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Choosing cooperation over competition; hospital strategies in response to selective contracting

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Summary

With the introduction of market competition in health care, the Dutch government enabled health insurers to contract hospital care selectively. The assumption is that "selective contracting" will stimulate efficiency, effectiveness, and innovation and will diminish overcapacity. In 2010, the first Dutch health insurers started experimenting with "selective contracting" by setting a minimum treatment volume per year for complex treatments. In an explorative, multiple case study among 15 hospitals in five regions, we found that instead of competing, hospitals started to cooperate and strengthen their networks. The government intended to remove redundant hospital capacity and improve quality by stimulating specialization and concentration. Our study showed that specialization was indeed stimulated, which may have increased quality of care. However, facilitated by the absence of a countervailing power (government or insurer), hospitals in our cases negotiated to the effect of preserving hospital capacity. Within the current political debate between supporters of competition and advocates of a national health service, the importance and role of the (medical) networks should be taken into account. Otherwise, the outcomes of health care governance will be different than intended by either party.

KEYWORDS

competition, governance, hospitals, network, selective contracting

1 | INTRODUCTION

As is the case for many western countries, the Netherlands has been implementing health system adjustments, which more heavily rely on competitive forces and incentives. This holds particularly true for hospital care, where a new governance structure called "regulated competition" is taking shape after 20 years of political discussion and 10 years of designing and implementing new institutions.[1] The regulated competition for hospital care takes shape on a market where health insurers are empowered to select hospitals based on quality and price, and negotiate volumes and prices with the selected hospitals. The Dutch government believes this better ensures universal access to affordable care of good quality.[2] The market design chosen by the government assumes that "selective contracting" of health care providers will stimulate efficiency, effectiveness, and innovation and will reduce overcapacity.[3] This study looks at the strategic responds of Dutch health care providers to the introduction of "selective contracting".

Selective contracting has become possible since 2006, with the introduction of the Dutch version of a DRG reimbursement system.[4] Since then, health insurers were free to negotiate prices starting with 10% of the budget of hospitals in 2006 to 35% in 2010. Health insurers play an important role in the new market-oriented policy, as they became prudent buyers of care on behalf of their enrollees. Selective contracting in regulated competition enables insurers to not contract hospitals, which are not competitive on price or quality. Selective contracting is therefore expected to stimulate competition between care providers, to the effect that only the best providers stay in business.[3] Dutch health insurers have however been (and remain) reluctant to implement it in fear of problems with enrollees.[5] In 2010, the first Dutch health insurer started experimenting with "selective contracting" of breast cancer treatment by setting a minimum treatment volume per year for hospitals to be contracted. Although the underlying assumptions about its positive effects were debated by health scientists.[6] From 2011, more health insurers followed with selective contracting for specific complex treatments. These minimum treatment volumes were all based on norms developed by Dutch professional associations and especially focused on high complex, low volume treatments such as oncological surgery of esophagus, pancreas, gastro-enterology, lungs, head, and neck etcetera.

In this study, we are taking a closer look at how Dutch hospitals and medical doctors actually responded to these treatment volumes. What strategic actions did they take to reach these volume norms? Also, how did that affect the governance structure of the Dutch Health care system? This paper will address these questions by presenting the results of a multiple case study in five regions in the Netherlands.

Seen from a "strategy-as-practice" lens, this study is about "doing strategy", about what strategy hospitals execute, and how they execute it.[7] Strategizing comprises actions, interactions, and negotiations of multiple actors and the situated practices that they draw upon in accomplishing that activity.[8] In our cases, strategies of hospitals are understood in the context of the interaction between government regulation and the strategic responses in the "triad" of hospitals, medical doctors, and health insurers. In his classic paper, Selznick[9] states that the first imperative for organizations is "*The security of the organization as a whole in relation to social forces in its environment*". The choice of strategy, defined, as "the long-term direction of an organization",[10] is crucial to their survival and growth. Strategy concerns suitable decisions about products, markets, and their combinations.[11,12]

The strategic options available to organizations are influenced by the prevailing governance structure. Governance can be defined as "*the processes of interaction and decision-making among the actors involved in a collective problem that lead to the creation, reinforcement, or reproduction of social norms and institutions*".[13] A sector can, ideal typically, be governed by hierarchy, market, and network.[14] In countries where health care is governed by *hierarchy*, governmental organizations issue regulations that individuals and organizations are supposed to comply with. Compliance strategies of organizations include judicial proceedings, agency hearings, and noncompliance.[15] Where health care is governed by *markets*, competition is leading, driven by (self-interested) actions of autonomous competing individuals and organizations. Actors in the market are independent in setting goals, making choices and taking actions mostly driven by their efforts to optimize market position.[14] Finally, governance by *networks* is based on cooperation between the actors. Governance takes shape by means of interdependency of the actors, mutual benefit, reciprocity, and relations based on trust. Trust can be defined as an actor's expectation that another actor will not act

opportunistically.[16] Within a network, it is crucial that there are positive results for each actor.[17] Identification of prevailing governance structures is difficult not only because of their ideal typical character, but also because in practice governance structures of health care systems are usually mixed.[18,19]

2 | METHODS

This explorative study is designed as a qualitative multiple case study. Five regions in the Netherlands were selected for this study. First, an internet search was performed to identify how hospitals in different regions respond to the volume norms. This revealed that especially top-clinical hospitals were taking the initiative and were cooperating with small regional hospitals to organize concentration of treatments. In the Netherlands, top-clinical hospitals are large hospitals, specialized in complex treatments (eg, cancer, organ transplantation, IVF).[20]

Next, in different parts of the Netherlands, three top-clinical and two regional hospitals were asked to participate. If a hospital agreed, we also contacted all the other hospitals in the area involved in the concentration of treatments. After all hospitals in five such regions agreed to participate (none refused), inclusion stopped. In these five regions, spread over the Netherlands, 15 hospitals participated in this study, out of 91 hospitals in total in the Netherlands.[21]

Data collection focused on a reconstruction of the decision-making processes in each region concerning concentration of care. Data collection started by collecting and studying private and publicly available documents in each region to get acquainted with the relevant decision-making processes and to identify relevant stakeholders, but also national documents were studied to be able to reconstruct governmental involvement in the concentration process. Next, half-structured interviews were done with representatives from each participating hospital involved in the concentration process: upper and middle managers (25) and medical specialists (18).

In addition, representatives from the health insurer with the largest market share in each region were interviewed (10). In total, 53 interviews were done. All interviews were structured and guided by a topic list focussing on motives for concentration, hospital strategies, partner choices, decision processes including implementation, and possible outcomes. The interviews were recorded and transcribed. The researchers deductively analyzed each interview and document using "motives for concentration, hospital strategies, partner choices, decision processes, outcomes" as sensitizing concepts to identify relevant themes for each region. Based on these analyses, case descriptions were made for each case with a reconstruction of the decision-making process and a thematic description. These case descriptions were used to compare cases and develop our final analyses.

3 | RESULTS

3.1 | Hospital strategies

All included hospitals perceived selective contracting as a threat to their portfolios. Even though insurers did not use minimum treatment volumes until 2010, each of the hospitals was working on a strategic protective response as early as 2008. Hospitals had been informed early and were already expecting insurers to start contracting selectively. As one health insurer stated:

> *So, a process was set in motion in which all sorts of parties, specialists, hospital boards, started to talk to people to make sure they were going to reach these minimum treatment volumes. We have clearly stated, this is the norm, we follow this norm and if you are not able to reach this norm in the future, at some stage we're not going to give you a contract.*

Especially top-clinical hospitals with their many high complex/low volume treatments became convinced that this was a real threat to their portfolios and their strategic position. They proactively developed new strategies to counter this threat. The strategic responses were either initiated by the board of directors (case 3) or by medical

specialists, in our cases especially surgeons (case 1, 2, 4, and 5). At the start, other stakeholders such as insurers, patient organizations, nurses, or municipalities were not involved.

In theory, the initiators had several strategic options. They could simply comply and stop treatments for which they did not reach the threshold, try to enlarge their volume by increasing their market share, or seek cooperation with other hospitals. However, compliance might weaken their competitive position. Especially smaller regional hospitals feared not to survive if minimum treatment volumes norms were implemented. Competition was often not considered a viable option either, as Dutch patients and GPs are very loyal to the hospital in their catchment area. One director perceived hospitals as monopolies:

> *Autonomous growth or expansion of your domain is problematic. It is not like there is nothing out there; each domain is stuck to another. These are all monopolies standing back to back. Therefore, one has to find another solution.*

Hospitals viewed these volume norms as an external pressure they needed to deal with to survive or strengthen their position. All hospitals opted for the strategic response of regional cooperation. The top-clinical hospitals, for instance, chose to cooperate for the reason of continuing growth. A director said:

> *They (top-clinical hospital) also realized that they would not be able to keep all top clinical treatments. To this end, they would need to extend their reach to a bigger area of clients. It is much easier to reach this based on cooperation than on (the basis of) competition.*

Interestingly, none of the actors in our cases refers to the governmental goals of accessibility, quality improvement, and cost containment. They doubt if the volume norms are instrumental to realizing all of these goals, especially cost containment. While cost containment is seen as the primary motive of the government for stimulating concentration of treatments. None of the cases evaluated the results in terms of formal governmental goals. As one of the surgeons said:

> *The whole discussion about concentration is a financial issue, which may lead to quality improvement (...). The new minister wanted to talk about quality, not money. So now, we're talking about quality, but mean money.*

In addition, a director stated:

> *Concentration is supposed to solve our cost issues. That is really not going to happen; they are pushing the wrong buttons.*

In our data, two types of cooperative strategies emerge: exchange and integration (Table 1). In two of our cases hospitals decided to exchange treatments for which they had difficulty reaching the (future) threshold. In case 1, two hospitals exchanged oncological surgery of esophagus and pancreas. They developed protocols for referral and made plans for increased oncological cooperation. As one of the surgeons remarked:

> *... it resembles horse-trading, you give something away, but you also get something in return.*

In case 4, a more complex exchange emerged between three hospitals for several types of oncological surgery for gastro-enterology, lungs, head, and neck. Each hospital protected their core competencies,[9] the treatments in which they had invested most in terms of knowledge and money, felt most competent, and/or fitted a preferred profile.

> *We will give you the esophagus and pancreas; in return, we would like gastric surgery. We would like to keep that specialism because it fits our reflux, stomach and bariatric profile.*

Again, the three partners developed referral protocols, but also formalized their agreements in a covenant (Table 1).

TABLE 1 Summary of strategic characteristics of the five cases (*N* = 53 interviews)

	Region	Partners	Contract	Trends
1	**S**outh	Two top clinical	Exchange oncologic-treatments	**Deepening:** Health paths, consultate **expanding:** Plan cooperation
2	**C**entral east	One top clinical three regional	Central and satellite services/vascular care	**Deepening:** Health paths **expanding:** More surgical subspecialties. Forming regional partnerships
3	**W**est	One top clinical three regional	Concentration IC level 3 IC - satellites	**Deepening:** Protocols IC exchanging staff. **Expanding:** Oncological surgery education IC-nurses **formalizing:** Cooperation
4	Central east	One top clinical one regional	Centralized and satellite nephrology	**Expanding:** Plan lung treatment urology, clinical geriatrics. **Deepening:** Protocols, exchanging staff
5	**E**ast	One top clinical two regional	Exchange sub specialisms lung, gastroenterology and head/neck surgery	**Deepening:** Protocols **formalizing:** Joint venture

In the other cases, hospitals developed an integration strategy. In case 2 and 3, a top-clinical hospital cooperated with several regional hospitals. Although still independent, the regional hospitals started working as satellites for the larger top -clinical hospital, by sending their patients for treatment. A director of a top-clinical hospital said:

> *We were already looking for a sort of satellites with whom we could develop an intensified form of cooperation and the dialyses (the treatment for which the threshold was introduced) was basically a means to an end.*

For the regional hospitals, the "deal" is also attractive because when possible, the patient is sent back to the same regional hospital for the (separately reimbursed) additional treatment or follow-up. As a satellite, they enjoy more protection to the dangers of redundancy, but keep their autonomy. A director of a regional hospital stated:

> *We quickly realized that we were not going to make it with current marked developments. Even though we are a large hospital, relatively speaking. (..) That is when you think: whatever happens, we need a top-clinical hospital as a partner.*

So, these strategies allow the top clinical hospitals to grow and the regional hospitals to survive. Interestingly, in the arrangements pre-operative and post-operative care for (their) patients is still done in the same hospitals, which also means that they still are paid for these patients. These are still "their" patients. That is why the arrangements resembles outsourcing[22]; regional hospitals refer their high complex/low volume treatments to the top-clinical hospitals and get a strong partner in return that has enough power to protect them. Part of this protection can involve sharing knowledge and resources and collective purchasing.

The integration of these regional networks did not stop with collaboration on treatments for which volume norms were introduced. Even though our data collection only stretches a 2-year period, we witnessed a dynamic collection of plans and initiatives to increase coordination.[23] Increased inter organizational coordination is observed in several ways: expanding cooperation into other treatments and disciplines, deepening their agreement by guidelines and protocols, and formalizing their agreements into contracts (see Table 1). In four out of our five cases, respondents explicitly stated that they were planning to expand their cooperation. First to treatments with minimum treatment volume, but preferably also to other low volume/high risk treatments as well. In one region, the medical specialists even were developing a regional partnership between all involved surgeons, so they could circulate between hospitals and each individual surgeon would be able to reach the minimum treatment volumes. For one part, further integration was directly related to the efforts of these initiatives to deal with the volume norms, for instance because of the need to develop protocols to regulate patient transfers between hospitals. However, for another part

integration also expanded to other areas, as a result of intensified inter organizational interactions and development of mutual trust.

Because of these cooperative strategies, the role of Antitrust Authorities is potentially relevant. They are the designated "watchdog" of the new market system, authorized to forbid cooperation between organizations in health care if it offsets market competition by introducing monopolies. Although the Antitrust Authorities studied many hospital merger plans until recently they did not block any of them,[24] as they saw no negative consequences for market competition. Moreover, by choosing to cooperate by way of referral, hospitals felt free to engage in cooperative strategies.

3.2 | Strategy development process

Our cases contain rich data that give insight in the way the strategies "have been made".[25] The analysis shows that these hospitals focus on cooperative strategies. Nevertheless, how are partners selected? In general, the corresponding process of "courting" is crucial but may be a very complex subject.[26] As in personal life, finding the "right" partner asks for search and tryouts. In our data, we notice the strong tendency to search in "embedded" relationships.[27] Partner choices were based on existing relationships in networks of medical professionals or managers. As one of the medical doctors explained:

> *One needs to get along, there has to be a good personal relationship. That is a precondition for cooperation. Doctors will only cooperate with doctors they trust.*

A board member said:

> *Outsiders can create pressure by setting norms and standards; for example minimum treatment volumes. But when it comes to choosing a partner, one chooses the one with whom one feels most connected.*

Importantly, health insurers are practically absent in the strategy development processes we studied. This is remarkable as health insurers have great interest in restructuring the regional "hospital landscape", in their newly acquired capacity of purchasers in the new system of "regulated competition". As one of the board members said:

> *When we initiated our cooperation, we did not speak about it with the insurers. We needed to do this ourselves. At a certain moment, we contacted them and said: this is what we are planning to do.*

It seems that most insurers were not that keen on being involved; they appreciated the fact that there are now norms they can use for contracting hospital care, basically set by the professional organizations themselves, and if the other parties are working on that, they were satisfied. As a representative of one of the insurers said:

> *The interest of the insurer is secondary to the quality aspect. We see that some surgeries are being performed sub optimally. We want to optimize quality and costs.*

The next question is how relationships between actors and stakeholders develop and establish. Our cases show some interesting patterns. First, CEOs and the boards of medical specialists succeed in making a *dominant coalition*, and in keeping health insurers at a distance from strategic decision making even when health insurers can be seen as (key-) stakeholders.[28] This pattern is remarkable against the backdrop of the traditional distrust between medical doctors and CEOs and persistent failure to integrate medical specialists into the hospitals.[29]

Second, the decision-making processes to develop these cooperative strategies often started as *informal meetings* between small groups of initiators from the participating organizations: senior doctors and/or board members. These initiators typically met in informal settings with an open agenda. In case 3, for example, meetings were organized at a holiday home of one of the board members. In order to prevent opposition during this early stage, these meetings were mostly kept secret. Only after general agreement was reached, other stakeholders were involved, mostly rank and file medical specialists. Again, much time was taken to discuss mutual interests and shared ideas. One of the

initiators said that they were careful not to try and roll out a pre-set plan for the other stakeholders, to further develop the cooperation together. As one of the board members said:

> *The conviction has been that the strategy develops during the process. If one wants to develop the strategy in advance and share it, nothing will happen. There are people who will tell you to make a blue print. But, these will mostly not get executed. It takes a lot of time and discussion; that is not something one should want.*

Third, the negotiations strongly reflect *win-win objectives* of the parties. For the sake of success, they prudently take care of the positive balance of profits and losses for every participant, otherwise negotiators might fear protesting rank and file. As one of the directors of a small general hospital stated about his talks with a larger top clinic hospital:

> *A precondition was mutuality; because if I want to involve my doctors knowing that the other party would get all the benefits, they would say no.*

Interactions of CEOs and medical specialists predominantly take place in mutual trust and informality. Sometimes, as in case 2, even in well-organized secrecy. CEOs and doctors take great pains to fly their strategic endeavor "under the radar" of health insurers and authorities. Predominance of trust and informality in interactions of CEOs and doctors can also be recognized in the absence of business tools in the decision-making process. Only if external stakeholders were involved in strategic decision making (banking) demanding benchmarking and business cases and risk analyses, management tools are practiced.

4 | CONCLUSION

With the introduction of market competition in health care, the Dutch government enabled health insurers to contract hospital care selectively. The assumption is that "selective contracting" will stimulate competition between hospitals. Dutch health insurers started experimenting with "selective contracting" by demanding a minimum treatment volume per year for hospitals to be contracted. Our case studies reveal that hospitals adopted a different strategic response than expected. All studied hospitals chose cooperative strategies instead of competition to protect their portfolios. Whereas they initially perceived the new policy as a threat to their portfolios, hospitals began to use minimum treatment "volumes" as a route to strengthen their strategic positions. These strategies allowed the top clinical hospitals to grow and the regional hospitals to survive. The strategic decision-making processes reflect typical network characteristics: dependence on embedded relationships, trust, informality, and focus on win-win objectives of the partners.[17] The integration of these regional networks did not stop with collaboration on treatments for which volume norms were expected or introduced, but also extended to other arears.

Our study underlines the relevance of network governance in the regulation of Dutch hospital care. The government assumed selective contracting would stimulate competition, leading to more efficiency, effectiveness, innovation, and also a reduction of overcapacity. Our study showed that competition did not increase, instead hospitals started to cooperate more. However, this did result in more specialization. Mesman et al showed that as a result of these volume norms the number of low volume hospitals performing complex surgeries in the Netherlands has decreased. Literature suggests that this may lead to improved outcomes.[30] Our study, however, questions if it will also lead to more efficiency and a reduction of overcapacity. Hospitals in our cases choose to negotiate with each other in a clear win-win spirit, to the effect of preserving hospital capacity, and preserving their own continuity. Many stand-alone hospitals cannot survive without belonging to larger networks, as they seem to be too small to deliver health care conforming to modern standards of quality and costs. That is why the network is strengthened.[31] As a result, inefficiencies seem to have been preserved in these hospitals, although there maybe efficiencies of scope.

5 | DISCUSSION

This study has some limitations. First of all, we mention the case selection. We started with a web-search to get an indication of how hospitals respond to the minimum treatment volume. However, we lacked an overview of all strategies used. That is why we could not select regions based on these strategies. We therefore randomly selected cases spread over the Netherlands. Also, we only selected hospitals that were actively taking steps in concentrating treatments. Our cases therefore do not represent all hospitals in the Netherlands. However, 15 hospitals out of 91 hospitals were part of our study. Second, we asked our respondents to reconstruct a decision-making process that stretched over several years. We cannot be sure that all their recollections are accurate. However, we tried to verify our findings by using different respondents and data sources (documents and interviews). Third, our research focused on high complex, low volume treatments, as the volume norms were only for these treatments. It may be that especially for these treatments network relations are strong and important, as doctors need to share knowledge and consult each other. That may be different for routine, low complex, high volume treatments.

The current policy debate mostly considers two options for system regulation,[32] which are market versus hierarchy. As our study reveals however, especially in health care, network governance plays an important part, as professionals are characterized by the fact that they operate in networks, which may be more important for them than their employer organizations.[33] Our study shows that these networks play a dominant role in the strategic responses of hospitals to market design changes. The introduction of selective contracting by minimum volume treatments in the Netherlands did not increase competition between hospitals, but rather pacified it, as it was adapted within existing networks.

After the introduction of minimum volume standards in the Netherlands, the increasing surgical volume is achieved for several high-risk surgeries after collaborating of surgeons by concentrating surgeries in a limited number of Dutch hospitals.[30] Concentration is expected to result in better quality and higher efficiency for these health products. However, it also leads to fewer hospitals offering these services, giving them a stronger position. Therefore, this may undermine competition. On the other hand, hospitals can compete and insurers negotiate not only on these specific products, but also on the complete case-mix of products of a hospital. One could also argue that a hospital needs excess capacity to be able to compete, and reducing overcapacity may undermine its position on the health care market. However, as overcapacity also implies unnecessary costs, the regulated competition incentivizes hospitals to avoid (wasteful) overcapacity and incentivizes insurers to identify and eliminate costly overcapacity. Insurers therefore indeed continuously seek to drive total volumes and total turnover down, while being respectful of the capacity needed to provide timely and high quality services for their patients. Moreover, hospitals balance cost of overcapacity with the capability to accommodate expansion when possible. It is within these forces, that hospitals organize themselves and form networks, to reduce their exposure to the risks of the market.

However, why did Dutch health insurers not simply pay less to reduce inefficiencies and overcapacity? That is because there are several dependencies within the Dutch system. First, as was already mentioned, insurers negotiate not only on these specific products, but also on the complete case-mix of products of a hospital. Insurers are therefore reluctant to push too hard on the products with a minimum volume, to prevent difficult negotiations on the much larger volume and monetary value of the remaining products.[34,35] Second, insurers are also dependent on these hospitals, as they have a duty to provide care for their enrollees. On the short term, it is possible to reallocate some products and clients to other hospitals in the area, but only to a certain extent. Path dependencies[36] restrict the flexibility they have to reallocate capacity. Third, it is not so easy for health insurers to identify the amount of overcapacity, as capacities are or can also be used for other processes. They need the help of the hospitals to label this excess in capacity. Therefore, to reap the benefits of this type of selective contracting in terms of costs requires a strategic, long-term view of insurers on purchasing, while most insurers still have a short-term focus.

So what lessons can be drawn for the future? Our study shows that network governance plays an important part in the health system. It has positive effects on quality of care, but in our view, the government and health

insurers need to play an active role as countervailing powers for these networks. Our study showed that Dutch insurers chose not to participate and/or allowed not to be involved in the strategy processes following the introduction of minimum treatment volume. Providers in our cases showed distrust in health insurers, that is why they wanted to keep them at a distance. It seems that at least for these complex treatments, market relationships mostly exist between insurers and providers, while between providers network relations prevail. Although positive results came out of these network relations, the distance of insurers from these strategic issues is untenable, because they also represent important values (eg, cost-effectiveness), which were not taken into consideration. Until recently, Dutch Insurers typically adopted a short-term, transactional focus on procurement, where agreements were renegotiated yearly with individual hospitals in terms of price multiplied by volume. Long-term perspectives, innovation, organizational learning, and customer value of hospitals played a minor role at best. This seems to have a negative effect on trust relations between insurers and providers; it fuels the perception of providers that insurers are opportunistic.[5] As an alternative strategy, insurers could also develop a long-term regional strategy, which guides their negotiations with individual hospitals. However, for some treatments also negations with networks of hospitals is worthwhile, focusing on increasing customer value, and not just costs. Although in this process, it is not easy to overcome the reluctance between these parties[37]; it serves the value for patients the best. Very recently, a Dutch insurer (Menzis[38]) stated that from 2018 on they would focus on value-based procurement based on multiple-year contracts with providers.

To reduce hospital capacity, the Dutch government can also play a part. The Dutch government is currently reluctant to set rules and regulations, afraid of losing the support of the parties concerned. The government still assumes that by making agreements based on quality improvement, cost-effectiveness will follow. But our study shows that if it is not in the interest of all parties concerned this will not happen. The Dutch government needs to watch over the balance between profits and losses for each stakeholder. Within organizations, it is for example very common to redirect a part of budget cuts to budget holders, allowing them to spend it for quality improvement or innovation.

Finally, within the current political debate between supporters of competition and advocates of a national health service, the importance and role of the (medical) networks should be taken into account. Otherwise, the outcomes of health care governance will be different than intended by either party.

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ETHICAL APPROVAL AND CONSENT TO PARTICIPATE

Our study was outside the scope of the Netherlands' Medical Research Involving Human Subjects Act because it did not concern “medical/scientific research” about illness and health, nor did the content or methods cause “an infringement of the physical and/or psychological integrity” of the participants (source: Your research: does it fall under the WMO. Available at: http://www.ccmo.nl/en/your-research-does-it-fall-under-the-wmo). Therefore, according to Dutch law, no formal ethical approval was needed. Verbal informed consent was obtained from all participants. Potential respondents were informed about the content of the interviews as well as the purposes of the study. All participants agreed to participate voluntary and they were free to quit at any time during the research.

CONFLICT OF INTEREST

The authors have no competing interests.

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