tema study association

Healthcare Purchasing

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/ **MSc. SCM Elective**

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WEEK 1: Intro

De Bakker et al. (2012)

In the Netherlands numerous initiatives to improve quality of care for chronically ill patients have been introduced. In 2010 a bundled payment approach has been introduced for several chronical illnesses. Before, the fragmentary funding of these initiatives hampered the establishment of nationwide, sustainable programs. In this bundled payment model, health insurers pay a single fee to a principal contracting entity (care group) to cover all elements of primary care for patients with a specific chronic disease. Care groups consist of multiple health care providers and are often owned by general practitioners.

Two weaknesses in the Dutch healthcare system in general has led to the introduction of this new system of payment:

1. Primary care has been provided mainly in small physician practices that lack the capacity to deliver a spectrum of needed care to the chronically ill. There are no formal collaboration with practitioners of other primary care disciplines such as physiotherapists or pharmacists. This makes it difficult to coordinate the care of patients with chronic diseases.
2. 2. The second weakness concerns the strict division between primary and specialty care. Chronically ill need both generalist and specialist care on an ongoing basis, the division obstructs the delivery of integrated care. Financing primary and specialist care separately hinders collaboration.

The bundled payment model makes it possible for different elements of care for specific chronic diseases to be purchased, delivered, and billed as a single product of service. Here, health insurers pay a single fee to a principle entity, the care group, which serves as the general contractor and is responsible for organizing care and ensuring its delivery. Care group refers to the principal contracting organization involved in a bundled payment contract with an insurer, not the the healthcare providers who actually deliver the care. The services to be included in generic care bundles have been described in disease-specific health care standards. In attempt to encourage competition among providers, the standards do not specify the discipline of the provider who delivers the care.

The implementation of the bundled payment system has led to better collaboration, better process quality, and more transparency. Negative consequences were the dominance of the care groups by general practitioners, large price variations that were only partially explained by differences in the provision of care, and an administrative burden.

Results:

- Patient organizations – stress the importance of promoting patients' self-management and the development of individual care plans.
- Insurers – aim for better integrated care. However, insurers see the bundled payment as a kind of 'black box' because they pay a fixed price per patient without begin informed at the patient level about what consultations take place. Another concern is that it is unclear which services the insurer is paying for. Worries about double funding also plays are role, it is difficult for insurers to check whether the treatment of diabetes patients with other chronic conditions is paid for twice. Also there is fear of 'cherry picking' patients whose conditions are relatively stable and simple, leaving the expensive cases to be paid for in the traditional way.
- Care groups – reported improved collaboration within primary care and between primary care providers and specialists.
- Subcontracted providers – the implementation of the bundled payment system improved the coordination of care. Also their record keeping improved as a result of the formalized working arrangements between care groups and individual providers.

Concluding, the new system of bundled payment led to important changes. First, they forced disciplines within primary care to collaborate routinely, whereas in the past such collaboration was more ad-hoc and voluntary. Second, the introduction of regulated competition meant that negotiations with insurers on price and quality took place at the regional level, whereas in the past they had taken place at the national level among organizations of providers and insurers, working within regulatory constraints imposed by the government.

Bonfrer et al. (2018)

Previous studies have found that pay for performance programs have had limited impact on process measures and no impact on patient outcomes.

- Pay for performance programs provide financial incentives to improve quality.

However, no study has examined whether early adopters of pay for performance programs outperformed late adopters of pay for performance programs.

- Advocates argue that it takes time for hospitals to make meaningful improvements and that we need patience to better understand how delivery of care under pay for performance programs changes care. Improving outcomes is difficult; it can require changes to workflows, restructuring the way providers are paid, and alignment of information technology systems.

The study of Bonfrer found that clinical process scores, or 30 day mortality for Medicare beneficiaries, were not found to be better at hospitals that have been operating under pay for performance programs for more than a decade. So, pay for performance programs as currently implemented are unlikely to be successful in the future, even if their timeframes are extended.

- It might have been the case that the definition and communication of specific, measurable processes to provide good quality care as part of the highly visible HQID (Hospital Quality Incentive Demonstration) resulted in non-participating hospitals also improving their processes, because of a more intrinsic motivation to provide good quality care.
- Also the inevitable interaction between early and late adopters might have further led to spillover effects by healthcare personnel teaching each other about standards and approaches to improve quality.

The limited effects might by explained by different factors, first the incentives are very small. Second, the program was extremely complex, making it more difficult for hospitals to engage meaningfully in the program (program should focus only on a few measures that matter most to patients). Third, waiting for the end of the year to receive bonuses or penalties might have reduced the impact.

WEEK 2:

Klasa et al. (2018)

Purchasing is the process of allocating pooled funds to healthcare providers, whether within a NHS system with a purchaser-provider split (i.e. England), through contracts with insurance funds as in social insurance (i.e. Germany), and in more market-based systems (i.e. Netherlands). Contracting is a process that specifies what is purchased. Strategic purchasing goes beyond mere purchasing, contracting on price and quantity, or reimbursement of providers.

A synthesized definition of strategic purchasing given in the article is: 'Strategic purchasing is an evidence-based process that sculpts health care systems by prioritizing the financing of certain goods and services over others through collaborative planning across various healthcare stakeholders while incorporating the needs and priorities of citizens in the distribution of health care and promoting equity, quality of care, efficiency, and responsiveness in the provision of health services'.

- Purchasing approaches attempt to answer the four fundamental questions of what interventions to buy, from whom to buy them, how to buy them and how much to pay for them.

Strategic purchasing is different from purchasing since it adds also equity and quality to the basic definition of purchasing.

Comparing elements of strategic purchasing across ten european countries has led to five salient elements of strategic purchasing (know them all!):

1. Addressing population health;
2. Ensuring citizen and patient empowerment within the health system;
3. Strenghthening governance through efficient stewardship and adequate capacity to ensure accountability;
4. Development of effective purchaser and provider organizations;
5. Incorporation of cost-effective contracts in healthcare purchasing.

1. Population Health

A strong public health infrastructure, availability of meaningful population-level data and information and the analytic capacity to use them in forecasting future needs are important elements in identifying population health needs and incorporating them into strategic purchasing decisions. However, all researched countries find it difficult to gather and interpret adequate population health data and to translate it into strategic purchasing decisions. Furthermore, not all countries conducted formal health needs assessments, but if countries do, there are also problems with translating data into purchasing decisions. Often purchasers buy what they bought last year with small modifications to price and quantity.

2. Citizen Empowerment

Purchasers and governments should ensure that citizens' and patients' views and values are asserted, purchaser accountability is enforced, and/or citizen choice is increased. Citizens should actively participate in determining the benefits package, have formal representation on purchasing boards, and have access to healthcare services and medical records.

3. Strengthening Governance

Strong governmental stewardship and the capacity to monitor and audit stakeholders are key components of a country's respective strategic purchasing system. Regulation and monitoring of purchasers and providers to ensure that they are meeting health objectives (i.e. quality, efficiency, equity, cost-containment) is difficult to enact in practice. Many health systems have regulatory policies in place to ensure purchaser accountability, but implementation is often poor or not functional, stemming from poor managerial skills and low government buy-in.

- Most countries still struggle with a highly fragmented health care system. Competition reguires fragmentation rather than collaboration in many cases. Asking providers to integrate operations and sharing vital business operation information and data with each other is difficult.

4. Developing effective purchaser and provider organizations Strategic purchasing places demands on the competence of purchasers and providers and creates new accountability challenges. Therefore, effective and accountable purchasers and providers are integral to all the definitions and frameworks of strategic purchasing.

- Purchaser and provider effectiveness is based upon their organizational structure, level of autonomy, level of transparency, and their accountability to various stakeholders.
- Purchaser Organizations – The type of organization that defines itself as a purchaser of health services varies among countries. Purchaser organizations are public, private, or a combination of public and private.

Purchaser organization have various degrees of power and autonomy in determining criteria and conditions for the purchasing framework in any given country.
- Provider Organizations – Lack of autonomy among provider organizations stifled their ability to respond to changing policy landscapes, contracting criteria and payment mechanisms. Increasing competition seems logically to call for them to have greater agility if they are to survive and the system to reap the benefits of competition.

Accountability is a national priority across all included countries, notably the need for greater transparency. Increased transparency must accompany increased provider autonomy to ensure the development of proper accountability across organizations. The article defines five sub-components:

- Financial accountability – ensures the appropriate use of funds. All countries have mechanisms in place, some stronger and others weaker, to ensure that money is equitably allocated to providers (e.g. hospitals) and in turn used ethically.
- Professional accountability – delivery of service according to ethical and professional standards. Contracts help ensure that appropriate human resources are available across all regions, ideally to meet population health needs.
- Political accountability – the accountability of the entire system to voters – among providers needs to better represent public interests and respond to population health needs while also meeting performance targets and quality outcomes.
- Public accountability – mechanisms to link health system organizations directly to voters and patients. Occurs by providing information on performance indicators, prices, and quality data on purchaser or provider organizations which can increase their accountability to the public, allowing citizens to make more informed choices.

5. Incorporating cost-effective contracting

Contracting is the core mechanism through which a purchasing transaction occurs between purchasers and providers. A lack of proper policy and appropriate contracting criteria can lead to opportunistic provider behavior that is misaligned with national health priorities. Ideally, a contract's terms and criteria are based upon evidence based measures, but currently such attempts are difficult to implement because of a lack of available research, data, and national evidence-based guidelines.

- Volume and prices are the most often used tools to assist purchasers in establishing contracts, with some countries incorporating conditions that promote quality of care among providers or experimenting with mechanisms that measure efficiency.

The push to provide patients with a choice in provider weakens the influence that purchasers have in steering patients to providers of better quality (and lower costs). The growth of patient empowerment and its importance in a strategic purchasing framework presents an irreconcilable contradiction. Despite its role in governance through participation, citizen empowerment and patient choice may conflict with the goals that strategic purchasing is aiming to achieve, namely efficiency, cost-savings, and optimal levels of purchaser and provider autonomy.

Olsen & Ellram (1997)

The literature on buyer-supplier relationships tends to focus on a single relationship or a single type of relationship, ignoring or downplaying the important interdepencies between relationships and the important task of allocating scarce resources between relationships.

- Portfolio models have primarily been used in strategic decision making to support resource allocation decisions among strategic business units. In general, portfolio models concentrate on categorizing a product, a customer, or a supplier relationship. They do not depict the interdependencies between two or more items.
- Portfolio models have been most widely used in strategic planning. Although the use of portfolio models in strategic planning has been criticized, portfolio models can be an useful tool.

A portfolio model with the strategic importance of the purchase and the difficulty in managing the purchase situation as the key classification dimensions is suggested. Strategic importance can include the following factors:

1. Competence factors – describe the extent to which the item purchased is a part of the company's core competence. An evaluation of the competence factors also includes whether the purchase can improve the knowledge or the technological strength of the buying firm.

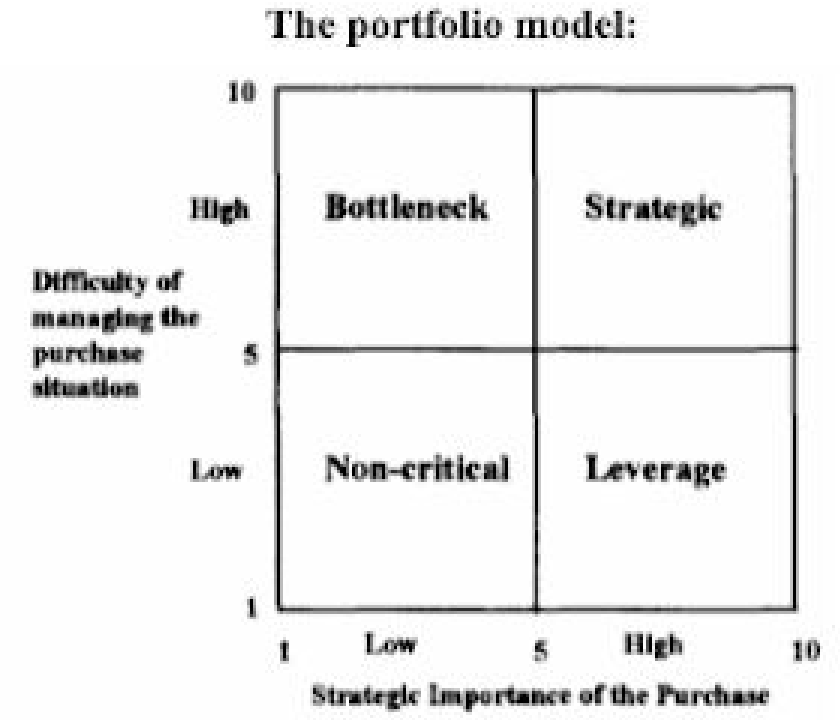
2. Economic factors – describe the economic importance of the purchase in terms of the dollar value and the impact on the company's profits. Also includes an evaluation of the extent to which the items purchased are critical to get leverage with the suppliers of other buys.

3. Image factors – importance of the purchase to the company's image among customers and suppliers.

Factors describing the difficulty of managing the purchase situation:

1. Product characteristics (novelty, complexity)
2. Supply market characteristics (suppliers' power and technical/commercial competence)
3. Environmental characteristics (risk, uncertainty)

The portfolio model:



Leverage Category: includes purchases that are easy to manage but strategically important to the company.When managing these purchases, it is important to identify particular value added of the purchase and leverage volume across product lines and suppliers to lower the material cost. The goal is to create mutual respect in the supplier relationship and communicate requirements further into the future.

Noncritical Category: includes purchases that are easy to manage and with a low strategic importance. Keywords are standardization and consolidation. The company should reduce the number of suppliers and the number of duplicate products/services. Focus to reduce administrative costs.

Strategic Category: encompasses purchases that are difficult to manage and strategically important to the company. Establish a close relationship with the supplier. The supplier should be viewed as a natural extension of the firm.

Bottleneck Category: includes the purchases that have a low strategic importance but are difficult to manage. Standardize the purchases or find substitutes if possible. The company should try to establish some sort of relationship focusing on concurrent engineering and involving the supplier in value analysis in order to lower the cost of operations.

The relative supplier attractiveness describes the factors that make a company choose a specific supplier. Factors that could be used to evaluate the relative supplier attractiveness are: financial and economic factors, performance factors, technological factors, and organizational, cultural and strategic factors. This list is not comprehensive and firms may benefit from including more specific factors.

Wu, Z., Choi, T. Y., and Rungtusanatham, M. J. (2010)

To improve the flow of ideas and materials, many buying firms now work with a smaller number of suppliers and relegated to them much of the product design and product coordination. Recent studies suggest that buying firms are proactively creating co-opetition among suppliers to elicit both collaborative synergy and market efficiency. The idea is that competing parties, individuals or organizations, being mindful of potential retaliatory actions of their counterparts in future interactions, are willing to engage in collaboration. A co-opetitive relationship can induce optimal gains for both parties. Competition between buyers and suppliers would attenuate (verzwakken) as they consider the prospect of future interactions.

- Supplier-supplier co-opetition is defined as the cooperative behavioral actions which two competing suppliers of a given buyer engage in.

Because of its business interest, the buyer is motivated to influence the nature of the relationship between suppliers. Interactions between suppliers, or lack thereof, would eventually affect the performance of the buyer's supply chain operations. The buyer must be engaged in supplier-supplier relationships, otherwise the buyer stand to lose control and understanding of its supply chain.

- Triadic relationships can take place among the buyer, downstream vendor, and upstream supplier or among a buyer and two suppliers. Here, the buyer can directly influence the relationships between suppliers in a buyer-supplier-supplier trade. Buyer influence here are the activities that a buyer engages in to manage competing suppliers

In a tightly coupled supply chain, the suppliers' operations need to be closely coordinated. Disruptions of suppliers' operations could have immediate and severe consequence on the buyers.

- Buyers directly engage the suppliers and influence their behaviors with contractual incentives and penalties to reinforce the desired co-opetitive supplier-supplier relationship.

Analyses suggest that supplier-supplier co-opetition would produce stronger supplier performance compared to competition or cooperation alone. Mutual assistance between suppliers helps them to resolve quality and technical problems in production. Cooperation sparks synergy and induces the creation of both explicit and tacit knowledge.

Results:

- For each triad, the power/leverage of a buyer over suppliers is contingent on such factors as the nature of product technology and quantities purchased.
- Buyers are able to influence the relational behavior between competing suppliers. This supplier-supplier link is one that the buyer is not directly connected to, this link exists as an indirect connection through the suppliers.
- Supplier performance is actually lower when the level of supplier-supplier co-opetition is high. Maybe this is because suppliers view cooperative activities as something extra, over and above what they are naturally included to do. Another alternative interpretation of this finding is that poor supplier performance actually induces (causes) supplier-supplier co-opetition, not vice versa.
- So, when competing suppliers deliver poor performance to the buyer, the buyer would be motivated to step in and subsequently instigate collaboration between competing suppliers with the aim being to have them help each other out to resolve operations problems.

WEEK 3:

Marini, G., and Street, A. (2007)

Payment by Results (PBR) is a policy that rewards hospitals for volumes of work. Hospitals receive a fixed payment – the national tariff – for each type of patient treated. In England patients are offered now a choice where and when they receive treatment and the options include both NHS (public) and independent sector (private) hospitals. The overhaul of contractual relations is intended to provide stronger incentives for NHS hospitals to increase activity and/or lower costs. Payment by Results (PBR) encourage hospitals to find ways to cut costs and reduce length of stay in order to find capacity to accommodate more patients. In the past hospitals were reluctant to accept patients that were not included in their formal contracts, with PBR it is intended to avoid such matters and allow patients a greater choice of hospitals.

Transaction costs arise in any situation of imperfect agency, where bounded rationality and opportunism give rise to incomplete contracts between the principal and agent.

- **Bounded rationality** describes the limitations of either party to act as fully informed rational agents, because of the complexity of the decision-making process and uncertainty about future events.
- **Opportunism** refers to the pursuit of individual self-interest, where the goals of the agent do not coincide with those of the principal.

It is costly to manage the impact of bounded rationality and opportunism, and the level of costs varies according to the governance arrangements between principal and agent.

The level of transaction costs and optimal governance structure also depend on the nature of the exchange that constitutes the basis of the relationship between principal and agent.

- Frequent and repeated exchanges are likely to entail lower transaction costs.
- Costs will also be lower in context where assets are highly specific to the particular agreeement, meaning that they cannot be diverted easily to other tasks.

Ex ante transaction costs are incurred prior to entering into a contract and can be subdivided into search costs and negotiation costs. **Ex post transaction costs** are those costs incurred after the contract has been placed and can subdivided into monitoring costs and enforcement (incurred when a case of disputes arises from incomplete contractual specification) costs.

Previously, block contracts has been used. These contracts stipulated a total contract value, usually specified at specialty level. The primary care trusts decides how much of its budget to devote to each specialty level contract and negotiated with a hospital how much activity would be made available. Thus there was little uncertainty about the expected level of total expenditure and limited scope for opportunistic behaviour.

Under Payment by Results, local specialty level prices have been replaced by national prices based on the healthcare resource groups to which each patient is allocated. Hospitals no longer face a ceiling on the amount of activities they undertake. Furthermore, patients have greater choice about where and when they are treated.

- Low cost hospitals have the incentive to undertake more activity to increase revenue
- High cost hospitals have incentives to reduce their costs

With PBR price setting is now a centralised function, and transaction costs associated with this function are lower than when prices were determined locally. But for two other aspects the transactions costs have increased:

1. Activity is described more precisely under PBR.

2. Hospitals are likely to require more precise financial information because of the clearer relationship between activity and revenue under PBR.

Under PBR it is more difficult for Primary Care Trusts (PCT) to ensure that expenditure equates to their budget allocation, because they cannot impose activity ceilings or reduce the unit price paid.

In summary, the net effect on total transaction costs of moving from block contracting to PBR depends on whether reduced effort spent on negotiating prices is offset by greater attention to other aspects of the contracting process.

The study of Marini & Street showed that transaction costs increased when PBR was introduced. Mostly because of the additional expenditure due to recruitment of additional staff. The main changes in transaction costs arise from:

- Higher costs of negotiation – while there are lower costs in negotiating prices and volumes, this is offset by difficulties PCTs have in managing activity levels.
- Higher costs of data collection – due to PBR's requirement for accurate patient-level data.
- Hospitals have recruited staff to ensure better extraction of data.
- Higher monitoring costs – hospitals no longer have to get approval to increase their activity which means that PCTs face greater uncertainty about they might have to pay for.
- Higher enforcement costs – with the sharper relationship between activity and income/expenditure increasing the potential for more disputes between hospitals and PCTs.

The net effect is an increase in transaction costs. As PBR is rolled-out, hospitals need to focus attention on both their coding and costing activities, particularly to ensure that patients are allocated accurately to their appropriate healthcare resource group. However, interviewees indicated that PBR had led to improvements in the process of care delivery, by enabling resources to be shifted across settings and, because of the improved specificity of information. PBR sharpened incentives and introduced greater clarity into the contracting process.

Fayezi, S., O'Loughlin, A., and Zutshi, A. (2012)

Agency theory is relevant for the situation wherin one party (the principal) delegates authority – in terms of control and decision-making about certain tasks – to another party (the agent). When the agent is acting for the principal it resembles behaviours such as performing for the benefit of the principal or acting as the principal's representative or employee. In agency relationships, typically, the principal will seek to minimise the agency costs, such as, specifying, rewarding, and monitoring, and policing the agent's behaviour, while the agent works towards maximising rewards and reducing principal control.

Developments in agency theory are largely based on two important streams of inquiry, namely, principal-agent research and positivist-agency theory.

- Principal-agent relationship assumes that the principal and agent will attempt to maximise their positions through individual interpretation of the contract.
- Positivist-agency theory (PAT) seeks to synthesise political science, expert agency, the law of agency and sociology into a single framework, which in turn attempts to explain how relationships in business and government develop, and offers suggestions as to how they might be managed more effectively. PAT is thus useful for explaining non-rational behaviour of agents.

Two important challenges in agency relationships are misrepresentation of ability (adverse selection) and lack of effort (moral hazard), both of which are attributed to the agent. Hidden information and hidden action models, respectively, have been specifically developed to assist in designing an appropriate contract.

- Hidden information models focus on the problem of agent selection, specifically, the potential for falsification of skills and abilities of the agent. The benefits of such models is that they can assist in designing a contract which can be used to motivate the agent to take appropriate observable action. Furthermore, hidden information models focus on making agent capabilities explicit through the use of various management processes such as screening, signalling or providing opportunities for self-selection.
- Hidden action models deal with the design of the contract, which can be used to mitigate the moral hazard problem and motivate the agent to take appropriate action. Principals are assumed to be risk-neutral whereas agents are typically risk-averse. The underpinning rationale is that because principals have more power to diversify their investments, agents are highly dependent on the principal and are less likely to engage in appropriate behaviour.

Agency theory provides a mechanism that may be used to explain how players within the supply chain respond to transaction cost dilemmas where rational and non-relational behaviour occurs.

Agency theory provides a useful basis for understanding the diverse range of relationship activities within supply chain management. Mutual information, risk and reward sharing, integrated relations and processes, goal congruence across the chain, and establishment and maintenance of long-term business relationships are areas where agency theory has proved most useful.

- Agency theory can be used to inform contractual responses to outcome/behaviour uncertainty of agents (or principals) within the supply chain relationships.

Agency theory identifies behavioural change by supply chain actors and sheds light on activities involving principal and agent, self-interest, risk aversion, lack of trust, goal conflict and imperfect policy implementation.

- Positivist agency theory provides a holistic view of the potential causes of the abnormal behaviour of agents (or principals) within the supply chain relationships.
- Positivist agency theory extends views centred on task and transaction by attending to specific attributes of agents (or principals) operating within the supply chain.

It was found that information sharing and incentivisation have received considerable attention in agency theory-based explanations of relationship/behaviour-contract alignment. Communication as an aspect of relationship development within the supply chain has received less attention by scholars. This is in contrast to the potential influence of inter-organisational communication on the mitigation of behavioural uncertainty across the supply chain. It is therefore suggested that more work needs to be undertaken in this area to fully understand how agency theory might better explain supply chain relationships and behaviours.

In conclusion, agency theory is a useful tool for managers to diagnose and segregate their portfolio of relationships. Agency theory can explain how players within the supply chain respond to transaction cost dilemmas where rational and non-rational behaviour occurs. Hence, abnormal behaviours of network partners can be analysed and counterbalancing remedies can be devised. This process might contribute to the development and maintenance of a trusting atmosphere in business relationships. Agency theory may help managers to factor social, economic, political and behavioural aspects into their contract decision-making, by undertaking adaptive measures around incentivisation, information sharing and goal congruence.

Reay, T., and Hinings, C.R. (2009)

Institutional logics provide the organizing principles for a field. Logics are an important theoretical construct because they help to explain connections that create a sense of common purpose and unity within an organizational field.

Provincial government in Canada introduced a new logic of business-like health care. This meant that new governance structures were put in place to increase efficiency and do more with less. Principles associated with a business-like logic were cost-effective treatment, lowest cost provider and customer satisfaction. However, the business-like logic here was competing with the logics of medical professionalism. Physicians used their professional knowledge to determine appropriate care for their patients, not always efficient. Physicians did not agree with the principles of business-like health care as set out by government. They did not believe that patient care should be provided based on government determinations of cost-effectiveness and patient satisfaction.

- Institutional logics are the organizing principles that shape the behaviour of field participants. Because they refer to a set of belief systems and associated practices, they define the content and meaning of institutions.
- An organizational field is a community of actors held together by their joint values and beliefs, thus, describing the institutional logic that guides actor behaviour helps to define the field.
- Institutional change is usually associated with a new logic for the field. Institutional change can be seen as movement from one dominant logic to another. Although other logics exist, it is the dominant logic that guides behaviour. When a new logic is introduced to an established field, rivalry among key actors is likely because challenger actors support a new logic while incumbent actors support the old logic.

Collaboration is an effective way for interested actors to take action, so, institutional fields are shaped by collaborative activities through the development of networks, structures of domination and the production or maintenance of institutional rules. Some types of collaboration bring together disparate actors holding different interests. Through the process of managing these interest, collaborative activities can impact on changes in institutional logics or 'institutional or community norms and values'. Different intentions, different learning approaches and different goals are all associated with different patterns of collaborative activities, and ultimately different outcomes.

Extant literature contained two general explanations on how rivalry between competing logics can be managed:

1. Rivalry is managed through battles where actors supporting the winning logic achieve dominance and conflicting logics are not relevant anymore.
2. Rivalry is managed through covert (secret) operations where actors work 'under the radar' to gradually bring their logic to dominance or to subvert (ondermijnen) the currently dominant logic.

The study showed that rivalry between competing logics can be managed through collaborative relationships where the collaborators maintain their independence but work together to achieve the desired outcome. In this case, actors collaborate to achieve short-term goals, but through the process of working together developing new institutionalized working arrangements that supports the co- existence of competing logics.

P1: When competing logics co-exist in an organizational field, actors guided by different logics may manage the rivalry by forming collaborations that maintain independence but support the accomplishment of mutual goals.

Maintaining identity differences is important to a successful collaboration. In some settings, groups work together best when each maintains its own identity and also collectively develop a superordinate identity. This is in contrast with previous research suggesting that the creation of a common identity is critical in developing a positive collaborative relationship. Identity is an important component of institutional creation, maintenance and destruction.

P2: When competing logics co-exist in an organizational field, actors guided by different logics may maintain strong separate identities and engage in collaborations that results in mutually desirable outcomes and thus sustain the co-existing logics.

Several studies highlight the considerable time and energy investment required for micro-level action to result in macro-level change. The effect of micro-level actions can be cumulative as well. Working on a series of continuous and persistent actions at the micro level by a small number of individuals can lead to legitimating new system-wide work practices. Considerable time and energy has to be invested at micro-level to result in macro-level change.

P3: When the rivalry between competing logics is resolved through collaboration at micro levels, macro-level actors will develop field-level structures to support the co-existence of multiple logics.

In conclusion, it is necessary for micro-level actors to maintain their separate identities in pragmatic collaborations that allowed them to accomplish work and meet professional responsibilities. The research highlights the importance of collaborative activities within processes of institutional change.

Mitchell, R.K., Agle, B.R., and Wood, D.J., (1997)

Stakeholder salience is the degree to which managers give priority to competing stakeholder claims. A stakeholder is any group or individual who can affect or is affected by the achievement of the organization's objectives. However, there are many different definitions of stakeholders in literature. Stakeholders can be identified by the following attributes:

- Stakeholder's power to influence the firm
- The legitimacy of the stakeholder's relationship with the firm
- The urgency of the stakeholder's claim on the firm

Excluded from having a stake are only those who cannot affect the firm (have no power) and are not affected by it (have no claim or relationship). The idea of comprehensively identifying stakeholder types is to equip managers with the ability to recognize and respond effectively to a disparate set of entities who may or may not have legitimate claims, but who may be able to affect or affected by the firm nonetheless, and thus affect the interests of those who do have legitimate claims.

- Claimants vs Influencers – claimants may have legitimate claims or illegitimate ones, and they may not have any power to influence the firm. Influencers have power over the firm, whether or not they have valid claims or any claims at all and whether or not they wish to press their claims.
- Actual vs Potential Relation – the potential relationship can be as relevant as the actual one, and should be included therefore.

Power is the probability that one actor with a social relationship would be in a position to carry out his own will despite resistance. Coercive power is based on the physical resources of force, violence, or restraint (use a gun). Normative power is based on symbolic resources (e.g. love or acceptance). Utilitarian power is based on material or financial resources (money).

- A party to a relationship has power, to the extent it has or can gain access to coercive, utilitarian, or normative means, to impose its will in the relationship.

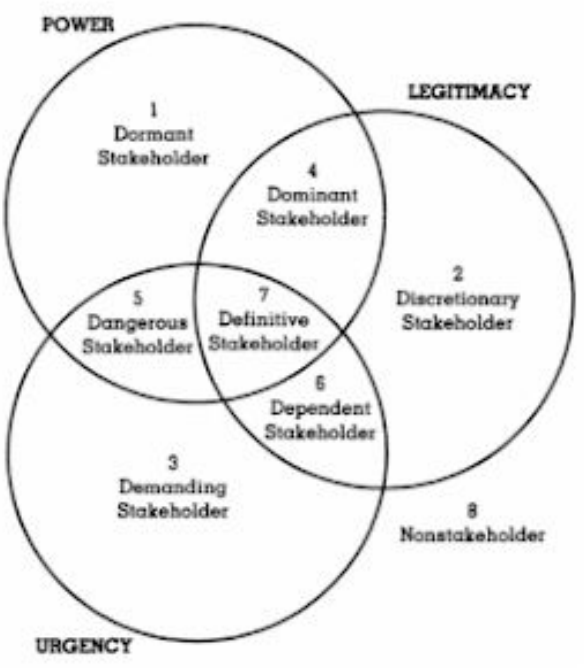
Legitimacy is a generalized perception or assumption that the actions of an entity are desirable, proper, or appropriate within some socially constructed system of norms, values, beliefs, and definitions.

- Together, legitimacy and power can create authority.

Urgency is based on two attributes. First on time sensitivity, the degree to which managerial delay in attending to the claim or relationship is unacceptable to the stakeholders. Second on criticality, the importance of the claim on the relationship to the stakeholder.

- Urgency is the degree to which stakeholder claims call for immediate attention.

Although groups can be identified reliably as stakeholders based on their possession of power, legitimacy, and urgency in relationship to the firm, it is the firm's managers who determine which stakeholders are salient and therefore will receive management attention. Managerial characteristics will be an important moderator of the stakeholder-manager relationship.



Latent Stakeholders:
Stakeholder salience will be low where only one of the stakeholder attributes – power, legitimacy, and urgency – is perceived by managers to be present.

1. Dormant stakeholders – possess only power and have little or no interaction with the firm. Because of their potential to acquire a second attribute, management should remain cognizant of such stakeholders. E.g. power is held by those who have a loaded gun, those who can spend a lot of money of those who can command the attention of the news media.
2. Discretionary stakeholders – possess only legitimacy. The absence of power and urgent claims makes that there is no pressure on managers to engage in an active relationship with such stakeholder.
3. Demanding stakeholders – possess only urgency. Are 'mosquitoes buzzing in the ears' or managers. Annoying but not dangerous, so not warranting more than passing management attention.

Expectant Stakeholders

Stakeholder salience will be moderate where two of the stakeholder attributes – power, legitimacy, and urgency – are perceived by managers to be present.

4. Dominant stakeholders – both powerful and legitimate, so their influence in the firm is assured. Dominant stakeholders will have some formal mechanism in place that acknowledges the importance of their relationship with the firm. They expect and receive much of managers' attention.

5. Dependent stakeholders – both legitimate and urgent. Because power in this relationship is not reciprocal, its exercise is governed either through the advocacy or guardianship of other stakeholders, or through the guidance of internal management values. Example can be the natural environment itself, has no power to enforce their will.

6. Dangerous stakeholders – both urgent and powerful, will be coercive and possibly violent. E.g. political terrorists using bombings to call attention to their claims. These actions are outside the bounds of legitimacy and dangerous.

Definitive Stakeholders (7)

Stakeholder salience will be high where all three of the stakeholder attributes – power, legitimacy, and urgency – are perceived by managers to be present. When a stakeholder possesses all three attributes, managers have a clear and immediate mandate to attend to and give priority to that stakeholder's claim. Most common occurrence is likely to be the movement of a dominant stakeholder into the definitive category, but every expectant stakeholder can become a definitive stakeholder by acquiring the missing attribute.

WEEK 4 & 5:

Ahaus, C.T.B. (2018)

In most healthcare systems, healthcare providers are paid predominantly by volume (fee-for-service) instead of by value. This has turned out to be one of the drivers of rising costs in healthcare. Therefore, Porter accentuates that we need a shift in focus from volume to value.

- Value is health outcomes achieved per dollar spent

Focusing on value requires reforming the fragmented, siloed organization of healthcare delivery governed by an equally partitioned healthcare purchaser. Orchestrated multidisciplinary teams are needed that take responsibility for the combined efforts over the full cycle of care.

Porter proposed a three-tiered hierarchy where tiers 2 and 3 are dependent on tier 1.

Tier 1: health status achieved or retained (e.g. % survival rate, % re-interventions)

Tier 2: process of recovery (e.g. length of intensive care stay, time to return to work, % infections)

Tier 3: sustainability of health (e.g. 3-year survival rate, % patients with a dysfunction of other organs due to a liver transplantation)

Costs can be measured based on the activities performed in the full cycle of care. An analysis of the process might reveal non-value-added activities, which can be eliminated without any reduction of value.

The strategic value agenda, is about transformation in:

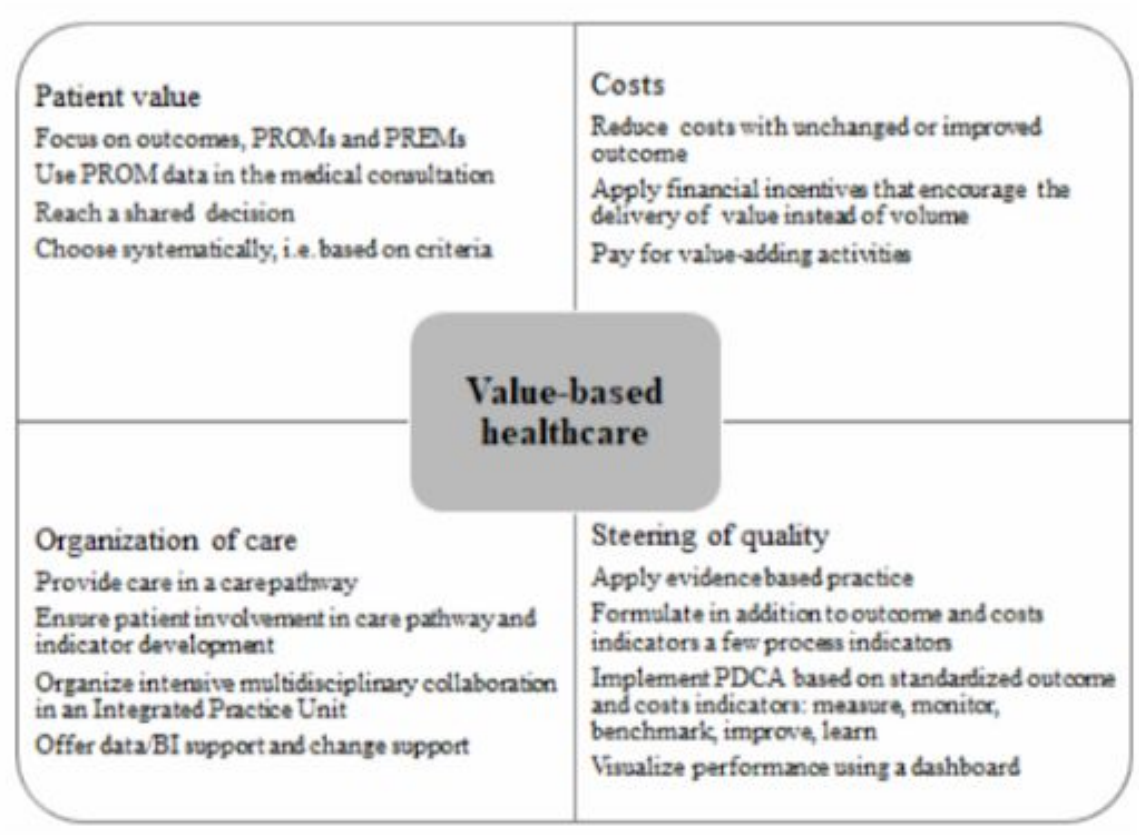
1. The way healthcare is organized into Integrated Practice Units (IPUs)
2. The way we measure quality and costs
3. The way the healthcare provider gets paid for the value delivered

IPUs are organized around a group of patients with similar needs. Based on these needs, their care can be explicated in a clinical program or care pathway. The transformation toward a value-based healthcare system needs an orchestrated team-based redesign, where the redesign emerges in a long series of local experiments. The teams take care of delivering the right care for the patient at the right place in the supply chain.

- Preferably, volume will be concentrated, as concentration is considered to indicate quality (more experience is better performance)

The current system of fee-for-service rewards quantity instead of quality. However, fee-for-service is considered transparent and fair and helps in reducing a possible gap between demand and supply. But it can lead to under-investment in non-reimbursed care delivery. Porter proposes a bundled payment for the full cycle of care. When linked to outcomes it will incentivize collaboration and reduce inefficiency. Downside might be the payment for patients, e.g. for elderly with several co-morbidities it might be complex.

Value-based healthcare framework (important!):



1. The patient value category emphasizes the focus on clinical outcomes, patient reported outcome measures (PROM) and patient reported experience measures (PREM).
2. The costs category accentuates the need for costs reduction and for the introduction of payment systems that include incentives that drive value.
3. Organization of care promotes care pathway development with patient involvement and data and change support, based on a close and flourishing multidisciplinary collaboration.

4. Steering of quality category points out the importance of evidence-based practice, of linking outcome to its determinants and of implementing a PDCA cycle.

In order to aim for value-based healthcare, the following elements should be included in the approach:

1. Use of PROM-data as the subject of the medical consultation and as an important input for shared decision-making
2. The strengthening of an open and safe culture with the professional in the lead
3. Use of data to manage segments or target populations on a regional level

Porter, M. E. (2010)

Achieving high value for patients must become the overarching goal of the health care delivery, with value defined as the health outcomes achieved per dollar spent. If value improves, patients, payers, providers, and suppliers can all benefit while the economic sustainability of the health care system increases. Value always should be defined around the customer, and in a well functioning health care system, the creation of value for patients should determine the rewards for all other actors in the system.

- Since value depends on results, not inputs, value in health care is measured by the outcomes achieved, not the volume of services delivered, and shifting focus from volume to value is the central challenge.

Since value is defined as outcomes relative to costs, it encompasses efficiency. To reduce cost, the best approach is often to spend more on some services to reduce the need for others. Cost reduction without regard to the outcomes achieved is dangerous and self-defeating, leading to false savings and potentially limiting effective care.

The proper unit for measuring value should encompass all services or activities that jointly determine success in meeting a set of patient needs. These needs are determined by the patient's medical condition. For primary and preventive care, value should be measured for defined patient groups with similar needs. Value for the patient is created by providers' combined efforts over the full cycle of care. The benefits of any one intervention for ultimate outcomes will depend on the effectiveness of other interventions throughout the care cycle. Therefore, value for patients is often revealed only over time.

- For patients with multiple medical conditions, value should be measured for each condition.

In the current organizational structure providers only measure what they directly control, and mostly that is too narrow or too broad to be relevant for patients. Sometimes costs are measured for departments or billing units rather than for the full care cycle over which value is determined.

To determine the group of relevant outcomes to measure for any medical condition, outcomes should include the health circumstances most relevant to patients. Covering both near-term and longer-term health. The outcomes for any medical condition can be arrayed in a three tiered hierarchy:

1. Tier 1 is the health status that is achieved or retained. The first level, survival, is of overriding importance to most patients. The second level in tier 1 is the degree of health or recovery achieved or retained at the peak or steady state.
2. Tier 2 outcomes are related to the recovery process. The first level is the time required to achieve recovery and return to normal or best attainable function. The second level is the disutility of the care or treatment process in terms of discomfort, retreatment, short-term complications, and errors and their consequences.
3. Tier 3 is the sustainability of health. The first level is recurrences of the original disease or longer-term complications. The second level captures new health problems created as a consequence of treatment.

Providers can differentiate themselves especially in Tiers 2 and 3 by making care more timely, reducing discomfort, and minimizing recurrence. Improving one outcome dimension can benefit others.

Today, health care organizations measure and accumulate costs around departments, physician specialties, discrete service areas, and line items such as drugs and supplies. Costs, like outcomes, should instead be measured around the patient. Measuring the total costs over a patient's entire care cycle and weight them against outcomes will enable truly structural cost reduction, through steps such as reallocation of spending among types of services, elimination of non-value-adding services, better use of capacity, shortening of cycle time, provision of services in the appropriate settings etc.

Porter, M.E., Larsson, S. and Lee, T.H. (2016)

Health care is shifting focus from the volume of services delivered to the value created for patients. Progress has been slow and halting, partly because measurement of outcomes that matter to patients, aside from survival, remains limited. In order to reach value-based health care, outcome measurement must accelerate. That means committing to measuring a minimum sufficient set of outcomes for every major medical condition and then standardizing those sets nationally and globally.

Yet process measurement has had limited effect on value. Process measures don't truly differentiate among providers, so incentives for improvement are limited. Nor does improving process compliance from 95% to 98% matter much for outcomes. What matters to patients are outcomes that encompass the whole care cycle, including health status achieved; the time, complications, and suffering involved in getting care; and the benefit sustainability achieved.

Efforts at outcomes measurement have overwhelmingly focused on clinical status (e.g. survival) and left out functional status, even though improving functional status is why patients seek care. Patient reported outcomes are beginning to be measured but are not yet routinely captured for most conditions. Progress on outcome measurement has been slowed down also because each organization reinvents the wheel, tweaks existing measures and risk factors, or invents ones of their own.

So far, there have been no effective mechanisms for standardizing outcomes measures regionally or nationally. Each organization that sets out to measure outcomes thus faces an arduous process of agreeing on what to measure and how, and then convincing reluctant providers to go along with it. The ability to compare performance, spark competition, and foster learning is compromised (aangetast).

Providers, payers, patient-advocacy groups, and regulators should come together to create a process to agree on a minimum sufficient set of outcomes for each important medical condition – including rigorous definitions, risk-adjustment factors, and methods. Then we can agree on standardizing these measures both nationally and internationally.

- Reaching agreement among international groups of clinicians on condition-specific outcomes sets has been suprisingly straightforward These standards are putting providers, payers, patients, and information technology vendors on a common path for tracking what needs to be tracked, making implementation of outcomes measurement easier and more efficient.
- Porter believes that agreeing on and implementing respected standard sets of outcomes for each medical condition is a practical and devisive step in accelerating value improvement in healthcare.

VanLare, J. M., and Conway, P. H. (2012)

Value-based purchasing (VBP) rewards providers who deliver better outcomes in health and health care for the beneficiaries and communities they serve at lower cost. VBP applies to nearly all providers in a given setting. VBP programs are being launched even as the quality of care is improving. Furthermore, a new trend of slowing growth in health care costs has emerged. The authors are optimistic that VBP can improve quality and reduce costs, given that providers have enhanced their efforts to measure and imrpove performance since the current VBP programs were launched. VBP can improve quality only in areas that it measures and for which it provides incentives.

Measurement to date has focused primarily on clinical care processes, safety, and patient experience. In keeping with the three aims of better health, better care, and lower costs, the scope of measurement will be expanded to include the objectives of better health for communities, care coordination, andlower costs.

- A more comprehensive set of measures that includes costs, population health, and care coordination will help providers focus on the care and support available outside their walls.

Six domains of measurement are the basis for a proposed reorganization of VBP measures:

1. Safety

2. Patient- and caregiver-centered experience and outcomes

3. Care coordination

4. Clinical care

5. Population or community health

6. Efficiency and cost reduction

The use of these six domains will allow to create shared accountability for performance. Five principles are important in developing the VBP portfolio further:

1. Programs must define the end goal, not the process for achieving it. Emphasizing patient-centered outcomes in VBP programs will allow providers to focus on a concise core set of measures in which they have the greatest opportunities for improvement without being unduly burdened with reporting.
2. All providers' incentives must be aligned. VBP has the potential to harmonize types of measures and provider incentives across settings.
3. Right measures must be developed and implemented in rapid cycle. There has to be collaboration in the development of measures to fill gaps and implement measures as quickly as possible while maintaining the review and public-commenting processes.

4. Centers for Medicare and Medicaid Services must actively support quality improvement. VBP programs should reward improvement as well as overall achievement whenever possible, but incentives alone cannot improve quality.
5. The clinical community and patients must be actively engaged VBP. VBP will improve care only when clinicians, provider organizations, and patients understand its goals, are engaged in active improvement, and make decisions on the basis of value.

VBP programs are a step in the transition from a fee-for-service health system to one that is fully accountable for these outcomes.

WEEK 6:

Vogler, S., Vitry, A., and Babar, Z. U. D. (2016)

Spending on cancer constitues about 5% of health-care cost in Organisation for Economic Co- operation and Development countries, and this number is growing. This increase is attributable to increasing incidence and prolonged survival, but also to high costs of new drugs and technologies. Drug prices vary between countries.

Results of the conducted study suggest that prices for cancer drugs vary across Europe, Australia, and New Zealand. Prices in Sweden, Switzerland, and Germany ranked high. Prices in Portugal, Spain and especially Greece and the UK were at the lower end. Prices of cancer drugs in Australia and New Zealand were similar to prices in European countries, with no substantial outliers.

- The existence of generics, on the market might have affected originator prices in some countries. In some countries, originator prices might have decreased because of generic competition, whereas in other countries originator prices remained at a high level.

In view of the large effects on budgets of new cancer drugs, public payers have been considering managed-entry agreement as possible funding and success policy. Although managed-entry agreements might contribute to ensuring patient access to new drugs, especially those with limited cost-effectiveness, they can lead to limited transparency because the content of these arrangements, including the agreed prices, is not usually made public.

- The inaccessibility of confidential, discounted prices is a limitation of the conducted study, and it is also a major shortcoming in pricing for public payers. However, list prices are of high relevance for policy makers because undiscounted list prices are applied in external price referencing which is a common pricing policy.

Many European countries, and to some extent Australia, apply the policy of external price referencing (benchmarking) that is the practice of using the prices of a drug in one or several countries to derive a benchmark or reference price for the purposes of setting or negotiating the price.

The low list price level caused by the external price referencing method might lead to delays, and even non-availability of drugs in the market. This might be because manufacturers are incentivised to launch these drugs in high-priced countries first and defer (uitstellen) market entry in the lower priced countries so they will not be obliged to negatively affect the international reference price.

Gobbi, C., and Hsuan, J. (2015)

There is an increased focus of public sectors to promote the procurement of goods and services in a more efficient manner, such as through collaborative purchasing (CP). CP provides the opportunity to operationalize group purchasing strategies in order to gain from economies of scope and scale. The purpose is to benefit from better pricing, service and technology from suppliers than it could be obtained if each organization purchased goods and services alone.

- CP can significantly provide savings in the healthcare sector: solely the purchasing of pharmaceuticals and other medical nondurables represent on average 18% of the total healthcare expenditure.

Purchasing in healthcare differs from purchasing in other typical industrial contexts as it is characterized by a high level of complexity due to the multitude of different supplies and the myriad of distribution channels.

- Frequently there is not a direct link between those making buying decisions (healthcare managers) and those making use of the supplies (physicians).
- Mix of healthcare supplies changes frequently due to rapid technological and medical innovations making the management of purchasing critical in terms of information and knowledge update.

Often sourcing in healthcare is executed by centralized public purchasing institution acting at the national or regional level and a large amount of efforts is placed in contracting.

CP can attain favorable conditions with the vendor by using the collective bargaining power. Activities such as supplier evaluation, negotiation and contract management are transferred to the purchasing group. The buyers of the purchasing group have to define and combine their individual requirements before engaging in the CP process. In order to reach mutual benefits between buyers and suppliers, alignment is important. Alignment refers to the integration of key systems and processes to achieve strategic fit or strategic match at service and operational levels.

CP adds an intermediary actor (the purchasing group) to the supply chain structure, which means that the alignment of the requirements has to be attained within the purchasing group as well as between the group and the vendor's offering strategies. Alignment is the mechanism of reaching the agreement between the members of the purchasing group and the fit between the buyer's and the vendor's.

- Shareholder alignment is the alignment with the purchasing group. It is about achieving consensus between the business and supply chain strategy and employees expectations with the shareholders objectives.
- Customer alignment is the alignment between purchasing group (buyers) and vendors. Here business and supply chain strategy is aligned in order to meet customer expectations and needs.

Continuity in the participation of the purchasing group is crucial to assure smooth communication and avoid misunderstandings. Fair allocation of cost savings between the members is critical: inequities in the allocation of gains can cause a failure in CP. Standardization of the purchased products and services should be pursued. Therefore, group members have to compromise between each member's-specific needs. Standardization and compliance require coordination to reach agreement on a set of standard requirements.

- CP can be hindered by local politics and differing priorities, supplier resistance and a lack of common coding systems.

Elements of integration:

1. Integration of information flow includes: sharing of data and information, information exchange and frequent communication.
2. Integration of physical flow includes: participation in new product and process design, collaborative forecasting and replenishment, vendor management inventory, replenishment synchronization schemes and synchronization of order cycles. To lessen interdependency and reduce development lead time, modularity can be applied.
3. Integration of financial flow includes: payers' intervention and commensurability of value capture are crucial. Joint goal setting, joint responsibility, cooperative behavior, operational and strategic long-term orientation etc.
4. Technology and systems supporting integration include: communication infrastructure and IT integration.

- Shareholder alignment factors are: commitment and trust, fair allocation of gains, common objectives, smooth communication and knowledge exchange, similar or complementary resources.
- Customer alignment factors are: standardization of processes, transparent behavior, high levels of commitment and trust, development of collaboration structures, strategic long term orientation, participation in new product and process design, collaborative forecasting and replenishment.

Standardization of processes and procedures is often mentioned as a way to simplify CP. Complexity of equipment require high levels of expertise and knowledge in identifying the technological needs and combine them in bundles.

P1: The complexity and criticalities of the CP process increases when the purchased goods are technologically complex.

In sourcing of complex technologies or critical components, the vendor and buyer should seek strategic partnerships. Modularity is often mentioned as a powerful concept for managing complexity as a way to overcome problems related to product variety and frequent product changes and upgrades. The standardization process and identification of common hospital needs for the technologies during the bidding process was on of the main factors that facilitated the communication and purchasing process with the vendors. Once the specification were set and maximum commonality sharing among the hospitals identified, the purchasing of complex medical technologies became much easier, in the sense that strategic involvement with the vendors was not a constraint.

P2: CP lowers the degree of buyer-vendor dependency in the purchasing of complex technologies.

Service operations are concerned with delivering services to the customers. This involves the understanding of the customers' needs, the management of the processes that deliver the services, ensuring that the objectives are met and paying attention to the continuous improvement of the

services and how to allocate operational capabilities that are aligned with customer needs. Many manufacturing firms are adding services into their offerings as a way to increase sales and to create higher value, referred to as servitization. The increased level of servitization was also recognized within healthcare.

P3: Modular design positively moderates the servitization performance of vendor in CP.