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

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ABSTRACT

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

1. Introduction

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

Over the last decade, the dependence between healthcare organisations and financial stakeholders in many Western European countries has become more complex and diffuse because of (1) health policy changes, which have encouraged competition in healthcare, and (2) the 2007 financial crisis, which has influenced how financial stakeholders (and indirectly healthcare organisations) perceive risk. The health policy changes that occurred in the early 2000s created competition between providers of care and health insurers [1,2]. Governments implemented 'business-like' and 'market-oriented' models that placed more focus on performance indicators, accountability and control systems, and risk management in the healthcare sector [3,4]. The healthcare organisations' financial affairs and relationships with financial stakeholders became an important focal point for all concerned in the healthcare sector.

In the years following the 2007 financial crisis, European healthcare organisations encountered difficulties gaining access to

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capital since capital expenditure is affected by financial crises [5,6]. Governments adopted austerity policies aimed at reducing healthcare budgets [7-9]. Institutions such as banks and (health) insurers faced stricter capital regulations from international and European supervising authorities. The Basel III regulation for banks and Solvency II regulation for (health) insurers influenced the conditions under which capital was provided, creating stringent loan conditions for healthcare organisations and shifting the focus of both banks and health insurers towards risk management [10,11]. These developments, derived from the financial crisis, created obstacles to getting capital and affected financial stakeholders' perceptions of healthcare organisations.

In light of these developments, role perceptions have changed and the relations between healthcare organisations and financial stakeholders have reshaped and redeveloped. A deeper understanding of the dynamics of these complex relations is necessary to revisit roles, interdependencies and ways of collaborating. Changing relations between healthcare organisations and their financial stakeholders have not been well studied, despite their importance for the functioning of individual healthcare organisations and the healthcare system as a whole. To address this gap, we have used stakeholder theory, particularly the salience model developed by Mitchell, Agle and Wood [12], to disentangle the relations between healthcare organisations and their financial stakeholders. This model enables us to analyse how executives of healthcare organisations value and prioritise stakeholders based on three attributes: power, legitimacy and urgency. Although the salience model intends to identify all stakeholders and then compare them to their relative salience, we have followed the approach of Magness [13] and apply the model to two types of stakeholders.

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

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

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

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

Banks

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

Five banks are involved in the Dutch healthcare sector; these are either commercial banks (ABN AMRO Group, ING Bank, Rabobank) or public sector banks (BNG Bank and NWB Bank). The healthcare sector comprises about 5% of the total loans provided by Dutch monetary financial institutions [14].

Since the introduction of managed competition in 2006 and the deregulation of governmental healthcare real-estate policies in 2008, Dutch healthcare organisations are responsible for their own financial stability and real estate [15]. This break with the previous risk-free policy – which based financing of real estate on subsequent funding by the government – has considerably affected the relations between banks and healthcare organisations. It has raised barriers to accessing capital for healthcare organisations and has made the financing of healthcare real estate more uncertain and riskier for both healthcare organisations and their capital providers [16-19]. Banks have been affected by stricter regulations (Basel III) induced by the financial crisis. This affected loan conditions, making healthcare organisations increasingly reliant on their financial stakeholders [11].

Health insurers

Since the introduction of managed competition in 2006, Dutch health insurers, including former public sickness funds and private insurers, consolidated into 23 competing health insurers that operate under ten concerns (2018). The four largest insurance concerns (Achmea, VGZ, CZ and Menzis) have a total market share of 86.5% [20]. Dutch health insurers operate in managed competition in two markets: the health insurance market and the health purchasing market [15]. In the health insurance market, health insurers offer annual health plans to Dutch citizens, who are obliged to select one. In the health purchasing market, health insurers annually negotiate on price, quantity and quality of services with healthcare providers [21]. In practice, these markets are interrelated; they depend on each other as the health plans offered to citizens are based on the negotiations for healthcare services.

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

The contracting process is crucial for health insurers to fulfil their legal obligation to provide healthcare for the insured (*zorgplicht*). However, this can be a stringent process. Not only do health insurers find it difficult to negotiate on quality of care [22], there are also powerful bargaining positions at play that hamper the finalisation of contracts and prolong the process [23,24]. This already indicates a complex relation between health insurers and healthcare organisations.

3. Theoretical framework: Stakeholder theory and the salience model

Clarkson defines stakeholders as "voluntary and involuntary risk bearers" [25]. Both banks and health insurers place voluntary stakes and resources in healthcare organisations, whose activities put them at risk. For banks, the stakes and resources at risk are capital investments and short-term credit availability. For health insurers, the stakes and resources at risk concern outsourcing their legal responsibility to provide care for the insured by contracting healthcare services.

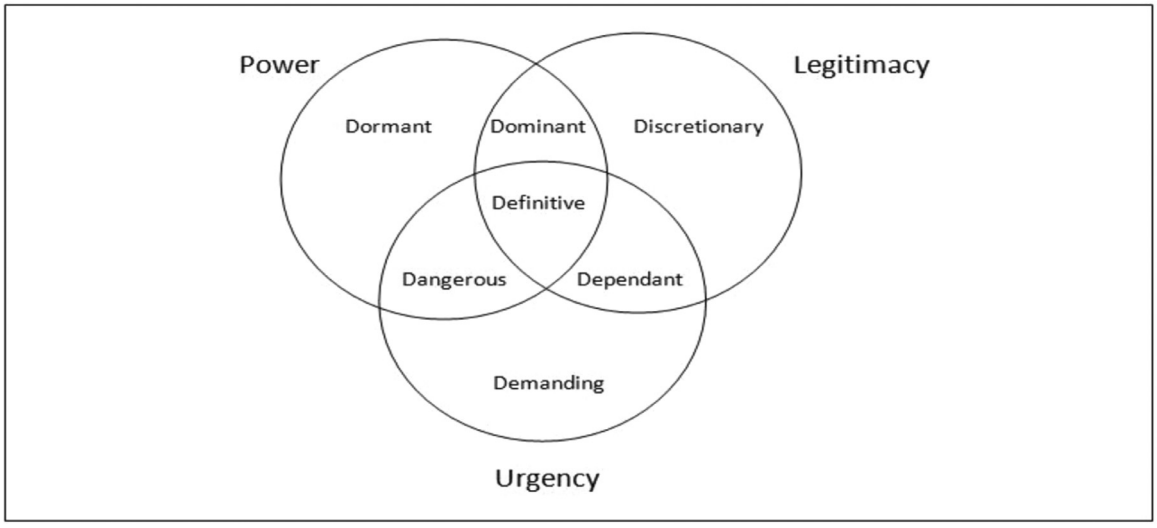

Fig. 1. Salience model as proposed by Mitchell, Agle and Wood (1997).

To better understand the relations between healthcare organisations and banks and between healthcare organisations and health insurers, we use the salience model developed by Mitchell, Agle and Wood [12] (Fig. 1). This model has two functions: it identifies and values stakeholders and describes how salient managers are to these stakeholders. Mitchell et al. define salience as "the degree to which managers give priority to competing stakeholder claims" (p. 854) [12]. Salience has three essential stakeholder attributes: power, legitimacy and urgency. To determine overall salience, managers rate these three attributes for each stakeholder. Thus, besides offering a typology of stakeholders, the model reveals the power, legitimacy and urgency of the stakeholder–manager relationship. Combined, the stakeholder attributes represent different types of stakeholders depending on the presence of either one, two, or three attributes (Fig. 1).

Mitchell et al. defined the three stakeholder attributes as follows (p. 869) [12]: power "as a relationship among social actors in which one social actor (A) can get another social actor (B) to do something that B would not have done otherwise"; legitimacy "as a generalised perception or assumption that the actions of an entity are desirable, proper, or appropriate in some socially constructed system of norms, values, beliefs and definitions" [26]; and urgency "as the degree to which stakeholder claims call for immediate attention." For the power attribute, the overall role of the stakeholder is emphasised, while for legitimacy and urgency the focus is on the actions and claims of that specific stakeholder [26,27]. The main idea behind the model is that the more attributes a stakeholder can employ, the more salient managers will be towards that stakeholder. Over the years, several studies have confirmed the reliability of the model [27-37].

However, there is also criticism. The two main criticisms relevant to this study involve the discrepancy between the method to calculate the degree of stakeholder attributes (on a continuum) and the stakeholder typology (binary), and the lack of context included in the model. The first criticism [26,38] relates to the discrepancy between a model that assumes attributes to be either present or absent and measuring them on a Likert scale continuum [28]. We argue that interpreting stakeholder attributes and typology involves normative judgements, whether a Likert scale or a threshold is used. This is, for example, reflected in the names assigned to the different types of stakeholders (Fig. 1). Results should be interpreted in relation to the context that stakeholders operate in and should be relative to all stakeholders. Therefore, we adopt a rather flexible interpretation of stakeholder typology in contrast to some other authors.

The above argument aligns with the second criticism on the model: its lack of context [26]. Mitchell et al. acknowledged that stakeholder relationships are dynamic, can change over time and can be different in certain situations [12]. However, they do not incorporate this in their model, thereby possibly overlooking important aspects of the relationship between managers and stakeholders. Some authors have tried to incorporate context [28,34,39,40] with no or limited success. We attempt to incorporate context here by looking for differences in outcomes across sectors and in size of the organisation. We added questions on the influence of stakeholders on certain governance areas and interpreted our results in the context of stakeholder roles. This partly resolves the absence of context in the salience model and explains why certain attributes are valued lower or higher than others. Accordingly, we do not consider stakeholder attributes as static and fixed, but rather as a reflection of the institutional context.

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

4. Material and methods

Survey questions

We conducted a survey of healthcare executives to answer the research question. The questions on stakeholder attributes were based on the operationalisation of the salience model proposed by several authors [12,28,31]. We altered the question on legitimacy as suggested by Neville et al. [26]. Other questions in the survey explicated the power attribute in terms of influence on several governance areas of the healthcare organisation. There were also general questions on respondents and their organisation. To min-

imise confusion, the bank was specified as the main bank (*huisbankier*) and the health insurer as the one with whom respondents closed the largest contract for 2018 (see Online Appendix 1 for a complete overview of the survey). Four executives from different sectors tested the survey for clarity and validity. Agle et al. demonstrated the reliability and validity of the model (p. 514) [28] and the questions they proposed and tested form the basis of our survey. We also performed a reliability tests for the composition of salience for banks (Cronbach's Alpha = 0.605[1]) and health insurers (Cronbach's Alpha = .595[1]). Outcomes were slightly higher when legitimacy was deleted as an attribute for salience (respectively 0.746 and 0.714).

Respondents and their organisation

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

To reach respondents, the survey was sent out in collaboration with the Dutch Association of Healthcare Executives (NVZD) at the beginning of 2019. The NVZD is a professional association representing executives in the Dutch healthcare sector. In total, 714 members received an invitation and 308 (43%) respondents began the survey. The exact number of Dutch healthcare executives is not known. The NVZD claim that they represent two-thirds of all Dutch healthcare executives [41][2].

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

Information on participating healthcare executives and their organisations is displayed in Online Appendix 2. A cross table of organisational sector and size can be found in Online Appendix 3. Based on the organisational size of the primary care sector, we believe that this dataset mainly contains regional GP organisations, out-of-hours cooperatives and/or care groups. Overall, characteristics of healthcare executives and their organisations are convincingly representative of the sector as they are similar to available information of the NVZD on their members [41][2] and to previous studies of Dutch healthcare executives [42-44]. Therefore, results from our study population can likely be generalised to the total population of Dutch healthcare executives.

Analysis

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

The three attributes were checked for outliers, but no outliers had a significant influence on the results. Legitimacy had no outliers at all, indicating that healthcare executives have a shared view regarding this attribute. Salience was calculated as the average of all attributes weighted equally. This is in line with earlier research that found a positive relation between the cumulative stakeholder attributes and salience (p. 518, 520) [28,31] .

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

5. Results

Stakeholder attributes

Fig. 2 shows the mean outcomes of stakeholder attributes and salience as perceived by healthcare executives.

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

The exercise of power

There is a considerable difference between banks and health insurers regarding the power attribute (4.3 vs. 7.0). To decompose this attribute and discover where influence is exercised, respondents were asked to indicate the degree of influence on certain governance areas within the organisation (Fig. 3).

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

Stakeholder attributes across sectors and size

For each stakeholder attribute, the differences in outcomes were compared across organisational sector and size. Table 1 reports the significant differences based on one-way ANOVA and Tukey post-hoc tests. Significant differences (p <0.05) for banks were found between types of healthcare organisations on the power attribute ($F(5263) = 4.395$, $p = 0.001$) and between different-sized healthcare organisations regarding the power attribute ($F(5263) = 6.518$, $p = 0.001$) and urgency attribute ($F(5263) = 4.749$, $p = 0.001$). Significant differences (p <0.05) for health insurers were found between types of healthcare organisations on the power attribute ($F(5233) = 2.446$, $p = 0.035$), the legitimacy attribute ($F_{asymp} = 2.706$, df1=5, df2 = 128.48, $p = 0.023$) and the urgency attribute ($F_{asymp} = 4.884$, df1 = 5, df2 = 189.931, $p = 0.001$).

The distinction between groups across sector and size account for contextual factors that are generally overlooked by the salience model. Therefore, the results presented in Table 1 contribute to the understanding and interpretation of the stakeholder attributes. The results for banks show that smaller (EUR < 50 million) healthcare organisations experience both the influence of banks and the ability of banks to pressure claims significantly differently compared with larger (EUR > 151 million) healthcare organisations. The perceived differences for banks between primary care and hospitals,

[1] Reverse-coded for legitimacy attribute.

[2] Source not publicly accessable. Document is available from the corresponding author on request.

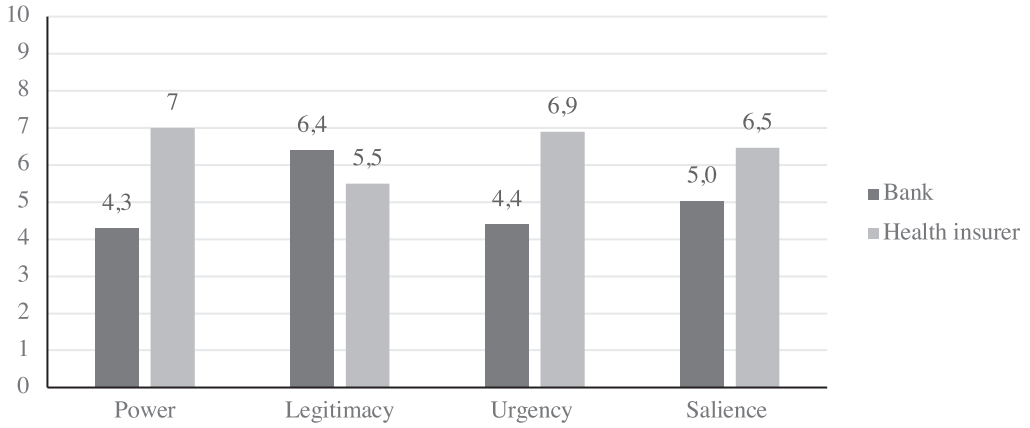

Fig. 2. Healthcare executives' perceptions of mean stakeholder attributes and salience of banks and health insurers.

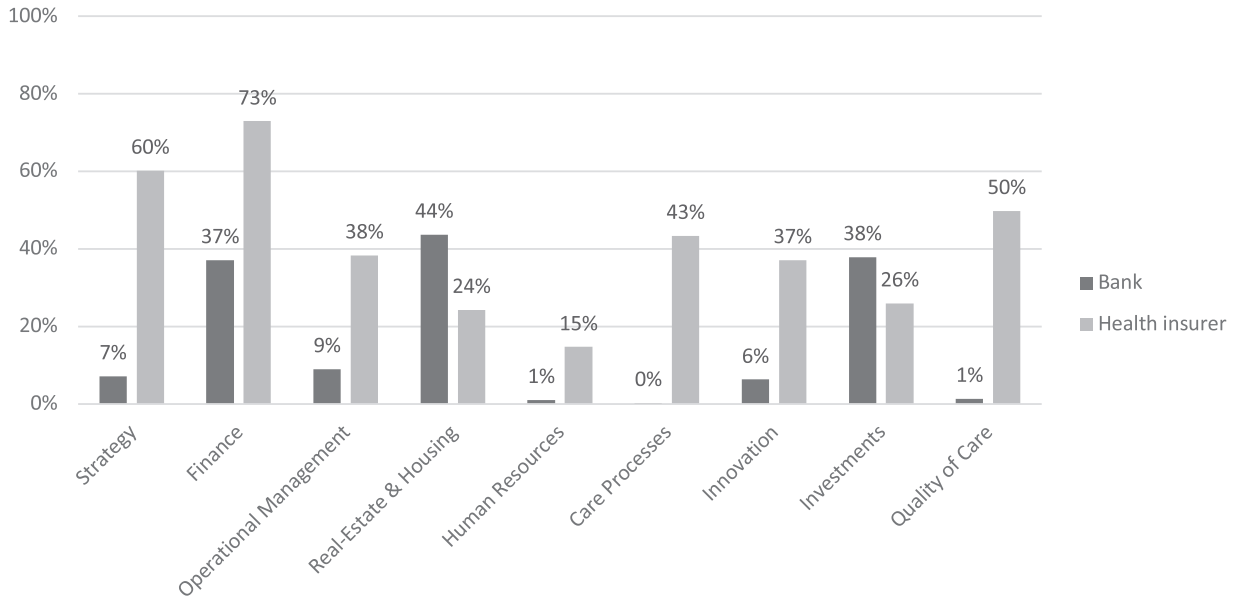

Fig. 3. Healthcare executives' perceptions of the (very) high influence (%) that banks and health insurers have on governance areas in the healthcare organisation.

Table 1
Significant differences between groups for banks and health insurers.

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

mental healthcare and combined healthcare organisations might be related to differences in size. The included primary care organisations all have an annual revenue below 50 million, while hospitals, mental healthcare and combined healthcare organisations have greater revenues (Online Appendix 3).

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

6. Discussion

This research tried to unravel the relationship between Dutch healthcare organisations and two crucial financial stakeholders: banks and health insurers. Our use of the salience model – interpreting results by taking contextual factors into account and by contrasting two financial stakeholders – made it possible to explore the relations in depth using data from a large group of respondents. The first part of the research question focused on the healthcare executives' valuation of the relationship in terms of power, legitimacy and urgency. The results showed that healthcare executives experienced more influence by health insurers than by banks. However, the claims of banks are perceived to be more legitimate than those of health insurers, while the claims of health insurers are more pressing. The results on the salience attribute indicate that healthcare executives prioritise the claims of health insurers over the claims of banks. Furthermore, banks have a clear-cut interest in certain areas of the organisation, which makes them an unambiguous stakeholder. The influence of health insurers is more diverse and diffuse. Based on the stakeholder typology of the salience model (Fig. 1) and considering the relative outcomes and context, healthcare executives perceive banks as 'discretionary' stakeholders and health insurers as 'dangerous' stakeholders.

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

For the valuation of health insurers, we found significant differences between sectors, indicating that sector-specific circumstances are at stake. For instance, the mental healthcare sector not only faced major reforms on the payment structure but also dealt with ongoing struggles regarding reimbursement practices [11]. Regional GP organisations, out-of-hours cooperatives and care groups employ GPs who are open about their dissatisfaction with health insurers, which is in line with our finding on significantly lower legitimacy [24]. In regard to other sectors, differences might be related to the share of health insurer contracts on the total revenue of the organisations.

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

The position of health insurers in relation to healthcare organisations proved to be more complex. Health insurers have a legal obligation to negotiate the price, quantity and quality of healthcare services with healthcare organisations. In line with this, our study shows that health insurers exert a great deal of influence on healthcare organisations that covers both financial aspects and substantive topics (e.g. quality of care). However, healthcare executives are questioning the desirability and appropriateness of this legal obligation. A lack of legitimacy will in most cases obstruct interactions between health insurers and healthcare organisations – as suggested by others [22,23,24]. Altogether, such impediments make negotiations an unsatisfying process from the perspective of healthcare organisations.

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

Strengths & limitations

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

Our study has limitations, especially concerning the survey. It might be possible that multiple executives working for the same organisation are members of the NVZD and have filled in the survey. We believe that this is not very plausible because executives are more likely to consult with one of their board members on who completes a time-consuming survey. Another difficulty might be that our use of legitimacy as 'desirable and appropriate' contains two different aspects. We believe both terms together refer to a situation that is 'ideal' or 'should be' and are not mutually exclusive. They complement each other in the construction of legitimacy by adding a moral characteristic as proposed by Neville et al. [26]. Nevertheless, it could be wise to separate these terms in future surveys or to choose one of the two terms. Finally, additional questions might have provided more specific information on the stakeholders, such as the type of bank (i.e., public or private sector) and the share of health insurer contracts on the total annual revenue.

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

7. Conclusion & recommendations

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

The results show that the role of health insurers in the Netherlands is under pressure. Despite their crucial role in the system, it is questioned whether insurers have sufficient support among healthcare executives. Two recent studies [45,46] have illustrated the danger of low trust in health insurers from the perspective of the insured. Here we show a different threat: the workability of the healthcare system when healthcare executives do not accept health insurers as parties with a legitimate claim. This highlights a broader legitimacy issue for health insurers to resolve on both the health purchasing market and the health insurance market.

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

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Declaration of Competing Interest

None.

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Supplementary materials

Supplementary material associated with this article can be found, in the online version, at doi:10.1016/j.healthpol.2021.05.002.

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