efficient ways to do this. The other is really aiming for a long-term relationship and might even want to extend this relationship in the future, therefore demanding a more personal relationship. It is possible that this attitude is closely linked to the size and level of entrepreneurship as growing parties might be more interested in long-term relationships. Moreover, the attitude might also be different because of the role of the interviewee, although the fact that one of the interviewee was clearly advocating from both perspectives diminishes the likelihood of the role having such an influence.

At this stage it can, however, not be confirmed that the proposed properties are indeed of influence to the preferred type of approach.

5.1.2 Case II: Core + No contract

In Table 6 the properties and perceptions that were discussed with both parties in Case II have been summarized and feed the discussion in this section.

It appears that the parties in the core that have decided not to sign a contract do this because they do not see the administrative advantages of contracting. On the contrary they see contracting as something that brings along more administrative work, as it involves separating invoices per insurer and taking into account (different) price requirements. These are things which one can get around when working with a factoring company, which can be considered an important influential factor in the decision not to sign contracts with health insurers. Moreover, different price settings are by some care providers just seen as something which is not in the patients' interest. Although the factoring company asks money for its services (around €0.90 per invoice), whereas VGZ does not, it seems that this is not a real issue. The underlying reason for the choice not to contract, however, appears to lie mainly in the lack of trust these care providers have in the relationship with a health insurer. Although the insurer can try to clearly point out the financial benefits for such a large insurance group and show that they will definitely weigh up to some extra administrative work, the distrust does not add to the opportunities for insurers to persuade these parties to sign an agreement. So the health insurer should first invest in creating more trust as convincing the care provider now will be very tough.

Table 6: Characteristics Case II: Core + No contract

Case II: Core + No contract [Eindhoven (3) + Rotterdam (4)]	
Case specific properties	✓ Core area: > 30% VGZ insured (or other main health insurer) ✓ No contract signed with VGZ
Interviewees' properties	* Medium to lower social-economic status * Dentist vs. Manager * Have not signed any contracts * Have an agreement with a factoring company
Perceptions on contract and relationship	**Similarities** ❖ Contracting implies more administrative work; there are no administrative advantages (not even for a well represented insurer) ❖ Price requirements are unfavorable ❖ There is a lack of trust **Differences** ❖ View on requirements such as volume control and quality measurement put in a contract ❖ The approach favored

Moreover, a difference in the approach favored is apparent. Some parties will just not be interested in the health insurer contacting them and have the view that they can always send a mailing as the insurer can always give it a try. Other parties might be interested in hearing from the (main) health insurer and

see mailing as a beginning that can eventually be followed by more personal contact to keep them informed about the latest development and be able to discuss things. It can thus be concluded that a mailing could be a first step for a health insurer to contact this group. If the care providers are then enabled to indicate whether they want to have more contact the contact could be followed up with regular mailings and more personal contact via telephone or in person every once in a while.

Requirements of volume control again depend largely on the possibility to take on new patients. Feelings about control and quality measurement depend on the attitude of the parties, some might not see it as part of the job of a health insurer, whereas others very well understand why insurers want to do this and might even see ways to use this information for their own good; benchmarking their performance. It does not appear that the area has any influence in this attitude. Health insurers might thus only try to explain why it is important to set these requirements; they are meant to secure high quality dental care.

The notion should be made that the fact that the care provider in Rotterdam did not have that many patients insured with VGZ can be neglected in this case, as for both parties the fact that they had a high proportion of patients from a certain insurer did not influence their ideas on contracting.

5.1.3 Case III: Non-core + Contract

In Table 7 the case specific and interviewee specific properties for Case III have been summarized. The table further shows the similarities and differences of the perception on contract and relationship which will feed the discussion on non-core contracted parties.

Table 7: Characteristics Case III: Non-core + Contract

Case III: Non-core + Contract [Nunspeet (5) + Emmeloord (6)]	
Case specific properties	✓ Core area: < 30% VGZ insured ✓ Contract signed with VGZ
Interviewees' properties	* Dentist vs. Manager * Signed contracts with several health insurers (≥ 5% of patient database)
Perceptions on contract and relationship	**Similarities**
	❖ Possibility of direct invoicing is in the interest of patients ❖ Volume control requirements are unfavorable ❖ Type of approach by (smaller) insurers less important ❖ Negotiation possibilities are less important
	Differences
	❖ Administrative advantages of a contract ❖ View on price requirements and quality measurement put in a contract

The parties in the non-core area of VGZ that decide to sign a contract with VGZ also sign contracts with other health insurers. Their incentive to sign lies in the fact that a contract makes direct invoicing possible. Direct invoicing is seen as a way to keep patients from being bothered with invoices;

something that they were also not used to before the free market situation was entered. Patients thus only have to pay the parts they are not insured for.

As the main reason is thus to make direct invoicing possible for their patients the parties do not really care about how they are approached by the (smaller) health insurer and whether there is lots of room for negotiation. If they feel that certain contractual clauses or prices are really not acceptable they simply decide not to contract and inform the patients that they will receive invoices. For the main health insurer in that area the approach and negotiation possibilities might, however, play a more important role.

Moreover, a contractual requirement of volume control is not something they really want to commit themselves to. This might, however, not be the case for all contracted parties in the non-core area as this depends more on the dentist density which will have its influence on the size of the patient database. In general the area where the interviewed parties are operating is one that has quite a low dentist density compared to other areas in the country (see Appendix VI). Because of this low density it is not that surprising that some dental practices are not eager to be obliged to admit new patients. Considering the size and location of a dental care provider different possibilities and desires in terms of volume control might thus appear.

Direct invoicing might for some be, besides a nice possibility to keep patients from receiving invoices, an administrative advantage as well. Others might not really see an administrative advantage in this as health insurers, such as VGZ, set certain requirements that make not every patient eligible for direct invoicing. The process of sorting patients caused by such requirements can be a time consuming process according to some. Although this was not a reason not to sign for the interviewed party, it might be an obstacle for others. VGZ should thus carefully consider the benefits and downsides for such requirements, for both themselves and the care provider, before deciding on the policy to follow in this. Factoring companies do not make such differences and might therefore be more interesting to some parties.

As the prices of the dentists interviewed were (almost completely) within maximum prices set by VGZ there was no real issue in terms of price requirements, however, these requirements are not favored by everybody in the light of the free market situation. For some the simple reason of price requirements might be reason enough not to sign a contract. In order to try to get around such resistance it might be wise for VGZ to communicate explicitly that these maximum prices are guidelines, but that there is definitely room for discussing these prices in case special circumstances can be denoted.

Quality measurement is, independent of the area, something that some might see as something the care provider has to take care of, possibly together with a professional organization such as the NMT. Others acknowledge that measuring quality is part of the developments of the dental care sector. The remark has to be made that it should be possible to measure real quality, which is a process that is currently being addressed by several parties; VGZ should not single handedly work on this as this will not gain the support of care providers.

5.1.4 Conclusion on within-case analysis

In this section the similarities and differences for the two parties interviewed for each care have been discussed and explained. Some key aspects appear to be consistent throughout a case, whereas on other aspects ideas differ a little within a case. These differences can largely be explained by influential factors such as the size of the party or the different attitudes. It is, however, possible that the negative view on quality measurement some have is influenced by the role of the interviewee as the managers with no dental educational background appear to be completely against this type of requirements, whereas dentists can live with such requirements as long as good quality indicators have been set. This difference cannot be confirmed based on the previous data, and because quality measurements cannot yet be used as there are no tested indicators the consequence of this difference in perception on contracting cannot be evaluated. Eventually, good indicators might be supported after all, moreover because dentists might inform about the quality of these.

Some case specific patterns have now emerged that can accelerate the next step of the analysis (Eisenhardt, 1989b), which is a cross-case comparison.

5.2 Cross-case analysis

Now that the within-group similarities are known it can be investigated whether other cases share these similarities or whether there are intergroup differences (Eisenhardt, 1989b). Depending on these findings the advising suggestions made in the within-case analysis might be more explicitly determined and substantiated.

There are several methods to execute a cross-case analysis, for this study the tactic of selecting and comparing pairs of cases is chosen. A comparison of Case I and Case III will be made to evaluate the incentives for contracting, furthermore a comparison of Case I and Case II will be made to evaluate the core area.

5.2.1 Case I vs. Case III: Contracted dentists

For both cases parties have decided to sign contract, however, the parties interviewed for case I have only signed a contract with well represented VGZ, whereas the parties interviewed for case III have signed contracts with several health insurers, also with the for them relatively low represented VGZ. As for smaller patient groups contracts are also signed, the administrative (financial) reasons that count for case I appear not to be the main reasons to sign for the parties falling under case III. This section indicates what other incentives there are and gives a suggestion on what approach seems to make sense for the parties in the core versus the non-core area.

The parties interviewed for case III, in general, also acknowledge that there can be administrative advantages in contracting. The main reasons for these parties to contract are, however, not the possible administrative advantages in terms of workload and financial terms, but the fact that direct invoicing makes sure that the payment process is executed by the health insurer and patients only have to make a payment if there is some uninsured part. The contracted parties in the non-core area of VGZ thus want to act in the best interest of their patients and that is in their opinion not charging them with invoices

and retrieving compensation from their insurer. These parties have therefore decided to sign contracts with as many health insurers (that enable direct invoicing) as possible. Requirements set by the health insurers are, however, not always appreciated and therefore a health insurer such as VGZ cannot simply keep relying on the more moral incentive these dentists seem to follow. Moreover, factoring companies also provide an invoicing service, and although a fee has to be paid for this, harsh requirements and low price settings might let the dental care provider turn to these companies. This may also apply to already contracted parties in the core area of VGZ, although they might really consider the financial benefits of providing these services for free as an order winner for a well represented group. The necessity of the requirements should, however, be carefully evaluated by the health insurer as opposed to the benefits they bring along in terms of contracting parties and keeping dental care affordable, accessible, and of high quality. As stated before, 'losing' a contract because of requirements such as volume control or the obligation to have a website might really be a shame.

As the possibility for direct invoicing is thus the main incentive to sign a contract for those falling under case III and the actual relationship with the (smaller) health insurers is not considered that important, negotiation possibilities are not such a big issue to them as they are to the interviewees for case I, and neither is the approach. This implies that VGZ might choose different approaching strategies for the core versus the non-core area. For both mailings could form a basis, but more personal contact and negotiation should be aimed for as a follow-up in the core area. However, as negotiation appears less valuable to those in the non-core area it is once again a matter of carefully setting requirements as these might otherwise simply cause for the proposed contract to be rejected. If VGZ does not want to lose possible contractual relationships in this non-core area they might explicitly state in mailings that negotiation on certain clauses is possible and the need for this can be expressed by e-mail. This medium is easiest for VGZ because of time issues and not unfavorably rated by care providers in the non-core area as they have other things to do and might rather spend time on a health insurer that is more important to them.

5.2.2 Case I vs. Case II: The core area

Although the parties for both cases considered are located in the core area of VGZ they have not all decided the same on contracting. Each of the parties has a high percentage of patients insured at VGZ or another health insurer, but not for everyone this is considered a reason to sign so other factors must thus be playing a role; this section defines these other reasons.

It appears that there are two different types of care providers, those who see administrative advantages in signing a contract with a health insurer well represented in their patient database and those who state that there is no advantage as separate procedures for each health care insurer must be completed which offsets possible administrative advantages. It should, however, be kept in mind that the parties considered in Case II both work with a factoring company, which already enabled them to leave the administrative work of invoicing and most default payments to others. Compared to this situation possibilities of direct invoicing can indeed deliver some extra work. However, with health insurer VGZ direct invoicing and taking over the default risk are done for free, whereas with a factoring company a fee has to be paid. The question is then whether this administrative work lives up to the costs of working

with a factoring company. Given the fact that a factoring company quickly asks about €0.90 per invoice, and a dentist has about 2000 patients on average that visit the dental practice twice a year (only considering standard visits), a factoring company can easily cost thousands of Euros a year. For a core party having over 30% of VGZ insured it can hardly be imagined that the suggested extra administrative work comes any near to the costs involved with working with a factoring company, for these amounts of patients.

Moreover, the parties for case II are of the opinion that the possible advantages of a contract do not outweigh all the requirements put by a health insurer. Especially if more health insurers would be contracted it would be hard to keep up with all the different requirements put by health insurers, moreover, different prices for different patients is thought to raise many questions. Perhaps what matters most is the fact that the parties want to stay independent and not feel obliged to live up to all kinds of requirements of which some according to them are far removed from what dental care is and should be about. This desire to stay independent will also partly be fed by the lack of trust the parties appear to have in the health insurers. Even for a large insurance group in the patient database, these feelings are a part in keeping them from wanting to consider contracting health insurers.

It can be stated that for parties in the core of VGZ a contract appears to be financially interesting at least. It is clearly interesting for the parties interviewed in Case I and might be interesting for other parties as well. So where one group decides to sign a contract with the most represented health insurer because of administrative (financial) advantages, the other group appears to be held back by administrative work, requirements and the overall feeling of trust.

In order for VGZ to have a chance with the Case II type parties, one should invest in creating trust. Furthermore, if VGZ wants to convince this type of core parties to sign a contract it can best first set out the financial benefits a contract with them implies compared to working with a factoring company. Also for core parties unwilling to sign a contract and not working with a factoring company the financial incentive can be addressed and possibly lead to changing attitudes. The necessity of requirements should also be critically considered. Volume control, for example, might form part of the obstacle for parties not to sign, whereas for some parties such volume control is simply not possible and it would thus be a shame to lose possible contractual relationships because of such a requirement. Other requirements are largely a matter of attitude or entrepreneurship aimed for. When people are simply against quality measurement or control one can try to enter in a dialogue with these people and transparently (as this is a critical to gain trust) explain why these requirements are set and possibly how the dentist might use the data for his own benefit; benchmark. Requirements should, however, not be overdone and for quality measurement to be used good performance indicators should first be set. It must, however, be noted that some parties might never change their opinion or will keep distrusting the health insurer no matter the efforts done.

5.2.3 Conclusion on cross-case analysis

This cross-case analysis has taken us beyond initial impressions through the use of structured and diverse lenses on the data (Eisenhardt, 1989b). The analysis reveals that the perceptions of the dentists

differ. Whereas one core group decides to contract a well represented health insurer to utilize administrative and financial advantages others (also core) neglect to do this because for them the different requirements and lack of trust outweigh these advantages. A third group (that may have followers throughout the country) is mainly guided by the feeling that the possibility of direct invoicing is in the interest of their patients and is therefore a reason to contract where possible; where contract terms are considered acceptable. However, providers can have different ideas on how they can best act in the interest of the patient. One might feel contracting is beneficial as it gives this opportunity to keep patients from having to put effort in retrieving compensations. Others might be of the opinion that contracting is difficult and confusing for patients as this contracting will come with price differences for the same treatments. Moreover, these price differences and direct invoicing possibilities are by some only found to result in more work for them.

The 'direct invoicing' incentive to sign is one that may actually be true for dental care providers throughout the country as it is a perception that is not influenced by the percentage of patients insured at a certain health insurer. This perception, however, appears not to apply to many dentists given the low number of contracted parties in the non-core area (see Appendix VII). This would elucidate why no such parties were interviewed in the core area of VGZ as chances to encounter these parties are thus quite low given the pool of contracted parties in the core area. It can, however, not be completely ruled out that there are some regional factors involved, although nothing points to this.

5.3 Buyer and seller perceptions compared

As the advising dentists themselves were formerly active as a dental care provider they might be very well aware of what thoughts and feelings there are on the buyer-seller relationship in that market and analyze this from both the care provider's and the insurer's perspective. This knowledge can be very useful for a health insurer operating in this particular healthcare market, as these advising dentists are then able to point out the problem areas of current or future purchasing procedures. In order to find out whether general dentists can indeed be considered well aware of what the current thoughts and feelings are, their general ideas are compared to those of the interviewed care providers.

5.3.1 Contract

In Table 8 the overall ideas of both advising dentists of VGZ and the care providers interviewed have been put next to each other. Color coding has taken place by scoring the contract aspects based on Table 1 (for the advising dentists) and Table 2 (for the dental care providers) and dividing them through the number of interviewees having made a statement on that specific aspect. Red is 1 point, Yellow 2 points and Green 3. Green (a score ≥ 2.5) indicating that that group overall leans towards seeing the specific aspect as an advantage of a contract, yellow (a score between 1.5 and 2.5) indicating that the aspect is approached more or less neutrally, and red (a score ≤ 1.5) indicating aspects that in general are considered a disadvantage of a contract when included.

Table 8: Contract perceptions compared

	Advising dentists VGZ	Managers & dentists in the field
Contract		
Administrative		
Direct invoicing	(3)	(2.6)
Default risk	(3)	(2.7)
Requirements		
Quality measurement	(2)	(2)
Prices	(1)	(1.3)
Controls	(2)	(2.3)
Patient database		
Patients	(2.5)	(2.2)

Considering the requirements the advising dentists were right about the fact that price arrangements are considered problematic, especially if there is no room for negotiation. Furthermore, the different perceptions on quality measurement and controls were also expected as there are different ways to look at these; it is part of the procedure and can show that good quality is delivered, or it is something that health insurers should not interfere with.

Direct invoicing and taking over the default risks are both considered incentives to contract according to the advising dentists. Overall dentists agree on the fact that administrative advantages can make contracting interesting, although they are not for everyone enough of a reason to sign as there are also parties in the market that see this as increasing administrative workload, especially compared to leaving invoicing to a factoring company. It thus cannot be presumed that the proposed administrative advantages hold for every care provider.

Advising dentists indicated that care providers could decide to sign a contract in the interest of their patients, although there would be a tendency to make a trade-off between advantages for the patients and the concessions that would have to be made in prices. Acting in the interest of the patient is, however, extensively applied throughout dental practices, but health insurers should recognize that there are other things at stake as well, such as transparency in prices that can influence the view on how to act in the interest of the patient.

5.3.2 Relationship health insurer-dentist

The perceptions of VGZ's advising dentists and the care providers on the relationship can also be compared. Table 9 visualizes the thoughts on several aspects. The color coding in the boxes should be read as in the previous section, but now looking at the relationship. The boxes on 'current perception' indicate how care providers currently perceive the insurer's performance on these aspects; red is bad, and yellow is not good not bad, but indicating there is still some room for improvement. The color coding is done the same as for Table 8, but for the care provider Tables 3 and 4 have now been used.

Table 9: Relational perceptions compared

	Advising dentists VGZ	Managers & dentists in the field
Relational		
Negotiation	(3)	(2.6)
Negotiation: current perception		***(1.6)***
Approach		
Mailing	(1)	(2)
Telephone	(3)	(3)
Personal contact	(3)	(2.5)
Meetings	(3)	(3)
Trust	(3)	
Trust: current perception		***(1.6)***
Publicity	(1)	
Publicity: current perception		***(1.3)***

Overall, negotiation possibilities are by both parties considered a good thing, but most dental care providers are not satisfied with the current possibilities. There is thus room for improvement in this area, especially by creating more transparency in price considerations and evaluating the need for other requirements.

Both buyer and seller considered meetings as a valuable addition to the buyer-seller relationship. These meetings can be used in order to create transparency as they give the opportunity to discuss the developments in the market, the plans of the insurer and the feelings of the care providers. Furthermore, according to advising dentists contact by telephone or in person is better as it gives the insurer a face, and thereby enhancing trust, which is considered a very important aspect for relationships to succeed. More personal approaches are indeed not considered harmful for the relationship. There is also clearly a lack of trust considering the bad perception on trust. A more personal approach could be considered helpful in bringing more trust in the relationship. In any case, steps must be taken to enhance trust. This also involves being careful when searching publicity; look out for (over) generalizing and also think about using publicity as a way for positive attention.

Looking at the advising dentists' opinion on the approach, mailing was thought to be bad for the relationship. In the market views differ, but a mailing is overall not seen as a bad starting point. Continuing contact via mailings or e-mail is, however, not always appreciated, thus indicating a need for more personal contact.

5.3.3 Conclusion on buyer and seller perceptions

The perceptions of the advising dentists on the aspects discussed during the interviews are in general quite similar to those of the care providers. This indicates that the advising dentists have a good idea of the thoughts and feelings that prevail in the dental care market. Given their (former) involvement in this market they are thus well aware of how things, such as ideas proposed by the insurer, will turn out in real life, and therefore their knowledge can definitely be used in deciding on how the relationship and the purchasing process should be designed.

5.4 Concluding results

Analyzing the data has revealed several directions in order to increase contract opportunities and to strengthen the relationship. For one, this chapter showed that the advising dentists have quite good knowledge of the perceptions of care providers have on the contract and the relationship. Gauging the opinion of advising dentists on sample contracts or the approach planned could therefore give VGZ an indication of how the market might react to a certain policy.

The incentive to sign for parties in the non-core area appears to lie with the possibility of direct invoicing, which is considered beneficial for their patients. Moreover, negotiation possibilities and the type of approach VGZ executes seem to be less important to these parties. Communication via mailings can be considered sufficient for these cases, although the insurer could explicitly point out the possibility to discuss requirements as these might form a reason not to sign a contract.

In another part of the dental market, the core area, dental practices have such a high percentage of VGZ insured that signing a contract with VGZ could possibly give them high administrative and financial advantages. It would be wise to point these advantages out to parties that have are not contracted. Incentives for contracting are thought of as important for buyer-seller relationships to succeed, so convincing parties of the contractual benefits can be expected to have a positive effect on the possible success of the relationship. However, as pointed out there is room for improvement of the negotiation possibilities that should be addressed as a part of contractual governance. An insurer should therefore be transparent about the ideas behind price requirements and other requirements and think thoroughly whether it is beneficial always to include all the requirements in a contract. Moreover, the approach and informative meetings also play an important role in the relationship with the health insurer. The suggestion is therefore made that there is still much to be gained in the relational field. Although mailings can be considered a good starting point in the core area as well, more personal contact and regular meetings are considered important steps to strengthen the relationship as this is expected to influence the level of trust care providers have in health insurers. Overall relational governance as discussed in chapter 2 appears to play a very important role in the buyer-seller relationships evaluated. However, in order to gain a better understanding of what is expected exactly in terms of relational governance, more in depth research needs to be conducted. The next chapter will discuss the design and results of the follow-up study executed based on the previously discussed findings.

6. Redesign: Strengthening the relationship

The previous chapter has indicated that there are several relational aspects in the relationship between VGZ and the dentist that can be improved. How to actually improve these relational aspects is, however, something that still has to be figured out. A redesign is thus necessary in order to solve or overcome the problems in the current situation. In this chapter the objectives of the redesign will be explained first. Next the action plan established in order to realize these objectives will be discussed. The third section will then discuss the findings of this redesign.

6.1 Objectives for the redesign

Besides the contractual preferences the interviews with dentists revealed that there was room for VGZ to make steps in order to improve the relationship with the dentists by extending negotiation possibilities, enabling more personal contact, and giving more information and feedback (i.e. in meetings). Especially parties in the core area of VGZ strongly expressed these needs. Moreover, it was found that there was quite some distrust towards health insurers in general. Especially transparently giving information and applying a more personal approach were thought of in order to diminish the lack of trust. So making improvements on these aspects can strengthen the relationship and eventually even lead to more parties willing to contract. What improvements are expected exactly is, however, not completely clear. Moreover, it is not know which improvements are considered most important.

The main objective of the redesign is thus to gain a better understanding of the exact needs of the care provider in terms of changing the relationship for the better. The underlying objectives for this redesign are therefore as follows:

- Knowing more specifically when to employ the different types of approaches.
- Gaining insight into what information/feedback the market wants and how this information should be shared.
- Knowing how to address negotiations and what terms there are for these negotiations.
- Revealing other ideas for actively strengthening the relationship.

6.2 Attaining the objectives: A redesign

In order to realize the objectives stated in the previous section, a brainstorm meeting was considered a good way to gather the necessary information. The reason why a brainstorm meeting is thought of as a good way to gain a better understanding of the situation is because such a meeting can tap into the collective knowledge and subconscious of a group and can thereby reveal ideas and connections around a particular topic. Furthermore, because there are multiple participants, people are able to find new connections between ideas from others.

In order to attain the objectives set, a brainstorm meeting should be well structured. Moreover, the necessary organizational steps should be taken. One should look for a location and arrange for the necessary materials to be present there. Preferably a projector, flip-over and whiteboard are available. Moreover, participants should be able to write down their ideas on separate papers; post-its are very suitable for this since they can thereafter also be stuck directly onto the board where all ideas are gathered. The necessary pens and markers should of course also be available.

Furthermore, it is important that there is a person that acts as a facilitator in such a meeting. The facilitator has to ensure a productive group process and should therefore lead the discussion by providing a focus, encourage a constructive discussion and allow new ideas to be submitted also from more introverted participants. Moreover, the facilitator should act as a referee by making sure that no participant is dominating and everyone is treated equally and can participate freely. Also the facilitator must be neutral to the discussion and encourage feedback by promoting discussion and asking pertinent and stimulating questions. The facilitator is furthermore responsible for the time-management.

Having arranged a location, made sure that the necessary materials are available, and that there is a facilitator, the meeting can be held. The main steps to follow for a brainstorm meeting are discussed below.

- **Phase 1: Introduction**
  The participants should introduce themselves in order to know everybody's roles in the discussion. Following this introduction a short presentation introducing the topic and revealing the time planning should be given by the facilitator. An introduction is a good starting point for a meeting as this will clearly reveal what the objective of the meeting is.
- **Phase 2: Actual brainstorm**
  This part of the meeting is about generating as many ideas as possible, the quality of the ideas is not important. In order to initiate the idea generation, idea categories can be given as a starting point. Giving such directions will also help in generating findings in the extension of previous findings and not completely wander off. An open category can also be given as this gives some more freedom and enables thinking out of the box, which might completely new idea directions to be revealed. Furthermore, participants should be given the time to note down ideas individually. Ideas can be written down on post-its as this allows ideas to be gathered at one point, but split up according to category. A whiteboard can be used to gather all ideas. When sticking the post-its on the board each participant has the chance to explain ideas in more detail if necessary. The facilitator can then, together with the participants, denominate the different (sub)categories.
- **Phase 3: Prioritizing**
  Lots of ideas can be generated, but not all ideas will be as good and not all will be equally rated in terms of importance. One would only want to analyze the best ideas further. In order to narrow down all the generated ideas to a few it is necessary to prioritize ideas. Prioritization can be realized by having each participant divide a certain amount of points over the different denominated (sub)categories. When using the points system, make sure that there is a maximum amount of points to give a category in order to make sure that a more dominant participant is not only scoring his own idea, possibly causing a bias in the ideas chosen to be analyzed further (e.g. divide 10 points with a maximum of 6 for one category). Adding up the points will reveal what ideas are highly rated and what ideas not so much. The facilitator can then check the results with the participants to furthermore downsize the possibility of creating biased results. The categories could also be ranked by importance (possibly simultaneously with scoring them with points) to disable participants from rating several different ideas the same. The highly rated ideas revealed by the prioritization process are the first to tackle in terms of how to effectuate them in reality.

- **Phase 4: Discussion**

  Given the time available for the meeting several ideas, the ones on top of the list after prioritizing, can be further discussed. Discussing the ideas more thoroughly gives the participants a chance to come up with a real action plan for how to start working with or implementing these ideas in a feasible way. In advance a certain amount of time can be set for every discussion. This is the time expected to be needed to discuss the idea thoroughly. Giving unlimited time can cause straying off from the main subject, which is not desired at this point. During this process the facilitator should be asking stimulating questions if necessary and moreover, be active in making sure one is not wandering off from the subject and that everyone is heard.

Following these different phases and properly preparing the meeting both in terms of substance and resources, one can expect very useful results from these meetings, especially if they are well led by the facilitator. One very important final note should be made and that is that it is also very important to choose your participants wisely. Involving the same type of participants (e.g. from one department) can make ideas less valuable as they might be more straightforward and less substantiated. Moreover, if the results of such a meeting also influence other groups they might be less likely to accept these ideas. One should thus try to involve people from all the groups involved in the matter discussed.

6.3 A brainstorm on improving the buyer-seller relationship

The general design of a brainstorm meeting, which was discussed in the previous section, was used to attain the objectives described in 6.1, which are specific for the study described in this thesis. For this particular study the idea was to enable a discussion between buyer and seller in this meeting. By enabling this discussion the desires of the care provider can come forward and the obstacles and feasibility for the health insurer can be pointed out as well, which can eventually lead to some satisfactory suggestions for improving the relationship.

Participants both from VGZ as well as the dentist population were thus necessary. These should, however, not be picked completely randomly. In order to enable a constructive discussion the participants from VGZ were looked for in the dental care/purchasing area; one purchaser and one advising dentist were found to be able to participate. Randomly picking from the pool of dentists was also not considered a clever thing to do. As especially the core area of VGZ expressed the need for strengthening the relationship with VGZ the precondition was set that the participating dentists would be active in this area. This choice is, moreover, justified by the fact that the parties in the core area can be considered most important to VGZ given the number of VGZ insured. Given the cases it would also be worthwhile to have at least one party that represents Case I and one party that represents Case II, so it can be investigated whether the parties have conflicting or additional ideas. As the interviewees from Eindhoven and the consortium in Limburg already revealed to really have an opinion on strengthening the relationship these interviewees were considered good participants and therefore the meeting was planned with them. So a meeting was organized with a purchaser and advising dentist of VGZ and two dental care providers, one with and one without a contract with VGZ (see Appendix VIII). This appendix also shows the exact action plan that was drawn up for this specific brainstorm meeting.

Although all participants were already involved in the study the study was shortly introduced, moreover, some of the findings so far were brought to the attention. The objective for this specific meeting was also revealed in this introduction; generating ideas on how to strengthen the relationship. After this introduction each participant was asked to note down several ideas that according to them could improve the relationship between VGZ and the dentist. Considering the findings of the interviews in terms of directions for improving the relationship, the given starting point was to note down at least two ideas in the categories: negotiation, approach, and information/feedback. Moreover, a category 'other' was given to be open to other, perhaps very useful, ideas. Including the the category 'other' thus enables to gather all relevant ideas, but given the other categories the direction in which ideas were sought was clearly revealed largely securing for ideas not straying too far from the subject. The ideas suggested were then put onto the whiteboard and simultaneously explained in more detail. The resulting whiteboard together with some of brainstorm notes put on it are shown in Figure 7.

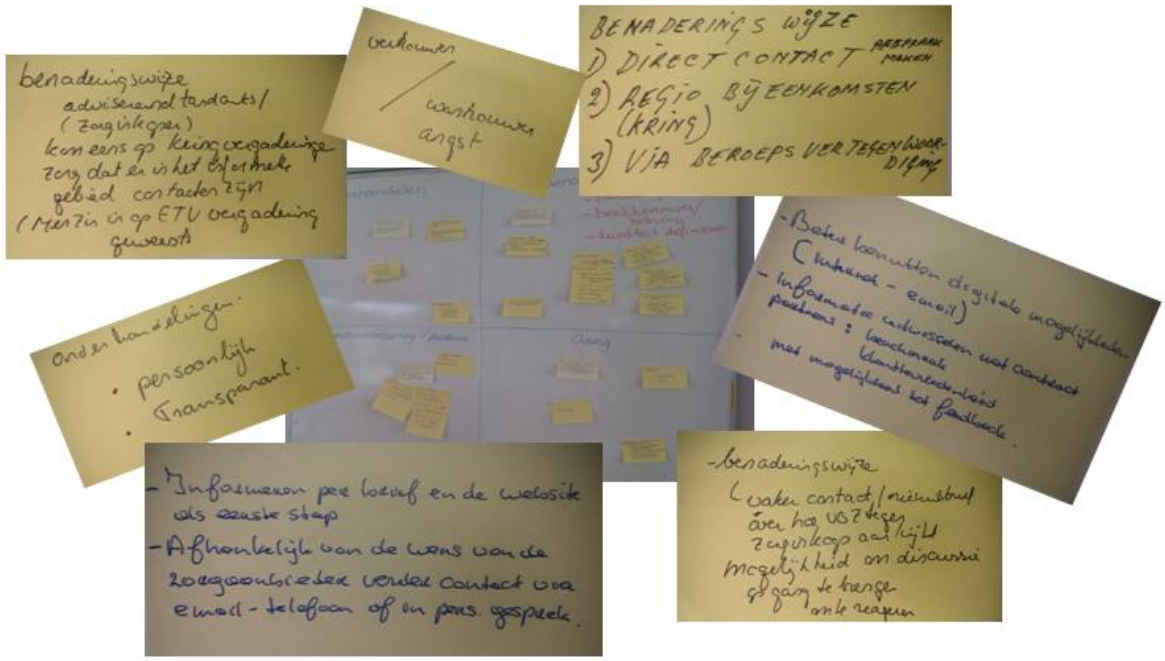

Figure 7: Brainstorm results

The notes, once more, revealed that there is a lack of trust with some parties. Moreover, direct contact, visiting regional meetings and sharing information in a transparent way were mentioned by several parties. The ideas and the detailed explanations that were given immediately revealed that there were a few basic things that should be tackled first before other steps that might improve the relationship should be taken. Due to this clear result the rest of the predetermined action plan was more or less abandoned by the facilitator (i.e. the researcher); not all (sub)categories were named and the prioritization phase that should result in three discussion points was skipped. Together with the participants it was found that more transparency should be created by sharing more information. Furthermore, more personal contact was part of several ideas that were mentioned, and could also play a role in creating transparency. Defining quality was another aspect, but this was left out of the

discussion as this involves more parties which are currently still working on how to measure quality, and moreover does not stand at the basis of the relationship. All in all, the way in which more transparency and thereby trust could be created between VGZ and dentists stood at the basis of the discussion that followed the brainstorm session. Moreover, the facilitator extended the discussion on the steps that should be taken up until the pre-contracting phase as this phase forms the basis of a possible formal relationship. The discussion on these suggestions for improvement and the associated plan will now be discussed in the next section.

6.3.1 Proposed plan of action: A discussion

As mentioned before the dentists would like health insurers to be more transparent in their actions. One of the aspects of this transparency is that the health insurer should share more information (e.g. on their policy plans) according to the care provider. Moreover, both the care providers and the representatives of health insurer VGZ revealed that they saw a necessity for joining regional dentists meetings. That one saw these meetings as a chance for the health insurer to actively share information and get a better feeling of the dental market was immediately clear. The discussion on these meetings will now be summarized, containing the most important comments made and also a critical evaluation of the researcher on the role for both VGZ and the dentists.

Meetings

It should be noted that before the Health Insurance Law was introduced in 2006 health insurers were operating regionally and advising dentists regularly visited regional meetings, which was considered a good thing by both the participating dentists as well as the advising dentist, who has regularly visited these meetings in the past. However, as was clearly brought to the attention during this meeting, and also in previous discussions with the advising dentist on the workplace, with the growth of the area in which VGZ does business and considering the number of advising dentists there is just no time given by the organization for them to join such meetings anymore. Purchasers can also do this and as mentioned by the participating purchaser he has also visited such meetings before. However, given the 1,5 FTE purchasing their time is currently also very limited. The purchaser, moreover, shared that he felt that dentists sometimes misused the presence of a representative of the health insurer as he had the experience of being overwhelmed with complaints when joining such a meeting. Holding a real substantive discussion was considered quite impossible.

Given these obstacles the dentists, however, still felt that meetings were a good setting for the health insurer to create the necessary transparency. VGZ's representatives agreed with this, but then one should look for a way to make sure that the health insurer could indeed share its story and start a real discussion on the matter during a meeting.

In order to stimulate the discussion the researcher then suggested that the health insurer perhaps might keep matters in own hands by organizing meetings themselves instead of joining regional meetings. At first glance the participants seemed a bit skeptical about this option. It would of course be somewhat time consuming to organize such a meeting or for dentists to visit an extra meeting besides the regional meetings. The idea behind the suggestion was therefore also shared by the researcher. When keeping

the organization of informative meetings in their own hands, the health insurer might be able to involve more internal employees that could shed their light on different policy aspects. Moreover, this would also increase the likelihood that the care providers visiting these meetings really want to have a constructive discussion, as there is only one objective of the meeting and this objective is shared beforehand so visitors know what to expect.

The participants then got further into this idea by discussing some of the aspects of such a choice further. Throughout the meeting the obstacles health insurer VGZ was facing with, for example, the new situation with free pricing, or the difficulty to employ advising dentists were also discussed to provide the dentist with an insight into the difficulties VGZ was facing which largely necessitated the choice for certain procedures or actions. It was mentioned by the participating dentists that they appreciated the fact that the participants representing VGZ were so open in explaining the troubles VGZ was facing and that this added to the perception of the relationship. When the health insurer could thus involve employees from different departments in the organized meetings more insight into the issues VGZ is dealing with internally (i.e. shortage of advising dentists) or process issues could also be revealed quite specifically as a representative from a certain department is present and can therefore clearly explain the problem. Such openness is thought to possibly create more understanding with the group of care providers in general, just as it did to the participating dentists. The participating dentists further mentioned that care providers should also be enabled to discuss their issues with for example the insurer's policy. In the situation of a purchaser and/or advising dentist joining regional meetings these discussions are, however, not considered appropriate. As purchaser and advising dentist both acknowledged they do not have any direct influence on the decisions made, the exact policy is decided upon by higher management. However, when keeping the organization of a meeting in one's own hands the time could possibly be taken for policy discussions and management could then be involved in the meeting as well. Further considering this suggestion it could indeed be considered wise to involve management in such meetings as such discussions could form an important source of information in terms of how policy decisions are or will be received by the market.

Looking back, one of the participating dentists was quite unsure about whether to trust the health insurer or not. This dentist, however, greatly appreciated the discussion and information shared and actually appeared to become less distrustful during the brainstorm meeting. This appears to further strengthen the idea that the lack of trust can be further diminished by organizing meetings. The participants also did acknowledge that the transparency created by meetings will certainly have its effect on the trust in the relationship. This will work from both sides as an open discussion on perceptions and issues from both sides can also increase the trust of the health insurer in the care providers. The care providers should, however, also visit and actively participate in a constructive manner in these meetings if they feel that the health insurer should listen to them, act more transparent and be open for discussion. Without their participation this effort of the health insurer will not show results and possibly change the relationship for the better, but one then cannot blame the health insurer as they have shown the effort.

Approach

After revealing that meetings were really considered necessary and that they could be beneficial for both parties the question was raised by the researcher how to approach dentists for these informative meetings and how to continue the contact with the care provider towards the start of the new contracting year. This question was raised in order to conclude the previous discussion on meetings and to get a more explicit view of how to design the complete pre-contractual phase of the buyer-seller relationship. This direction needed to be given to also enable the discussion about the approach which, from the interviews, appeared to be important. Furthermore, it was necessary in order to find out more about how to tackle VGZ's problem of a low contracting rate, which forms the basis of the practical aspect of this specific study. This discussion was quite short as the most suitable possibility seemed to be quite straightforward for all participants.

It was first considered wise to send a mailing with some basic information on important developments, for example on the policy plans for next year. This mailing could then include an invitation for a meeting. At this point the participating dentists stated that the meeting must first take place before a new mailing is sent as this mailing should inform the dentists on what has been discussed and what developments there have been or will come as a result of that meeting. It is made very explicit that they consider it important that this follow-up action is taken. In this way all care providers can see that the care providers that showed up at the meeting have been heard and possibly even action has been taken. Eventually the health insurer could invite all care providers for another meeting, but also give the care providers a chance to let the insurer know by e-mail that they would like to discuss things further in a more personal way and create a basis for a relationship or, in the complete opposite situation, to say that they are really not interested. The note is made by VGZ's representatives in the brainstorm meeting that it might not be possible to directly give completely personal attention to all single care providers preferring such an approach. This is indeed logical given the number of VGZ's purchasers/advising dentists that are expected to cover the whole market of dental care providers. However, it is not considered a bad thing if the care provider is thus given the opportunity to express the need for contact. Parties visiting the meetings or reacting on the mailings in a positive way can be considered parties with whom a foundation for a relationship has been laid that can be further developed. The chances of building on this relationship and perhaps even going towards a more contractual relationship with these parties can be considered higher than with those not interested at all. Putting more effort in contacting and informing these parties can thus strengthen the relationship. Moreover, putting more effort in more personal contact by telephone or even in person can certainly be justified. But the question is raised if and how to prioritize activities if they cannot all be handled at once.

It cannot be known in advance whether the group of visitors and other parties that actively show interest will be large or small, but once a first general mailing considering the new contracting year has been sent, these parties are the first to be contacted in a more personal way. Considering a large group of potential contractual partners (either seen from the viewpoint above or considering the whole dental care market) it is permissible for a health insurer to approach the different parties at different moments in time. It is considered very logical and permissible by the participating dentists that the health insurer first puts effort in parties that are also important to them (i.e. parties with a very high percentage of VGZ

insured), as long as other parties are informed that they will be contacted eventually. Thereby it can also be explicitly explained that not everyone can be contacted at once and that therefore a certain segmentation in the care provider database has been made, in which one group is contacted before the other. Such information can be shared via a mailing as well, or via e-mail. As long as the health insurer is transparent about the policy followed in this and keeps its promise to contact the care provider, the care providers will very well understand the situation and not feel neglected or react distrustful according to the participating dentists. For VGZ's representatives the fact that one should inform the care providers of this approach process seems logical given the necessity for more transparency. Moreover, this suggestion appears to be feasible and as it enables the health insurer to approach the market in a segmented way without care providers feeling completely neglected, this little extra effort in sharing information is strongly outweighed by the fact that it makes the purchasing process manageable. It is, however, important that the care providers do not judge or criticize the health insurer when they are informed that they are not the first that will be approached.

6.4 Concluding findings of the redesign

Although the execution of the brainstorm meeting was a bit different than planned beforehand, the objective of gaining a better understanding of the exact needs of the care provider in terms of building and strengthening the relationship was very well achieved. The designed brainstorm meeting thus succeeded in attaining its objective. It was revealed that care providers have a strong need for meetings in order to feel that the health insurer is transparent about his policy and open to discussion. Moreover, these meetings give dentist the opportunity to get into direct contact with the health insurer which will enhance the feeling that the health insurer is a trustworthy business partner. It is thus considered wise for a health insurer to organize these meetings, as joining regional meetings appears not to be the best option, on a regular basis. Furthermore, mailings are considered a very justifiable tool for informing care providers on certain developments or the policy in terms of contacting parties. However, it can be concluded that for those genuinely interested, more effort should be put in contacting them in a more personal way (i.e. by telephone). This was also one of the ideas generated considering on what terms negotiation should take place. So it appears that the personal effort should be prolonged in negotiations as well. This was, considering the time available, one step too far for the discussion held and was therefore not further elaborated upon. However, this eventually will also play an important part in increasing the contracting rate as not offering enough negotiation possibilities might become a deal breaker for a dentist considering a contract, as the interviews have showed. The first step is, however, one of creating transparency and trust in the pre-contractual phase, without tackling this problem the contracting rate will not rise.

Given the satisfactory results of this brainstorm meeting and such meetings in general, such meetings might well be applied more extensively in the follow-up of this study or for meetings proposed to be held between VGZ and the dentists, but this depends on the specific objective of such a meeting. Furthermore, this design might possibly also be used by the insurer in other contexts. The general design sketched in section 6.2 forms a good starting point, although a facilitator should always be well aware of the specific progression in a meeting and therefore be open to changing the plan if necessary.

7. Conclusions and recommendations

The aim of this research was to find out how buyer-seller relationships in the healthcare market can best be established and strengthened when buying professional services. A strong buyer-seller relationship is necessary in this sector to help secure high quality, affordable, and accessible healthcare services for the population. How to procure such professional component services is thus gaining more and more interest. In order to establish good buyer-seller relationships, the contract design and contractual and relational governance are considered important.

This chapter will now present the concluding findings on the executed case study, together with some specific advice for VGZ. Furthermore, a final conclusion on the findings of this study is given and answers the research question. Moreover, the theoretical contribution of this study will be discussed together as well as some managerial implications. The last section will then state what limitations this study has and will give direction for further research.

7.2 Conclusion and recommendations for VGZ

The ultimate objective of this study for VGZ is to achieve a higher contracting rate with general dentists. With a contracting rate of 0% in 2011 and a rise to 10% in 2012, which can be considered an effect of the new market situation of free pricing together with the decision of the health insurer to terminate the general terms and conditions, there is still much room for improvement. The study therefore focused on finding out how different contractual and relational aspects were perceived and what suggestions were made for improvement.

7.2.1 Concluding findings for VGZ

The study revealed that not everyone thinks the same about what VGZ considers an incentive for contracting; the administrative advantages. A part of the parties with a high percentage of VGZ insured in their patient database acknowledge the administrative (financial) advantage, but for other parties the requirements set appear to void this possible advantage. This does not mean that all requirements set are immediately considered negative, but one is careful in committing themselves to requirements that are hard to adhere to (i.e. volume control), or that do not include some kind of benefit to their patients or themselves (i.e. prices). Moreover, a factoring company can also help in downsizing administrative work and does not set such requirements. Furthermore, for a small percentage of parties acting in the interest of the patient is pursued by contracting as many health insurers as possible as the contract enables direct invoicing, the requirements should, however, be acceptable. For the parties that see great advantages in the possibility of direct invoicing and/or the health insurer taking over the default risk, the fact that VGZ terminated the general terms and conditions which previously included these clauses, appears to be the reason for them to sign the contract. However, requirements are at all times considered carefully.

Moreover, it was revealed that relational aspects are very important, especially to the care providers in the core area of VGZ. For one it was very clear that more trust should be created by being transparent and getting into more personal contact with the care provider. Considering the actual contracting

process more negotiation possibilities appeared to be desired. Also more personal negotiations would be appreciated.

Given the large percentage of not contracted parties, especially in VGZ's core area, the relational aspects and the requirements set, can be considered main reasons of why dentists decide not to sign the contract with VGZ. Some recommendations will now be given on how the relationship might be changed for the better; possibly also enhancing the contracting rate.

7.2.2 Recommendations

Considering the buyer-seller relationship between VGZ and the general dentist it thus appears that trust is an issue that should be tackled before possible changes in the purchasing process will have their effect on the relationship in terms of a possible higher contracting rate.

The following recommendations are given to VGZ based on the results of the study:

Building a relationship by creating trust

- Regularly organize meetings for which dentists are invited via a mailing. Use these meetings to transparently communicate VGZ's policy and be open in issues that the company is dealing with that might have their effect on the dentists.
  - ✓ *Participants:* If possible involve several internal employees (i.e. purchasing department, relationship department) to be able to let them explain the issues or answer questions for the relevant department. Also let at least one advising dentist join the meeting as their tight connection with the dental market from both the care provider's perspective as well as from the health insurer's perspective can be valuable and appreciated by the dentists.
  - ✓ *Follow-up:* Communicate the results of the meeting via a mailing to the whole group that was invited. Give the care providers a chance to reveal whether they want to get into further contact or are not interested in the mailings. If they want further contact make sure that this is followed-up in due time.

  Additional note: When organizing these meetings also consider where they are organized. Dentists might not be motivated to join the meeting as a long travel can act as a threshold. Therefore try to cover the country with more meetings in different places (possibly other VGZ offices are suitable). Possibly more meetings should be held in the core area compared to the non-core area given the overall higher incentive for core parties to sign a contract (i.e. the administrative advantage) in order to further activate them to sign.

The purchasing approach

- Make a segmentation in the dentist population for the purchasing process. This segmentation can be based on the percentage of VGZ insured in a dentist's patient database (e.g. < 30%, 30-40%, and > 40%), where the dentists with over 30% percent VGZ insured (generally speaking dentists in the core area), but especially those over 40%, are very important to VGZ and for whom VGZ can be very important as well.

- ✓ Use a mailing for *all dentists* to introduce them to the insurance policy and the contract terms set for the new purchasing year. Positive reactions should, of course, be immediately followed-up, preferably with personal contact by phone.
- ✓ Start contacting the category with the highest percentage (e.g. > 40%) by phone. Inform other categories, at least those above 30% (which are core parties), that they will be contacted later on and why this is. Do not forget to actually contact them as the process of creating trust will otherwise be undermined.
- ✓ Keep a database of the contacted parties and note why certain parties are not interested in order to know what to anticipate on next time, especially once policy has changed. Moreover, parties really not interested can then for some time get crossed off from the list as continuously contacting them might otherwise cause irritation.

Additional note I: In order to segment the dentist population request data at BI (Business Intelligence) which shows the percentage VGZ insured per dental practice. Sort the practices according to percentage categories, such as: < 30%, 30%-40%, and > 40%, suggested before. (Note: depending on the actual number of dentists falling in the higher categories it might be necessary to form more categories in order to be able to quickly handle a category.)

Additional note II: To make sure to enable a more personal approach an increase in VGZ's dental purchasing FTE's, especially those available for contracting general dentists, is considered necessary. The number of dental practices with over 40% VGZ insured will especially influence the increase in FTE's necessary. These purchasers can then live up to the request for more personal attention and also play a role in the organization of meetings. Each purchaser should be assigned certain regions for which they can then take responsibility of as much of the contact with a certain care provider.

Additional note III: If possible some more advising dentists should be hired as well. Preferably they should be co-responsible for a certain region in terms of meetings and also when contacting or contacted by a care provider in that specific reason. The fact that this enables direct personal contact with a specific person with the right know-how will be appreciated by dentists.

Contractual requirements

- ➢ Decide which requirements are absolutely necessary for a contract (e.g. volume control). Decide on what requirements negotiation is possible and what room there is. Be transparent in why the requirements are considered necessary and try to persuade dentist by showing them what financial advantages a contract might have compared to a factoring company (if cooperation with such a company is considered).
- ➢ Including extensive quality requirements should only be considered once quality indicators have been defined by the market and tested. Giving feedback in terms of benchmarking this quality can then be a way to extend the contractual relationship.

The extent to which the advice given is going to change the contracting percentage cannot be stated as the research has not directly focused on this, although a rise is definitely expected. In order to make some substantiated statements at this level a bigger sample would be needed. Moreover, with quality measurement still being such an issue in this market at the moment no conclusive statement can be made on what contract type to use; performance-based or behavior-based.

7.3 General conclusion: Answering the research question

The general research question was defined as:

"How can buyer-seller relationships in the healthcare market best be established and strengthened when buying professional component services, in order to secure high quality, affordable, and accessible services for consumers?"

Looking at the study described in this thesis, that was conducted to provide an answer to this research question, it can be stated that this study has shown that trust is a very important factor in the buyer-seller relationships evaluated. Without the parties trusting each other it will be almost impossible to establish a relationship at all (aside from the relationship imposed by the government as a result of the triad in the Dutch healthcare system). It was found that trust can be build by being transparent about policies and by communicating in a personal way. For this to work the care provider should, however, also be committed to this relationship by being transparent as well and by being open to constructive discussions. The information exchange thus plays a key role in creating a good relationship.

Once a basis of trust has been established the pre-contractual relationship can be strengthened further by continuing the information exchange and by enabling negotiation (e.g on prices and requirements), thereby continuing the personal approach. It is thereby important for the health insurer to be somewhat flexible about requirements that have been put forward as some might not be necessary in a certain situation and only bring down the chances of a good (contractual) relationship.

Moreover, the contract incentives also play an important role in the decision to contract, but they can be quickly overshadowed by the requirements put forward, especially if there is a lack of trust. This is why one should be careful with the imposition of requirements and thoroughly think through the consequences for both parties when using these requirements.

7.4 Theoretical contribution

Theory on buyer-seller relationships has not extensively looked into purchasing services in the healthcare sector. The studies that have looked at this sector mainly focused on purchasing *for* healthcare instead of purchasing *of* healthcare. This last thing is, however, exactly what Dutch health insurers try to do. In the triadic situation of the Dutch healthcare system the healthcare market (Figure 2) is the place where health insurer and care provider meet each other. For this market a new service type has been defined, a *ProCo service* (Hovens, 2012); a combination of both a *professional* (Silvestro et al., 1992) and *component* (Van der Valk et al., 2009) service. The study tried to look into the effects such a service combination has on the buyer-seller relationship (specifically for the healthcare sector).

As services are considered and the service type is a combination of two existing service types there are certain expectations based on previous literature. Although *ProCo* services are a combination of two thoroughly studied service types, knowing the effects of this service type in terms of contracting and managing the buyer-seller relationship can, however, only be guessed based on separate previous theories. Based on the literature review in chapter 2, one might expect the aspects in Figure 1 also to play a role for buyer-seller relationships in the healthcare sector, when purchasing care (ProCo) services.

This study adds to service purchasing literature in several ways. By studying the healthcare triad, it first of all acknowledges a new service type, a *ProCo* service, which is expected to make purchasing professional services even more difficult as performance management and measurement becomes even harder due to the component part; the service exchange takes places outside the buying organization. This appears to implicate that for this service type relational governance is very important as this is the way to keep some grip on the purchased service. For interorganizational exchanges between health insurer and care provider enforcement occurs through social processes that build trust; relational mechanisms are thus of importance for these exchanges to succeed. Studying the buyer-seller relationship in the healthcare sector, specifically for the healthcare market, reveals that trust plays a very important role in this market and that the social processes are indeed considered an important factor influencing the level of trust. Moreover, this study revealed that trust can be considered a prerequisite for buyer-seller relationships to have a chance of succeeding. This strengthens previous literature which states that relational governance is associated with trust, which is found to improve the performance of interorganizational exchanges (Poppo and Zenger, 2002).

Furthermore, it was also found that care providers are looking for information exchange to create transparency in the relationship. Information exchange is seen as a way to strengthen the relationship because it enables a better understanding of the situation. Moreover, it was found that this information exchange can further enhance the level of trust in a relationship; it thus also influences the level of trust. This study thus further substantiates the idea that information exchange can strengthen a relationship, but it does so through the mechanism of trust. Previous literature such as that of Poppo and Zenger (2002) has, however, not unambiguously linked this information exchange to the concept of trust. Both social processes in terms of approaches and information exchange to create more transparency are thus found to influence the level of trust, which is eventually the prerequisite concept in a buyer-seller relationship. Just as previous literature thus stated, relational governance can be seen as a mechanism to enhance the exchange performance (Ferguson et al., 2005); it can thus help in establishing a successful buyer-supplier relationship.

Negotiation is, furthermore, found to strongly influence the chances of successful buyer-seller relationship. Studies by Ferguson et al. (2005) and Poppo and Zenger (2002), however, promote the negotiation process as part of contractual governance as a foundation for social governance, whereas this study finds social governance necessary to come to negotiations at all. Poppo and Zenger (2002) found that relational governance should be predominant for established exchanges, but it appears that relational governance should also be predominant when trying to establish buyer-seller relationships. This study thus shows the importance of relational governance in the pre-contractual phase.

A last contribution of this study is that it showed us that, although planned incentives for contracting are considered interesting by the care providers, governance (especially relational governance) can make or break the chances of a contractual relationship in the healthcare market. Previous literature has, however, not explicitly stated such an influence to be present.

Figure 8 visualizes the factors that, in this study, have been found to influence the success of (contractual) buyer-seller relationships. Moreover, the green line suggests the relationship between governance mechanisms and contract incentives; with bad governance considered able to overrule otherwise perfect contract incentives.

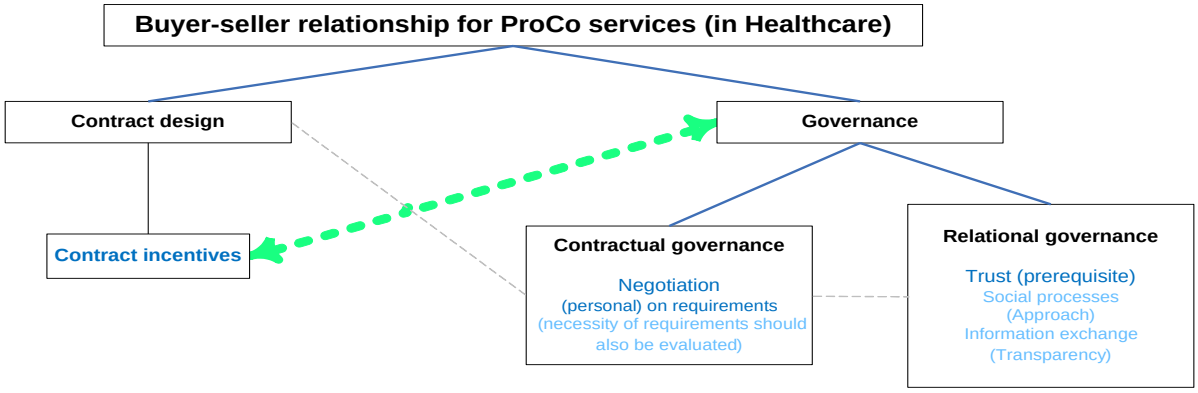

Figure 8: Factors influencing the success of buyer-seller relationships in the healthcare market

7.4 Managerial implications

The result of this study is useful to purchasing professionals in the healthcare sector. It shows that relational governance is a very important aspect in the buyer-seller relationships within this sector. Relational mechanisms that build trust should thus be a part of the interorganizational exchanges. These professionals thus need to strive for profound social processes in their purchasing process and the necessary information exchange as these will help establish a successful buyer-supplier relationship. As the, in this study conducted, brainstorm meeting was also seen as enhancing trust by the relational mechanisms of social processes and information exchange, such meetings appear to be an appropriate tool to activate these relational mechanisms. The general design of a brainstorm meeting discussed in chapter 6.2 can thus be used as a tool, not only in other or further studies, but also to really meet the relational needs in buyer-seller relationships. Such meetings can be a platform for further strengthening buyer-seller relationships as they can generate ideas on how these two parties might benefit more from the relationship. Overall, meetings can be considered a way that can simultaneously give an answer to the need for information exchange and the need for personal contact. Professionals using this tool should think thoroughly about whether to include all phases and especially about who to invite.

Moreover, when setting requirements purchasing professionals should carefully consider the implications of such requirements and evaluate whether these requirements are then necessary and worthwhile to include in a contract. Translating all uncertainties or risks on for example performance in requirements will only provide for a very rigid relationship or no real relationship at all. One could test the different perceptions on certain requirements or other policy plans with other parties. These other parties, such as care providers or employees from other internal departments, can then share their perception on these ideas. This reflection on ideas can then help in further refining the idea or might even lead to radically change the idea. Again brainstorm meetings such as the one used in this study can be used as a tool for realizing the objective of testing an idea (e.g. a requirement or a new policy plan).

7.5 Limitations and directions for further research

A possible limitation might be found in the fact that the brainstorm-meeting did include participants from the care provider's side that were already part of the 'sample' interviewed for this study. However, this enabled the researcher to be more secure about receiving constructive input. Moreover, the two participants represented very different perceptions of the buyer-seller relationship, which only strengthens the findings in terms of actions to take. It would, however, have been interesting to conduct this meeting in a larger setting; including more participants from either side of the relationship. Not only to increase the validity of the findings, but especially to find out whether the redesign is also suitable for larger groups or what adjustments should be made in such a situation.

The dental sector, that was the object of study for this research, was going through quite some changes just before and during the study. This could have altered the context of the data gathered somewhat, although the researcher was aware of these changes the turbulent context in combination with the open interviews and the overall time to conduct the study might have caused some findings to be drawn from another basis or not to be completely applicable to the in the meantime somewhat changed situation. The sector is also up against a big change in the near future, which might also have its effect on the buyer-seller relationship considered, especially in terms of contracting opportunities. The importance of relational governance will, however, still hold, but it might be necessary to reconsider contract incentives and requirements to set. VGZ might consider a follow-up study including a questionnaire that can be sent to all general dentists to see whether the findings of this study are correct and complete. Moreover, it will give them a clear indication of the precise chances, in terms of contracting opportunities, there lie for them in the dental market.

Given the difficulties with quality measurement in the sector studied the general opinion on more extensive quality measurement could only be asked, but since the interviewees cannot be fully aware of what is meant no conclusions can really be drawn on this aspect. This also inhibited the chance to make a substantiated statement on what contract type could best be used; performance-based or behavior-based. Based on this research nothing could thus be stated about what contract type should be pursued (for *ProCo* services) in the healthcare sector. Considering the performance indicators in Appendix IX, more quality measurement appears to be implemented soon. Further research could evaluate the indicators and their translation into the contract, thereby focusing research on the contract type that will be most suitable. Furthermore, in order to see the effects of the contract type, together with contractual and relational governance on the buyer-seller relationship in the healthcare sector, further research could be done in sectors in a further stage of professionalization in purchasing (i.e. where performance measurement in terms of quality is already possible and implemented) as such studies might really elaborate on the performance-based versus behavior-based discussion. The described study, furthermore, appeared to have found a difference in the perception on quality measurement between those interviewees with a dental background and this with only a more managerial background. This could then also be studied further; in case of a substantial difference the factor of the contact person (dental or managerial background) from the care provider's perspective might become an important influencer to the purchasing approach.

As with nearly any other empirical research a longitudinal study could give more insight in how the buyer-seller relationship develops over time. The results of the recommendations given can now not be evaluated. However, such insights could strengthen the directions for purchasers responsible for buying healthcare services.

Moreover, given the turbulent development of the dental care sector under consideration and its specific characteristics (e.g. no quality measurement possible yet, a large group of care providers, etc.), the generalizability of findings to the whole healthcare sector is difficult. Given previous research in other sectors and the findings for this case, focus on relational governance (and specifically on the building of trust) can, however, be seen as an important aspect throughout the healthcare sector. Further research with other care sectors could, however, be done in order to strengthen these findings. Moreover, this research should also try to focus on the in this study suggested importance of relational governance in the pre-contractual stage (i.e. the green arrow in Figure 8).

Looking at a completely different research field, the one considering human psychology, it appears that the findings of this study could be linked to the Self-Determination Theory, which suggests that motivational concepts might play a role in the decision of a care provider to sign a contract. Addressing certain concepts in order to influence extrinsic motivation in a positive way appears to be possible. Carefully addressing this extrinsic motivation, for example with concepts of contractual and relational governance, might thereby add to the success of the buyer-seller relationship. A feeling of choice (imposed by negotiation opportunities) could for example change motivation. Considering the time given for this study it was, however, not possibly to study the link between the concepts of the success of buyer-seller relationships with that of self-determination theory. Future research could, however, evaluate the link between these two concepts.

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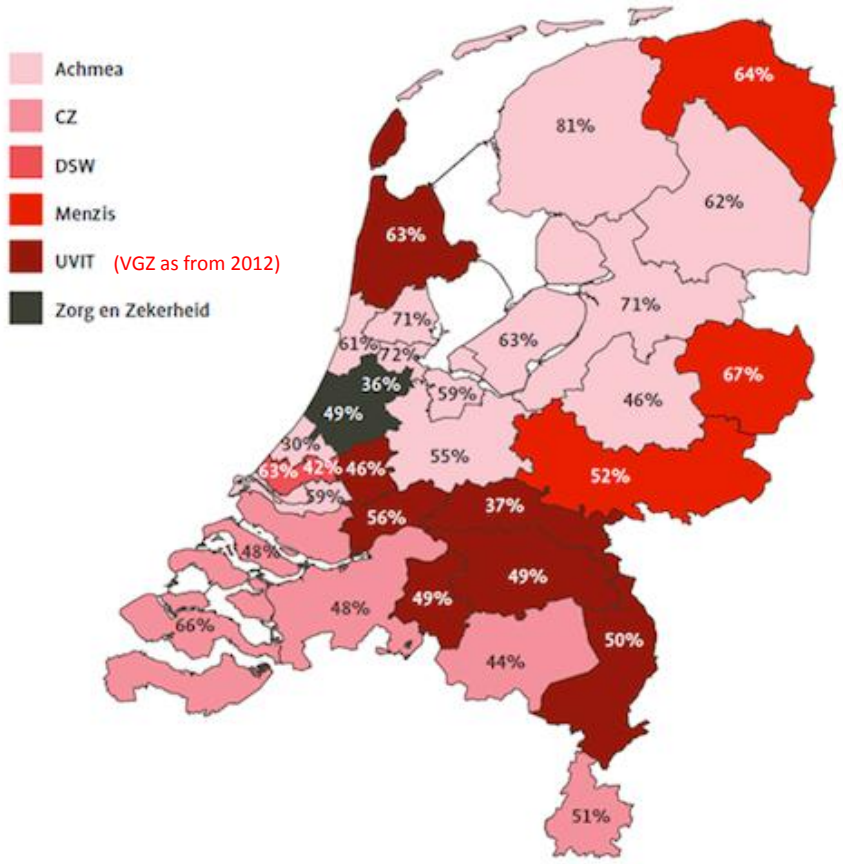
Appendices

Appendix I: VGZ's core area

Health insurers' market share (2011)



[Source: VGZ]

Top 25 of municipalities: > 20.000 insured *and* > 40% market share

GEM	UNIVE	IZA	UMC	ICURA	TRIAS	VGZ	IZZ	VM	TOTAAL	INW	PERC_UVIT
0772 EINDHOVEN	3.524	5.345	208	7	358	87.450	9.480	27.236	133.608	213.815	63
0855 TILBURG	3.595	6.511	150	20	673	59.720	10.631	7.992	89.292	204.865	44
0268 NIJMEGEN	3.566	6.430	5.774	5	285	48.692	9.450	5.710	79.912	162.955	49
0796 S HERTOGENBOSCH	2.011	5.806	248	-	365	53.855	6.953	7.118	76.356	139.605	55
0505 DORDRECHT	2.825	6.314	476	4.629	47.269	3.272	3.057	3.484	71.326	118.410	60
0935 MAASTRICHT	1.263	5.826	3.364	3	388	46.771	3.938	8.756	70.309	118.455	59
0983 VENLO	994	2.997	65	-	89	54.824	5.445	4.863	69.277	100.300	69
0361 ALKMAAR	42.664	3.585	196	-	110	2.203	3.997	2.280	55.035	93.845	59
0828 OSS	1.069	2.830	245		156	31.171	2.840	2.756	41.067	84.025	49
0513 GOUDA	1.609	2.748	383	5	28.858	2.059	1.706	3.506	40.874	71.125	58
0405 HOORN	29.820	2.394	241	-	105	1.970	2.324	1.944	38.798	70.255	55
0400 DEN HELDER	29.735	1.904	23	-	131	1.336	1.728	2.544	37.401	57.370	65
0748 BERGEN OP ZOOM	1.232	2.385	84	2	190	27.177	2.705	2.216	35.991	65.825	55
1674 ROOSENDAAL	2.519	2.671	119	5	260	24.071	2.491	3.649	35.785	77.580	46
0984 VENRAY	653	1.335	113	-	35	20.024	4.982	2.249	29.391	42.715	69
0398 HEERHUGOWAARD	20.446	1.924	78	-	90	1.266	1.773	1.289	26.866	51.175	53
1507 HORST AAN DE MAAS	304	1.324	48	-	16	19.084	3.958	2.035	26.769	41.465	65
0861 VELDHOVEN	768	1.243	15		46	15.536	2.306	6.597	26.511	43.230	61
1894 PEEL EN MAAS	327	1.600	24	-	34	18.630	3.456	1.891	25.962	43.070	60
0420 MEDEMBLIK	19.562	1.541	51	-	74	868	988	1.053	24.137	42.650	57
0867 WAALWIJK	541	1.365	11		327	17.779	1.601	1.891	23.515	45.745	51
0512 GORINCHEM	1.012	1.217	73	4	17.186	998	603	1.223	22.316	34.655	64
0826 OOSTERHOUT	982	2.144	33		522	13.996	1.559	2.750	21.986	54.135	41
0632 WOERDEN	900	1.510	406		14.065	1.441	1.273	1.987	21.582	49.325	44
0797 HEUSDEN	527	1.679	29	2	192	15.083	1.822	1.961	21.295	42.995	50

[Source: VGZ]

Appendix II: Interviewees

Health insurer (Buyer)

VGZ

- Team manager generic care purchasing
- Purchaser dental care
- Advising dentist
- Advising dentist (also active in the Capacity organ)

CZ

- Purchaser dental care
- Advising dentist

Dental care provider (Seller)

Interviewed dental care providers

Interviewed dental care providers		
	Core	Non-core
Contract	1) Dental practice, Dordrecht (2 Dentists) 2) Dental chain, Venlo (Managing director/ dentist-implantologist)	5) Dental practice, Nunspeet (Manager) 6) Dental practice, Emmeloord (Dentist)
No contract	3) Dental practice, Eindhoven (Dentist) 4) Dental practice, Rotterdam (Manager)	*Not further examined*

Appendix III: Telephone script

Telephone script (in Dutch)

Belscript

Receptioniste neemt op
Ik:

Goedemiddag, u spreekt met Ingrid Hovens. Ik ben student aan de Technische Universiteit Eindhoven en bezig met een afstudeeronderzoek op het gebied van het inkopen van zorg. Ik richt me hierbij specifiek op het inkopen van mondzorg door een verzekeraar binnen de huidige situatie van vrije tarieven. Voor dit onderzoek zou ik graag een afspraak maken met enkele tandartsen algemeen-practici. Zou ik dhr./mevr. <naam tandarts> even aan de lijn mogen om hun medewerking te vragen.

A.
Receptioniste:

Dhr. / Mevr. < naam tandarts> is op dit moment bezet.

Ik:

Wanneer kan ik terug bellen?
Indien bellen geen optie is vragen of ik wellicht meer informatie kan mailen.
Zo ja, naar welk adres?

B.
Receptioniste:

Hier werken wij niet aan mee.

Ik:

Zou ik wel nog een email met nadere toelichting mogen sturen?
Zo ja, naar welk adres?

C.
Receptioniste:

Een moment, ik verbind u door.

Ik:

Dank u

C1. of een tandarts die zelf opneemt
Tandarts X:

Goedemiddag u spreek met <naam tandarts>.

Ik:

Goedemiddag, u spreekt met Ingrid Hovens. Ik ben student aan de Technische Universiteit Eindhoven en bezig met een afstudeeronderzoek op het gebied van het inkopen van zorg. Ik richt me hierbij specifiek op het inkopen van mondzorg door een verzekeraar binnen de huidige situatie van vrije tarieven. Voor dit onderzoek zou ik graag een afspraak maken met enkele tandartsen algemeen-practici om te praten over de relatie zorgverzekeraar-zorgaanbieder, zowel formeel als informeel, en hun ideeën voor verbetering te vernemen. U kunt hierbij denken aan de manier waarop de verzekeraar u benadert, maar ook over de inhoudelijke aspecten van contractering. Zou u mee willen werken aan dit onderzoek d.m.v. een interview? Dit interview zal ongeveer een uur duren en kan bij u op locatie.

(Indien ze vragen vanuit welke verzekeraar zeggen dat VGZ de ondersteunende partij is.)

C1A.

Tandarts X:

Hier heb ik geen interesse in / geen tijd voor.

Ik:

Dat is erg jammer, toch bedankt voor uw tijd.

C1B.

Tandarts X:

Zou je mij wat meer informatie kunnen toesturen en mij later kunnen terugbellen?

Ik:

Natuurlijk, waar kan ik de informatie naartoe sturen?

Ik zal u zometeen e.e.a. toesturen en over een paar dagen nogmaals contact met u opnemen.

C1C.

Tandarts X:

Ik weet niet of ik hier de tijd voor heb.

Ik:

Uw medewerking zou wel erg op prijs gesteld worden, we nemen namelijk graag ook uw ervaringen mee in wat er allemaal speelt rond het inkopen van mondzorg. Zo wordt het bewustzijn hiervan bij de zorgverzekeraar ook vergroot en kunnen zij wellicht beter aan uw wensen tegemoet komen in de toekomst. Om u reistijd te besparen kom ik graag langs. Mocht u dit niet zien zitten dan kunnen we ook de mogelijkheid tot een telefonisch interview bekijken.

C1D. of positieve reactie op C1C.

Tandarts X:

Hier wil ik best aan meewerken.

Ik:

Wanneer zou u gelegen komen?

Spreek een datum, tijd en locatie af. Vraag ook om een e-mailadres zodat je een bevestiging van de afspraak kunt sturen en indien gewenst wat meer achtergrondinformatie. Ook je gegevens bijvoegen in geval van verhindering.

Vraag ook even of men ermee akkoord gaat dat het interview wordt opgenomen. Dit is puur om het uitwerken te vereenvoudigen.

Afsluiting

Bedankt voor uw tijd.

Indien afspraak gemaakt:

Bedankt voor uw tijd. Ik zal u vandaag nog een afspraakbevestiging en wat meer informatie toesturen en dan zie ik u de <datum>.

Appendix IV: Leading interview questions dental care providers

Interview dental care providers (in Dutch)

Interview tandarts X

Er is veel geschreven over hoe men producten moet inkopen en de laatste jaren ook steeds meer over hoe men diensten moet inkopen. Over het inkopen van zorg is binnen de literatuur echter nog weinig bekend. De zorgsector is een zeer specifieke sector waarvan het de vraag is of de, in deze sector aangeboden, diensten vergeleken kunnen worden met diensten binnen andere sectoren. Gezien de hoge mate van menselijke interactie en het zorgsysteem lijkt de huidige inkoopliteratuur moeilijk direct toepasbaar op de situatie in deze sector. De trend de afgelopen jaren is wel om steeds meer marktwerking binnen deze sector te krijgen en hiermee komt het belang van inkoop van zorg sterk om de hoek kijken. Binnen de mondzorg is men net begonnen met het experiment vrije prijsvorming om deze marktwerking in gang te brengen en is daarom ook gekozen als de casus voor dit onderzoek, zeker met de wetenschap dat het contracteren van algemeen practici (onderdeel van het inkoopproces) nog niet veelvuldig gebeurt. Dit onderzoek, uitgevoerd vanuit de TU/e in samenwerking met VGZ, zal moeten bijdragen aan de kennis over het inkopen van zorg door een antwoord te schetsen op de onderstaande onderzoeksvraag:

Hoe kan de relatie tussen zorgverzekeraar en zorgaanbieder het beste worden vormgegeven en versterkt wanneer de zorgverzekeraar diensten inkoopt, met als doel het zekerstellen van kwaliteit, toegankelijkheid en betaalbaarheid van zorg?

Een tandarts algemeen-practicus is een zorgaanbieder die een professionele dienst aanbiedt aan zijn patiënten. Die patiënten zijn daarnaast ook verzekerd bij een zorgverzekeraar welke er naar streeft zijn verzekerden toegang te geven tot de zorg die zij nodig hebben. Om de betaalbaarheid, toegankelijkheid en kwaliteit van de zorg te waarborgen probeert zij daarom afspraken te maken met zorgaanbieders, degene die de uiteindelijk zorg leveren. Aangezien de verzekeraar niet in het proces van het daadwerkelijk leveren van de dienst betrokken is spreekt men over component services.

Algemeen

1. Welke risico's spelen er voor u in de huidige markt (specifiek in uw werkgebied (denk o.a. aan sociaal-ecomische status van uw klanten))?
2. Hoe kijkt u over het algemeen tegen de relatie met zorgverzekeraars aan?
3. Heeft u contracten met zorgverzekeraars afgesloten?

Gecontracteerd

4. Met welke zorgverzekeraar(s) heeft u afspraken gemaakt?
5. Hoe groot is het aandeel patiënten binnen uw praktijk van deze verzekeraar(s)?
6. Waarom heeft u ervoor gekozen een contract met deze verzekeraar aan te gaan?
   Neemt dit contract bepaalde risico's weg?
7. Hoe is uw (persoonlijke) relatie met deze verzekeraar?
   a. Hoe benaderen ze u en hoe ervaart u deze manier van benadering?
   b. In hoeverre kunt u onderhandelen met deze zorgverzekeraar?

8. Hoe staat u tegenover het contract dat u met de verzekeraar heeft gesloten?
    a. Welke zaken worden er binnen dit contract behandeld (type contract)?
    b. Over welke onderdelen / afspraken binnen het contract bent u (zeer) tevreden?
    c. Over welke onderdelen/afspraken bent u niet zo te spreken en wat voor een verandering zou u daar graag in zien?
    d. Wat zou voor u echt een onoverkomelijk bezwaar zijn binnen een contract (een reden om niet te tekenen) en bent u dit ook wel eens tegen gekomen bij andere verzekeraars?
9. Welke redenen kunt u nog meer aandragen waardoor u zou besluiten / heeft besloten geen contract met een bepaalde zorgverzekeraar aan te gaan? (te denken in termen van relatie, weinig verzekerden van deze zorgverzekeraar e.d.).

Niet gecontracteerd

10. Bent u wel benaderd door zorgverzekeraars en wellicht ook in onderhandeling geweest?
11. Waarom heeft u geen contract(en) afgesloten?
    a. Algemeen (bijvoorbeeld uw mening t.a.v. afspraken met zorgverzekeraars).
    b. Risico's (bijvoorbeeld weinig patiënten van deze verzekeraar, dus daar geen/klein debiteurenrisico).
    c. Relatie (verkeerde benadering).
    d. Contractspecifiek (afspraken waar u zich niet aan wil binden).

Algemeen:

12. Wat zijn uw ideeën over hoe de relatie tussen zorgverzekeraar en u verbeterd zou kunnen worden? *(welke benadering, mogelijkheden tot samenwerking e.d.?)*
13. Welke zaken vindt u dat er in een contract meegenomen zouden moeten worden?

(Ga hierbij in op kwaliteitsaspecten, volumesturing van verzekerden naar de praktijk, innovatiemogelijkheden, administratievoordelen, klanttevredenheidsonderzoeken enz.)

14. Hoe staat u tegenover het toevoegen van (outcome) kwaliteitsafspraken in het contract en in hoeverre denkt u dat dit mogelijk is?
    a. Bieden de uitkomsten van ZIZO voldoende inzicht in de kwaliteit van uw praktijk voor uw patiënten?

Afsluitende discussie:

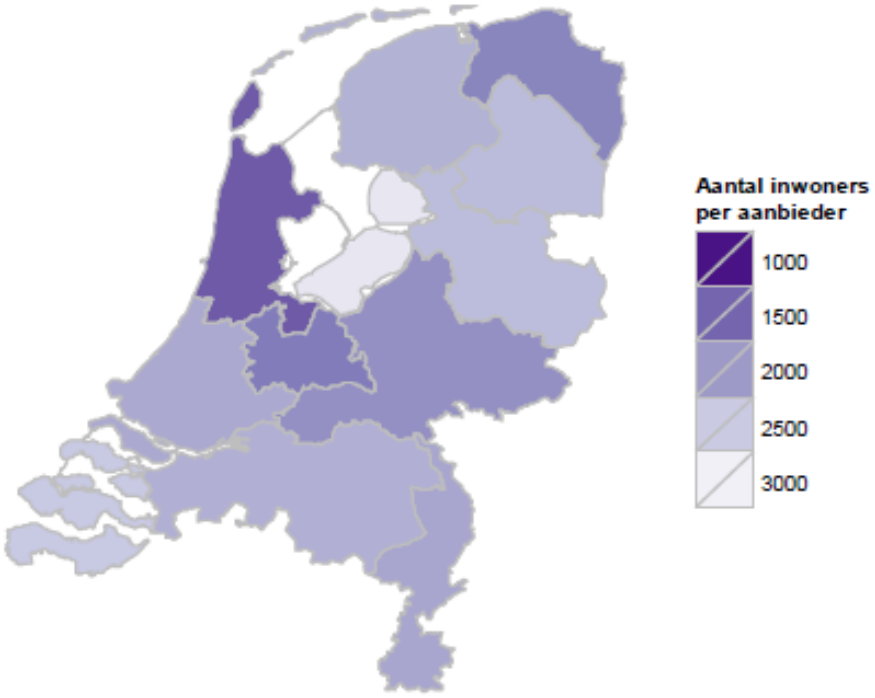
Hoe kijkt u tegen het experiment aan en welke verwachtingen heeft u voor de toekomst (uw rol en die van de zorgverzekeraar)?

Appendix V: Explanation of codes

Code	Explanation
Contract	
Administrative	*The effect a contract has on the administrative work*
Direct invoicing	The possibility for the dentist to send the invoice directly to the health insurer, which then pays the invoice.
Default risk	The health insurer taking care of receiving the payment from the patient for the part of the invoice that is not insured (VGZ takes over this risk indefinitely).
Payment	The part of the invoice that the health insurer is immediately paying to the dental care provider (for VGZ this is 100%).
Requirements	*Feelings about including certain requirements in the contract*
Volume (patient) control	The requirement that a dental practice takes on new patients from the contracted health insurer.
Quality measurement	The requirement that the health insurer can set certain quality specifications and is measuring these.
Prices	The requirement to set fixed prices for certain treatments.
Controls	The requirement that the health insurer is allowed to control the treatments executed.
Technical costs	The requirement to set fixed prices for technical costs.
Website	The requirement that a dental practice should have her own website.
Patient database	*The effect of the composition of a practice's patient database.*
Patients	Signing a contract to allow acting in the interest of the patients.
Patient % per insurer	Well represented health insurers (in terms of a high percentage of patients in a dental practice insured with such a health insurer) are making contracting more interesting.
Relational	
Negotiation	The possibility to negotiate on the contract terms set by the insurer.
Approach	*The way in which the health insurer approaches the care provider.*
Mailing	A health insurer communicating with the care provider via (standard) mailings or via e-mail to provide the necessary information.
Telephone	A health insurer communicating directly by phone.
Personal contact	A health insurer communication in a very personal way (face-to-face).
Meetings	The organization of meetings between insurer and care provider.
Trust	The trustworthiness of the health insurer as seen by the care provider.
Contacting health insurer	*The possibility to contact and get information from the health insurer.*
Contact (person)	The possibility to get in touch with the desired person.
Accessibility	The ease in which the health insurer (specific person) can be reached.
Knowledge	The extent to which the health insurer (specific person) has the knowledge to help/answer the questions of the care provider.
Publicity	The perception on the use of publicity to communicate the developments or performances of the care providers.

Appendix VI: Dentist density in the Netherlands

Number of residents per dentist in 2011



[Source: NZa Marktscan Mondzorg-juni 2012]

Number of residents per dentist in 2011

Regio	2006	2008	2011
Groningen	1.772	1.722	1.776
Friesland	2.433	2.356	2.232
Drenthe	2.633	2.542	2.329
Overijssel	2.486	2.511	2.339
Flevoland	2.942	2.936	2.861
Gelderland	1.916	1.932	1.888
Utrecht	1.693	1.662	1.683
Noord-Holland	1.419	1.407	1.408
Zuid-Holland	2.361	2.246	2.149
Zeeland	2.640	2.409	2.477
Noord-Brabant	2.455	2.292	2.215
Limburg	2.368	2.284	2.114
Nederland	**2.046**	**1.991**	**1.940**

[Source: NZa Marktscan Mondzorg-juni 2012]

Appendix VII: Contracted dentists VGZ

Overview of contracted dentist (end of March 2012)

[Source: BCG commissioned by VGZ]

Appendix VIII: Workshop design

Design workshop session (in Dutch)

Brainstorm bijeenkomst

Situatie
Algemene onderzoeksvraag:
Hoe kan de relatie tussen zorgverzekeraar en zorgaanbieder het beste worden vormgegeven en versterkt wanneer de zorgverzekeraar professionele component services inkoopt, met als doel het zekerstellen van kwaliteit, toegankelijkheid en betaalbaarheid van zorg?

VGZ is daarbij geïnteresseerd in hoe zij de relatie met de mondzorgaanbieders kan verbeteren. Er is hierbij gekozen voor het bekijken van de relatie met de tandarts algemeen-practicus. Daarbij rekening houdende met de nieuwe situatie van vrije tarieven in deze sector.

Om tot betere inzichten te komen zijn er interviews gehouden met verschillende tandartsen/ praktijkmanagers verspreid over het land. De insteek van deze interviews was vooral gericht op het contract(eren); om te achterhalen welke incentives er zijn om te contracteren en welke zaken het onaantrekkelijk maken om te contracteren. Uit deze interviews kwam echter ook naar voren dat er met name op relationeel gebied nog veel te winnen valt, dit gaat van benaderingswijzen, tot onderhandelen, tot het terugkoppelen van informatie. Om dieper te kunnen ingaan op deze aspecten en te bekijken wat eventuele mogelijkheden zijn om een relatie op te bouwen danwel te versterken wordt deze bijeenkomst georganiseerd.

Locatie
Vergaderruimte VGZ
Kennedyplein 300, 5611 ZV Eindhoven

Participants of the brainstorm meeting
Facilitator (researcher)
Purchaser dental care (VGZ)
Advising dentist (VGZ)
Managing-director (consortium of dental practices in Limburg)
Dentist (solo practice in Eindhoven)

Benodigde materialen
Flip-over/whiteboard
Markers
Beamer
Laptop
Post-its
Pennen

Actieplan

Introductie (25 min)

* Korte introductie van de deelnemers (5 min)
* Uiteenzetting stappenplan + tijdsschema bijeenkomst (5 min)
* Inleidende presentatie: introductie onderzoek en enkele bevindingen (inclusief korte behandeling inkoopproces) (15 min)

Brainstorm sessie (20 min)

Iedere deelnemer wordt gevraagd individueel enkele ideeën te noteren welke volgens hem/haar de relatie van VGZ met de tandarts ten goede zouden komen. Minimaal 2 ideeën voor ieder van de drie basisgebieden (deze zullen reeds kort behandeld zijn in de inleidende presentatie) die worden aangereikt, te weten:

- ✓ Benaderingswijze
- ✓ Onderhandelingen
- ✓ Informatievoorziening/feedback

Ideeën die niet onder deze noemers te plaatsen zijn, maar welke wel op relationeel gebied een toevoeging zouden kunnen vormen mogen ook genoteerd worden. (10 min)

De ideeën zullen vervolgens worden verzameld en geclusterd op het whiteboard komen te hangen (eventueel volgt een korte toelichting). Het kan daarbij zijn dat er binnen een basisgebied aparte clusters ontstaan. Ideeën die niet binnen een van de 3 eerder genoemde gebieden vallen worden apart geclusterd. Alle clusters worden vervolgens benoemd. (10 min)

Prioritering (10 min)

Iedere deelnemer wordt gevraagd 10 punten te verdelen over de clusters (maximaal 6 punten per cluster) om hiermee aan te geven welke aspecten zij het belangrijkst vinden (iedere deelnemer doet dit rechtstreeks op het whiteboard). Iedereen mag vervolgens voor het hoogst gewaardeerde aspect even kort toelichten waarom zij dit vinden. Vervolgens worden de punten opgeteld en worden de 3 belangrijkste clusters benoemd. Er wordt gekeken of iedereen het hiermee eens is.

Koffiepauze (10 min)

Discussies (50 min)

Ieder van de 3 clusters die uit de prioritering naar voren komen zullen apart worden behandeld. Hierbij kunnen de tandartsen hun wensen uitgebreid kenbaar maken en kan er tevens over de haalbaarheid van de ideeën worden gediscussieerd en/of welke zaken dit met zich mee zal moeten brengen. Kernwoorden worden genoteerd op flip-over. Ter afsluiting van elke discussie zal de facilitator beknopt een samenvatting/uitkomst geven (max. 2 minuten).

* Discussie cluster 1 (15 min)
    - Afsluiting
* Discussie cluster 2 (15 min)
    - Afsluiting
* Discussie cluster 3 (15 min)
    - Afsluiting

Afsluiting (10 min)

Korte samenvatting van de belangrijkste bevindingen van de bijeenkomst. Deelnemers bedanken voor deelname. Kort aan deelnemer (m.n. tandartsen) vragen hoe ze de bijeenkomst ervaren hebben.

Appendix IX: Performance indicators in the dental care sector

A first set of performance indicators for the dental care sector (possibly going to be implemented in 2013)

De vijf voorlopige outcome indicatoren VGZ:

1. Indicator: % van de patiënten onder de 18 jaar waarbij binnen de meetperiode een periodieke controle is uitgevoerd. C11, C12 , A111:

   Stand van zaken: De registratie voldoet, de validiteit voldoet bijna, de indicator heeft prioriteit.
   Ontwikkeltraject: Definitie en registratie in het systeem van de actieve patiënt

2. Indicator: % van de patiënten onder de 18 jaar (dat in de meetperiode een consult heeft gehad) waarbij een fluoride-applicatie is toegepast.

   Stand van zaken: De registratie voldoet, de validiteit voldoet bijna, de indicator heeft prioriteit.
   Ontwikkeltraject: norm voor onder- en overbehandeling

3. Indicator: % van de patiënten onder de 18 jaar(dat in de meetperiode een consult heeft gehad) waarbij is gesealed.

   Stand van zaken: De registratie voldoet, de validiteit voldoet bijna, de indicator heeft prioriteit.
   Ontwikkeltraject: norm voor onder- en overbehandeling

4. Indicator: Gemiddeld aantal bitewing röntgenfoto's onder de 18 jaar (dat in de meetperiode een consult heeft gehad)

   Stand van zaken: De registratie voldoet, de validiteit voldoet, de indicator heeft prioriteit.
   Ontwikkeltraject: outcome ipv proces indicator. norm voor onder- en overbehandeling

5. Indicator: PROMS.

   Stand van zaken: De registratie voldoet niet, de validiteit voldoet niet, de indicator heeft prioriteit.
   Ontwikkeltraject: PROMS die voldoen als Patient Related Outcome Measurement. Zie voorbeeldoutcome vragen in de Patientenvragenlijsten tandartsen (bijlage)

[Source: VGZ]