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

Tessa S. van Dijk[1] | **Martijn Felder**[1] | **Richard T. J. M. Janssen**[1,2] | **Wilma K. van der Scheer**[1,3]

[1]Erasmus School of Health Policy & Management, Erasmus University Rotterdam, Rotterdam, The Netherlands

[2]Tilburg School of Social and Behavioral Sciences, Tilburg University, Tilburg, The Netherlands

[3]Erasmus Centre for Healthcare Management, Erasmus University Rotterdam, Rotterdam, The Netherlands

Correspondence
Tessa S. van Dijk, Erasmus School of Health Policy & Management, Erasmus University Rotterdam, Bayle Building, Burgemeester Oudlaan 50, Rotterdam 3062 PA, The Netherlands.
Email: vandijk@eshpm.eur.nl

Abstract

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

of financialisation processes on the practices of healthcare organisations in financial distress.

KEYWORDS
financial distress, financialisation, healthcare organisations, qualitative case study, translation theory

INTRODUCTION

Healthcare organisations in financial distress[1] are in a contentious and uncertain situation that may lead to restructuring, acquisition, closure or bankruptcy and initiate a lengthy period of turmoil and stress for those directly affected: patients, local communities, nursing staff, medical staff, managers, other employees, executives, suppliers and investors (Dent, 2003; Pescosolido et al., 1999; Stewart, 2019). These stakeholders see their continuity of care, employment and/or income endangered (Holmes et al., 2006; Pescosolido et al., 1999). Moreover, because healthcare organisations are embedded in local communities and bear societal meaning (Kirouac-Fram, 2010; Moon & Brown, 2001; Stewart, 2019), financial distress affects these communities and draws media attention, public outrage and political involvement (Brown, 2003; Thomson et al., 2008).

Researchers have looked closely at the experiences of patients, medical staff, managers and local communities undergoing processes of financial distress. These actors often try to protect the future of endangered healthcare organisations but are not mandated to take part in negotiations and have little formal influence (Brown, 2003; Haas et al., 2001; Kirouac-Fram, 2010). What earlier studies lack is empirical evidence concerning the crucial roles, interests, interactions and practices of actors involved in decision-making in periods of financial distress, such as financial stakeholders, healthcare providers or governments. This is not surprising, as decision-making typically occurs behind closed doors and in the background of media-covered public outrage.

We had a unique opportunity to analyse two Dutch healthcare organisations in financial distress and focus on the dynamics between healthcare executives and their most important financial stakeholders. In The Netherlands, these are banks (for long- and short-term financing) and health insurers (the main purchasers of care and responsible for guaranteeing access for patients). The increased dependency of a healthcare organisations' survival on financial parties and the growing influence of banks and health insurers on how care is organised and where it takes place, is a process that especially took off after the introduction of managed competition in Dutch health care and the financial crisis (Van Dijk et al., 2023). This process, often described as 'financialisation' (Engelen, 2008; Van der Zwan, 2014), is not bound to The Netherlands, but also takes place in other countries and leads to the adoption of financial language, instruments and structures in health care. This often results in the preference for decisions and policies that lower costs and quantifiable risks over other values in health care. In the end, it not only influences the allocation and organisation of care but also the daily practices of those working in the healthcare sector (Cordilha, 2021; Horton, 2022; Vural, 2017).

In this article, we provide insights into the underlying practices of financial stakeholders in health care, how they relate to the sector and try to influence other healthcare parties and how and where care services are delivered. We examined the roles, interdependencies, interactions and strategies of banks, health insurers and executives to better understand why healthcare

organisations did or did not survive times of financial distress. We asked the following research question: *How do healthcare executives, banks and health insurers negotiate the future of healthcare organisations in times of financial distress?*

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

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

FINANCIAL DISTRESS AND BANKRUPTCIES IN A FINANCIALISED HEALTHCARE SYSTEM

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

Financialisation refers to the 'increasing dominance of financial actors, markets, practices, measurements and narratives, resulting in a structural transformation of economies, firms, States and households' (Aalbers, 2019). Meaning that the logic previously belonging to financial specialists becomes ingrained in healthcare practices and an important driver for decision-making (Engelen et al., 2014). By adopting financial instruments, language, techniques, goals and structures, financialisations has caused an institutional shift towards a financial regime in health care. This new regime requires its own financial expertise, working culture, new infrastructures and job positions. Financialisation has introduced concepts such as financial risks by adopting forms of debt financing and led to a new perspective on healthcare services as financial products (Appelbaum & Batt, 2021; Benoît, 2023; Cordilha, 2021; Hunter & Murray, 2019; Mosciaro

et al., 2022; Vural, 2017). Processes of financialisation are observed in many different countries, with different health systems ranging from public to private and everything in between.

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

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

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

ACTOR DYNAMICS IN TRANSLATION THEORY

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

Translation theory encompasses all negotiations, efforts and acts of persuasion that actors employ to forge a network with others to accomplish a certain goal. It follows the development of these new relationships and how certain actors seek to move others. This approach particularly helps to draw attention to the strategic and emotional (dis)positions and (inter)actions of actors under political, societal and temporal pressure (Callon, 1986). It provides a deeper understanding of the interactions between actors, with networks as places where negotiation and persuasion takes place and

decision-making is an intricate process. In other words, being embedded in a broader constructivist epistemology, translation theory offers an interpretive lens through which to make sense of the iterative and formative process that unfolds when healthcare organisations face financial distress.

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

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

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

METHODS

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

Case selection

To select cases, and since healthcare organisations in financial distress are largely unpublicised, we searched for news articles that reported on or hinted at financial instability among

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

Data collection

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

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

Data analysis

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

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

RESULTS

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

Case descriptions

To understand our cases, it is important to take note of policy changes in the Dutch context that promoted financialisation processes and affected healthcare organisations in financial distress and their relation vis-à-vis financial parties. Until 2006, healthcare organisations were regulated by government, which also decided on bailouts or closures. Regulated competition was introduced in that year and healthcare organisations became responsible for their own business operations. Government withdrew guarantees for building expenses, interests and repayments (Van de Zwart et al., 2010) and dissolved regulatory agencies that decided on infrastructure, such as the Board for Healthcare Institutions (*College Bouw Zorginstellingen*, CBZ).[2] Banks remained the principal capital providers, offering long-term loans for the construction, renovation and maintenance of property and short-term loans for monthly payments such as salaries and supplies. Health insurers became the principal purchasers of care, negotiating annually with healthcare organisations over price, quantity and (increasingly) quality of healthcare services. They were named national orchestrators of care and instructed to reduce overall healthcare costs (Kamerstukken II, 2003-2004; Noort et al., 2021), in line with subsequent administrative agreements.[3]

Despite government's apparent withdrawal after the introduction of market mechanisms, it still coordinates some tasks and responsibilities of healthcare organisations and health insurers through laws and regulations. The most prominent example is the 'duty of care' imposed on health insurers making them legally responsible for ensuring access to continued, timely and high-quality care for their insured. Consequently, when a healthcare organisation in financial distress is facing bankruptcy and there is no other healthcare organisation in the region that can reasonably deliver timely care to health insurers' clients there, then the health insurers are obliged to help that organisation stay afloat (NZa, 2020).

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

Hillside Mental Health

Hillside Mental Health's financial problems began back in 1996 and 1999, when the mental healthcare organisation obtained land at a high-end location and its board announced plans to transform the original building. These plans were rejected by the CBZ. New plans were delayed for many years because local residents objected to having a mental healthcare organisation in their neighbourhood and the municipal government was divided. In the meantime, the organisation agreed to rent an alternative location and signed a 10-year lease in 2009. 2010 was a turbulent year for the organisation. Its work council objected to a proposed merger and won legal proceedings. The executive resigned and was replaced by an interim executive. Construction of the new care facility began; 11 years after the initial land purchase. Three years later, the organisation

moved into the brand-new building under the supervision of yet another new executive. In 2011, however, the Ministry of Health and field parties had agreed to deinstitutionalise mental health care, leading to a reduction in 'beds' in favour of ambulatory health services (Ministry of Health, Welfare and Sport, 2012). This was problematic for the organisation, because their contract with the bank was based on a different business case. The new building was now too big and the organisation's income no longer covered expenses. As a result, it entered a state of financial distress.

General West Hospital

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

Problematisation: Making financial distress visible

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

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

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

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

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

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

Interessement & enrolment: Involving banks

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

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

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

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

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

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

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

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

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

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

> I was naïve to think that we could solve it together with Goldleaf Bank and Securago. We were all facing the same problem and I imagined that we could talk it through.

> Well, I was wrong. I remember one of the first conversations I had with the special account unit, I told them, "We need to come out on the other end together". They replied: "Mister Hackett, there is no 'together' here, this is your problem".
>
> (Owen Hackett, healthcare executive of Hillside Mental Health)

Interessement & enrolment: Involving health insurers

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

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

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

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

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

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

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

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

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

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

Mobilisation: Successful and unsuccessful network stabilisation

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

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

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

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

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

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

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

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

This incident reveals just how committed James Abbot, Robert Edwards, Rowan Murphy, Sarah Meyers and George Wilford were to saving General West Hospital from a bankruptcy. They closed ranks to stand up to the medical specialists. It also showcases how George could take back some control in an uncertain situation by mobilising his counterparts at the bank and health

insurer to exert pressure on resistance from within the organisation. Mutual trust grew and the network stabilised. Clear communication, close collaboration around the improvement plan, and the execution of a multi-annual contract with Agora Insurance had united the parties in a shared purpose.

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

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

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

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

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

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

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

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

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

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

As we saw in both cases, the executives tried to stabilise the network in the mobilisation phase (Callon, 1986) and execute plans to save the healthcare organisation, with or without the help of the banks and health insurers. The commitment of financial parties was important for a good ending, although executives still had some agency left (Mosciaro et al., 2022). Executives had to deal with networks being tested and there was the constant threat of different actors becoming alienated. Eventually, this resulted in a stable network for General West Hospital, in which actors trusted one another, and in a destabilised network for Hillside Mental Health, governed by distrust (see Figures 1 and 2 for an overview of events).

DISCUSSION & CONCLUSION

This study sheds light on the crucial role that financial parties play in decision-making processes surrounding healthcare organisations in periods of financial distress. Through the financialisation of health care, banks and health insurers have grown in prominence and importance;

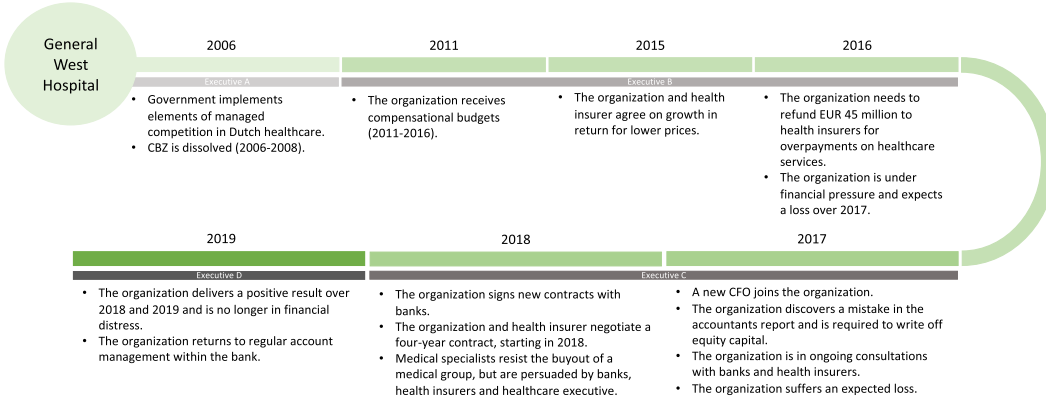

FIGURE 1 Timeline for general west hospital.

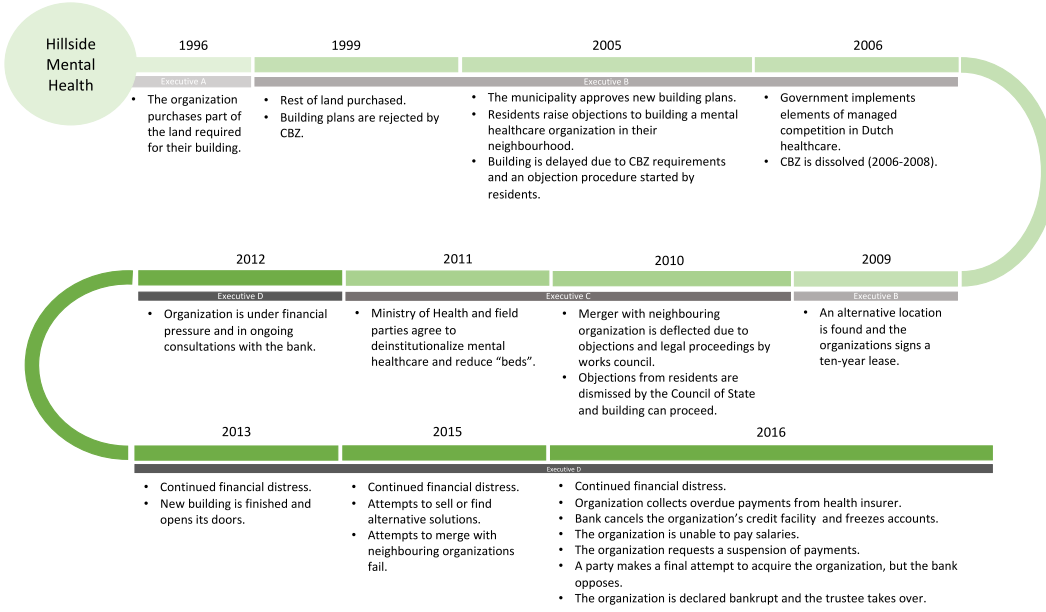

FIGURE 2 Timeline for hillside mental health.

healthcare organisations depend on them for their existence and by extension, banks and health insurers are able to determine where care is delivered, how care is organised and who can receive it. Especially when healthcare organisations face financial distress, financial parties operate from a position of strength and have influence reaching far into the organisation. Banks and health insurers follow their own logic and, in the process, reframe the financial problems as one of 'restructuring/recovery' or as a 'duty of care' problem.

Though the influence of financial parties in times of financial distress is far-reaching and legal obligations ("duty of care") had a major impact on the strategy of stakeholders, they were not all-important. They did not lead to a pre-determined outcome but did give the organisation a more or less favourable starting position. We have shown how executives and other parties still have possibilities to affect the process. For example, executives made financial distress visible, framed the problem strategically and endeavoured to shape banks and health insurers into

partners by aligning interests. For healthcare executives, it was important to understand the banks' and health insurers' motivation and be able to tap into their interests. The success of the networks also depended on whether banks and health insurers perceived enough transparency from executives, how executives dealt with tests and threats of alienation and with trust in the plan (and persons involved) either growing or deteriorating. The cases show that if trust falters, and actors are alienated from one another, the network destabilises; if trust is confirmed, however, the commitment of actors grows, the relationship eases and the network stabilises.

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

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

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

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

stukken II, 2018-2019b). Government also implemented an early-warning system to better control threats of financial discontinuity (Ministry of Health, Welfare and Sport, 2020) and so resumed increasingly more responsibility for healthcare organisations in financial distress, with communal and reputational values outweighing the current arrangements under regulated competition.

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

Limitations and future research

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

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

AUTHOR CONTRIBUTIONS

Tessa S. van Dijk: Conceptualization (lead); methodology (lead); investigation (lead); formal analysis (lead); data curation (lead); writing – original draft (lead); writing – review & editing (lead); visualization (lead). **Martijn Felder**: Conceptualization (lead); investigation (supporting); formal analysis (supporting); writing – review & editing (supporting). **Richard T. J. M. Janssen**: Conceptualization (supporting); methodology (supporting); formal analysis (supporting); writing – review & editing (supporting). **Wilma K. van der Scheer**: Conceptualization (supporting); methodology (supporting); formal analysis (supporting); writing – review & editing (supporting).

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CONFLICT OF INTEREST STATEMENT

The authors report no potential conflicts of interest.

DATA AVAILABILITY STATEMENT

The interview data generated and/or analysed during this study are not shared as individual privacy could be compromised. All other data is available in the public domain.

ETHICS STATEMENT

Ethics approval was obtained from the Research Ethics Review Committee of the Erasmus School of Health Policy & Management (20–31 Van Dijk). Written and/or oral informed consent was obtained from the respondents at the start of the interview. The authors have reduced the risk of disclosing commercially sensitive information by omitting or generalising certain details.

PATIENT CONSENT STATEMENT

Not applicable.

ORCID

Tessa S. van Dijk https://orcid.org/0000-0003-3338-2570
Martijn Felder https://orcid.org/0000-0003-4906-9933
Richard T. J. M. Janssen https://orcid.org/0000-0003-1032-7501
Wilma K. van der Scheer https://orcid.org/0000-0002-7910-5838

ENDNOTES

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

[2] CBZ was an independent regulatory agency responsible for the infrastructure of healthcare organisations and for regulating the construction and acquisition of healthcare properties. The agency was dissolved between 2006 and 2008.

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

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

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