Accelerating the Implementation of Value-Based Health Care

How Professionals in the Medical Field Negotiate the Implementation in their Working Context

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ABSTRACT
The Dutch Health Care landscape is transitioning to provide Value-Based Health Care (VBHC), which centres around the patient. Several challenges obstruct the implementation of VBHC, causing it to evolve slowly. To achieve implementation, new mindsets and collaborations are required. Agreements are being established through negotiation. This study explores how professionals in the medical field negotiate in the implementation of VBHC. The study revealed that they do not perceive to negotiate. However, three communication styles to convince were mentioned. Additionally, peers could speed up the implementation of VBHC by acting as ambassadors to create a shared mindset in 'Value Networks'.

Keywords
Negotiation; Value-Based Health Care;
Convincement; Communication; Value Networks.

INTRODUCTION
Dutch Health Care finds itself in a transition towards Value-Based Health Care (VBHC). This new discipline is a response to the demand for high-quality care while simultaneously having to reduce costs (Tersago & Visnjic, 2011). VBHC centres around the patient and providing them with valuable services (Porter & Lee, 2013; Porter & Teisberg, 2006).

Challenges in the Implementation of VBHC
The implementation of VBHC is obstructed by several challenges. Two of these challenges are that metrics to assess value are missing (SIEMENS Healthineers, 2015) and the reforms in care delivery and payment are unaligned, resulting in financial pains (Lee & Kaiser, 2015). This increases the current scarcity in care budget. Furthermore, there are opposing views about how change is achieved, whether it is initiated by individuals or by organisations (Beer, Eisenstat & Spector, n.d.). These challenges could hamper professionals working in the medical field to explore and implement value-based care approaches besides their daily activities (Stoimenova & De Lille, 2017).

Another challenge to provide a value-based care service is that organisations need to establish new multi-stakeholder collaborations to follow the needs of the patient. Currently, the fragmentation in the health care sector (Lee & Kaiser, 2015) results in unaligned interests among stakeholders. As a consequence, the implementation of VBHC is evolving slowly, which is not in favour of the patient.

Due to the aforementioned challenges, stakeholders may not be aligned in their views on the implementation of VBHC. Therefore, they need to negotiate about the relevance and practical implications of VBHC and each other's roles in the implementation. Negotiation is a process by which two or more parties with unaligned interests try to establish agreement about an issue (Pruitt, 1981).

Objective of the Study
Thus, negotiations about the implementation of VBHC are needed, both in and across organisations, to accelerate the transition. The objective of this study is to explore how professionals in the Netherlands negotiate in the implementation of VBHC in their own medical working context.

The study is relevant in multiple ways. First, to explore how the implementation of VBHC can be speeded up by supporting professionals in their negotiation process. Second, by creating awareness of how and why medical professionals negotiate in the implementation of VBHC. Finally, by demonstrating how design can spark reflection and dialogue among professionals and encourage them to define a common action plan towards VBHC. With these results, professionals and design researchers in the medical field can join efforts to realise the transition towards VBHC.

Therefore, this paper contributes by gaining understanding about how professionals in the medical field negotiate to implement VBHC, and how they can be facilitated to accelerate the implementation. With this research, we answer the question: *'How do professionals in the medical field negotiate in the implementation of Value-Based Health Care?'*

LITERATURE REVIEW
The current health care system is unsustainable as delivering care is too expensive and it is not future proof (Lee & Kaiser, 2015). This generates pressure on the system. This pressure will increase even more

with the current health trends, such as the ageing population and the increase in the prevalence of lifestyle diseases (Tersago & Visnjic, 2011).
Next, to this, health care is growing its repertoire of services, while at the same time broadening its scope to deliver both curative and preventive care (Tersago & Visnjic, 2011). These situations create the challenge of providing high-quality care while managing increasing costs.

Transitioning towards Value-Based Health Care
Due to this challenge, the transition into Value-Based Health Care (Burghard, 2019; Porter & Lee, 2013; Porter & Teisberg, 2006) seems inevitable. VBHC centres around the patient by providing the most valuable service, at the lowest cost (Tersago & Visnjic, 2011; Porter & Lee, 2013).

More specifically, the transition implies paying for value instead of volume (Gleason & Bohn, 2017). For example, in a cancer surgery, the tissue will be analysed looking for cancer cells; if more cancer cells are found during the surgery, the tissue could be immediately removed. As a result, a single surgery fulfils, whilst this was traditionally spread over two separate surgeries. Having a single surgery offers value for the patient as anaesthesia and possible concerns for surgery are reduced.

According to Philips, four pillars are needed to realise the transition into VBHC (Philips Future Health Index, 2018). The pillars are 'data and health informatics', 'benchmarking', 'incentives and payments' and 'change management'. Respectively, they stand for sharing data, identify best practices systematically, incentivize prevention and increase the levels of integration and collaboration. In change management, it is relevant to detect the new roles needed and the new organizational structures in the health care context (Philips Future Health Index, 2018). This study focusses on change management and develop an understanding of the interactions among professionals in the implementation of VBHC.

Restrictions in the Implementation of VBHC
However, several constraints are withholding organizations to implement VBHC (Lee & Kaiser, 2015). The main difficulties lay in the lack of validated methods to measure value (SIEMENS Healthineers, 2015) and the financial short-term pains that have to be overcome. Financial pain may be the result when care delivery and payment reform are not aligned. To go back to the example of having a single surgery to provide value to the patient, the hospitals may experience financial pains if the payment system is not adapted and pays them for the number of treatments, which is reduced in the example.

Furthermore, there are opposing views on who is responsible for the transition into VBHC; whether employees individually should be responsible or the organisations should take the first step. Some believe that change starts with individuals, whilst others imply that the organisational context should change first and individuals will change their roles, collaborations and attitudes accordingly (Beer, Eisenstat & Spector, n.d.).

Additionally, another problem to achieve integration and collaboration between stakeholders is the fragmentation in the health care sector (Lee & Kaiser, 2015). Integrating the delivery of care could help to eliminate the duplication of services (Lee & Kaiser, 2015) within organizations and also amongst institutions. The system is formed by multiple stakeholders and the transition requires collaboration between individuals within and across organizations. Therefore, it is necessary to collaborate and enhance today's fragmented system to provide more value for the patient (Lee & Kaiser, 2015).

Ambidextrous Behaviour in Transitions
These new collaborations, and other approaches to implement VBHC, demand changes in how individuals work. Care providers need to combine their daily work, referred to as exploitation, with an exploration of VBHC approaches to ensure its future viability. This dual combination of exploitation and exploration is known as ambidexterity and may result in tensions and conflicts (Tushman & O'Reilly, 1996). In the context of health care, this ambidextrous behaviour is observed in organizations that pursue quality and value improvement while still aiming for cost optimization. However, this exploration of value-based approaches is seen as distant, uncertain and ambiguous in connection to the current context (Stoimenova & De Lille, 2017).

'Contextual ambidexterity' looks at how individuals can be supported to balance their time between exploitation and exploration. To achieve this, a supportive organization is required that provides discipline and trust (Stoimenova & De Lille, 2017). People are influenced by the context they are working in and are therefore not fully able to achieve a balance on their own. As a result, implementation of ambidexterity remains to be problematic (Oehmichen et al., 2016), also for the implementation of VBHC. For example, a nurse may not be able to provide the care that she would like to deliver as she is constrained by procedures and time-pressure. Stoimenova and De Lille (2017) suggest addressing ambidexterity via design. Three challenges for organisations are mentioned, being 'mindset', 'infrastructure' and 'methods'. These challenges are

considered to be interconnected. To create change, people need to unlearn 'old-school' practises (Carlgren et al., 2016), such as traditional ways of providing care that is not value-based. Design methods, such as ideation and user research could be used to establish a shared mindset in care organisations to be patient-centred and be open to value-based care alternatives. When the 'VBHC mindset' is shared in the organisation, improvements in infrastructure and resources, such as money and manpower, are expected (Stoimenova & De Lille, 2017). This infrastructure contributes to implementing VBHC by providing facilities. Besides internal use, design-led ambidexterity could also be applied in care networks to develop a shared mindset and supportive infrastructure in collaborations.

Collaboration and Shared Value Creation

In these care networks, each stakeholder has their own role in building the foundations for VBHC (Hood & Friend, 2011), but at the same time, they all need to collaborate to create value. Their aim is to enhance their mutual benefits, also referred to as 'Shared Value Creation' (Porter & Kramer, 2011). In order to create value collaboratively, stakeholders need a shared mindset, which will result in more efficient value creation. The benefits of a shared mindset are reducing costs, increase in ownership and promoting stakeholders to take action (Ulrich, 2002). Once the mindset is implemented on a daily basis, collaborative processes are improved (Stoimenova & De Lille, 2017).

In Shared Value Creation, values are created collaboratively in interactive configurations of mutual exchange (Vargo, Maglio & Archpru, 2008). These interactions result in dynamic 'Value Networks' with interconnected stakeholders (Bocken, et al, 2013). Value Networks are essential for knowledge exchange and collaboration in organizations and also externally (Allee, 2000). The presence of mutual understanding is present in Value Networks, facilitates the generation of agreements between the stakeholders involved.

Negotiation Styles

These agreements are being established by negotiating. In this study, we are interested in the way different medical professionals negotiate in the implementation of VBHC. Negotiation is a process by which two or more parties with unaligned interests try to establish agreement about one or multiple issues, and therefore create a shared mindset (Pruitt, 1981). This process is characterised by verbalising the opposing demands, making concessions and exploring alternatives (Pruitt, 1981). Professionals in the medical field, need to negotiate with patients, colleagues and other stakeholders to provide the care with the most value for the patient in relation to the limited resources (Clay-Williams et al., 2018). Therefore, negotiation is stated to be one of the five components of the health care culture (Frankel, Haraden, Federico & Lenoci-Edwards, 2017).

To establish an agreement, the way of negotiating is tailored to what the other person finds convincing (Hyland, n.d.). In this study, different negotiation styles (see Table 1) are considered to understand how medical professionals negotiate. These include five behavioural labels, being: 'Attack', 'Evade', 'Inform', 'Open' and 'Unite', each containing several negotiation styles (Raider, Coleman & Gerson, n.d.). 'Attacking' is a behaviour perceived as unfriendly. By 'Evading', people prevent facing the subject. 'Inform' refers to the subject explaining to the other stakeholders. 'Opening' relates to the behaviour present when someone invites the other player to express their story. Last, 'Unite', refers to a relationship between the parties.

Table 1. Negotiation Styles (Raider et al, n.d.)

Behaviour Label	Negotiating Style
Attack	Threats, hostile tones or gestures, insults, criticizing, patronizing, stereotyping, balming, challenging, discounting, interrupting, defending
Evade	Ignore, change the subject, withdraw, postpone, table issue, caucus
Inform	Reasons, justifications, positions, requests, needs, underlying positions, feelings
Open	Listen quietly, probe, ask questions, nonjudgmentally, listen actively, paraphrase, summarize, understanding
Unite	Ritual sharing, rapport building, establish common ground, reframe, propose solutions, dialogue or brainstorming

Negotiations require that the parties need to be attentive to each other's demands (Pruitt, 1981). A potential side effect of negotiation is that it may result in a conflict and disturb relationships (Pruitt, 1981), which would have negative consequences for the care delivery. In this study, we explore how professionals in the medical field negotiate to achieve the implementation of VBHC.

Speculative Design

The implementation of VBHC presents several challenges. A challenge of transitions is the uncertainty that is introduced in new relationships and evolving markets (Thompson & MacMillan, 2010). Speculative Design (Neeley & Montgomery, 2016; Push Conference, 2018) can be used as a way

to deal with the uncertainty by reflecting on the upcoming future.

Speculative Design aims to prototype and understand the future's social, cultural, and ethical implications of emerging technologies or socio-cultural trends (Push Conference, 2018). The Speculative Design process is described in five steps (see Figure 1). The first step is to detect signals; to point out what is happening and what is emerging. Then, the signals are placed into a particular scene; in this case, the implementation of VBHC. Next, multiple future scenarios are defined as alternatives and stakeholders reflect on those alternatives to define the implications and impact from their perspectives. Finally, a strategy will be built to cope with the future (Push Conference, 2018).

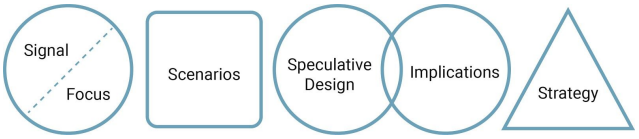

Figure 1. Speculative Design Process (Push Conference, 2018)

Subconclusion

Thus, the transition into VBHC is slowed down by several contextual factors. Change by individuals demands ambidextrous behaviour to combine current care routines with exploring new VBHC approaches. Also, design-led ambidexterity suggests that this happens in an interplay between design methods, mindset and infrastructure. To achieve the implementation of VBHC, medical professionals need to collaborate and negotiate to create a shared mindset and establish a common ground. Negotiation is a process to establish agreements between unaligned parties. Five behaviour labels and several negotiation styles have been identified in negotiations. Finally, as the future of VBHC is uncertain, Speculative Design could be useful to gain understanding and reflect on the implementation of VBHC.

METHODOLOGY

The objective of this qualitative academic research is to explore how professionals in the medical field negotiate in the implementation of VBHC. Six semi-structured interviews with professionals working in the medical field were performed. During these interviews, Speculative Design was used as a way to reflect on the implications of the transition towards VBHC.

As we are interested in the participants' perspective and their behaviour in relation to the negotiation, we collected self-reported data via semi-structured interviews (Patton, 2002). The interviews were performed by all three researchers individually. The main reason for a semi-structured interview guide was to minimize variation in the interviews, especially since they were carried out by different interviewers (Patton, 2002). At the same time, Patton (2002) states that a semi-structured guide provides freedom to the researchers to explore topics of interest that emerge during the interview.

Participant Selection

The study used Convenience Sampling (Miles, Huberman & Saldaña, 2014) to select participants for the interviews. Convenience Sampling was selected due to the researchers' limited access to professionals, as well as their probable scarcity in time. The participants were professionals working in the medical field in the Netherlands with diverse job functions. The diversity in functions was seen as important by the researchers, as VBHC is implemented in diverse health care domains. Within these domains, all employees from an organizational perspective and practitioners play a role in the implementation. Additionally, the variety of professions reflects the multi-stakeholder collaborations, which are central in VBHC (Lee & Kaiser, 2015).

No boundaries were considered for the participants as the study has an exploratory nature. A deliberate choice was to exclude patients, as they are not taking a role as a professional. For Dutch participants, the interviews were held in Dutch to enable more ease and nuance in sharing their thoughts.

In total, five participants were female. The age of the participants was between 23 and 65. The participants had an average of 10.5 years of working experience in healthcare, which ranged between 0.5 year and 37 years. The quotes described in the findings are referred with the participant number and their job function, as shown in Table 2.

Table 2. Variety of Professions Present in the Study

Participant	Function
P1	Medical design research student
P2	Organisation advisor in hospital
P3	Mesologist
P4	Nurse student
P5	IT manager in health care center
P6	Medical design intern

Procedure of the Interviews
The interviews combined inquiry via verbal questions and the use of frameworks, which were used as sensitizers and thinking tools (Casteleijn-Osorno, 2018) to support the participant in reflecting and answering. The agenda (see Table 3) shows an overview of the tools used in the interview, the sequence and time indication. The interviews were planned to take 60 to 90 minutes, as time is scarce for most professionals in the medical field. The tools used are described in the section named 'Data Collection'.

Table 3. Agenda of the Interviews

Activity	Duration in minutes
Before the interviews: fill in the booklet	15
Introduction	5
Tool 1: Scenario & Future Persona	10
Tool 2: Identify stakeholders	15
Tool 3: Dynamics among others	10
Tool 4: Engagement plan	15
Wrap up	5
Total	**60 minutes**

Previous to the interviews, the participants were asked to read a future scenario about VBHC and fill in a 'Future Persona' framework reflecting how their future job would be in the context of the scenario. The aim of the booklet was to sensitize the participants, by making them consider how their work functions may be in the future and reflect on what it entails. The content was briefly discussed with the interviewer, to gain a first impression of the participant's view. Based on this, the interview could be tailored to the participant.

During the interviews, three tools were used to explore the topic in more depth using follow-up questions that were specified in the semi-structured interview guide. For example, after using the tool 'Dynamics Amongst Stakeholders' (see description in the 'Data Collection' section), the participants were asked how they communicated and for what purpose. The tool enabled participants to create a visual map to structure their thoughts. They were asked to recall real examples of their communication with some of these stakeholders. This approach promotes rich, detailed and context-based stories of dynamics that took place in reality, enhancing the trustworthiness of the answers (Patton, 2002).

Pilot
A pilot session was carried out by the researchers internally. The goal of this session was to rehearse the interview and evaluate the procedure, the use of frameworks and the interview guide. Based on the pilot session, some questions were adapted. For example, complex questions were divided into multiple questions to make it easier for the participants to understand them.

Data Collection
During the study, data about negotiation was collected through six semi-structured interviews, which were recorded. We designed some generative tools to be used as thinking tools, to stimulate and support participants during the interview (Sanders & Stappers, 2012). The tools were designed based on existing literature; we named them 'Future Persona', 'Identify Stakeholders and Dynamics Among Others' and 'Engagement Tool'. While using the tools, questions were asked to explore how participants negotiate for the implementation of VBHC. The combination of verbal explanation and written records in the tools enabled data triangulation (Ravitch & Mittenfeller, 2015), enhancing the validity of the study.

Materials
In the following paragraphs, we describe the booklet used prior to the interviews and frameworks (see Appendix A) used during the interviews.

1) Booklet
Before the interview started, the participants filled in a booklet. It contained a 'Future Scenario' and a 'Future Persona' framework.

The booklet started with an introduction to the project. As part of the Speculative Design approach, a scenario was used to sensitize the participants about a possible future and create a shared starting point for discussion (Neeley & Montgomery, 2016). It consisted of a small script with an example case written through the eyes of a patient. A 'day in the life of' format (Sanders & Stappers, 2012) enabled participants to empathize with the patient and imagine themselves in that scenario.

The final part of the booklet consisted of the 'Future Persona' template. This template was adapted from the 'User Persona' tool by Cooper (2008). The goal was to invite participants to reflect on how their future role would evolve due to the implementation of VBHC. It invited the participants to reflect on the competencies and the responsibilities they consider they will need and possible constraints they foresee.

2) Frameworks

During the interview two frameworks were used as thinking tools, enabling easier sharing of thoughts without overthinking (Casteleijn-Osorno, 2018). The first framework is called 'Identify Stakeholders and Dynamics Among Others'. The second framework is called 'Engagement Plan'.

We designed both frameworks based on 'The Stakeholder Engagement Tool', which provides a systematic approach to stakeholder analysis and engagement in the health sector (National Collaborating Centre for Methods and Tools, 2012). The activities provided in this tool were simplified to fit the time frame of one hour.

The first framework, 'Identify Stakeholders and Dynamics Among Others', explores how participants position themselves in a map according to the level of influence they consider they have for the implementation of VBHC (see Figure 2; Appendix A). Followed by a reflection about which stakeholders they need to negotiate with; for example, in discussing their responsibilities for a project. The levels of influence were subtracted from the 'Stakeholder Circle' (De Bont, Den Ouden, Schifferstein, Smulders & Voort, 2013). 'Fast Arrangement Mapping' was used to simplify the exercise by getting a quick picture of the players and their influence (Bruns, 2000). The connection between stakeholders was adopted from the tool 'Net-Map' (Schiffer et al, 2008).

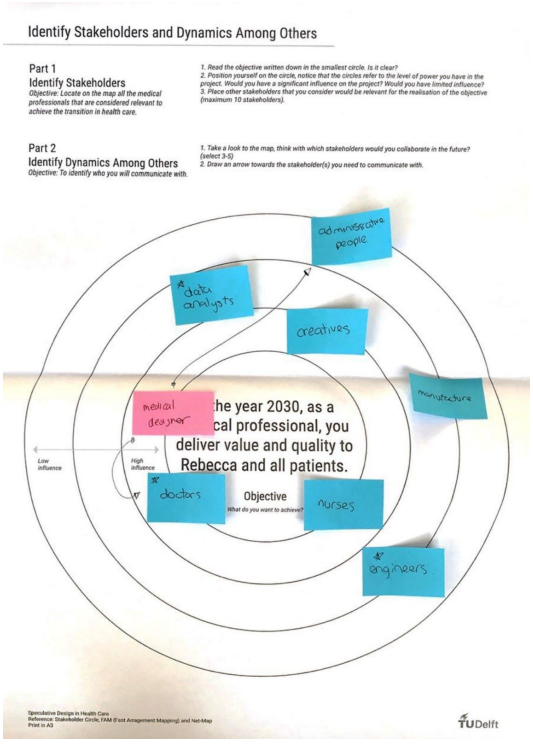

Figure 2. Framework 'Identify Stakeholders and Dynamic Among Others' filled in by a participant

In the second framework, named as 'Engagement Tool', participants were asked to bring the future vision to the present and reflect on actions they could take right now. The participants were asked to define three to five concrete actions in which they would contribute to the implementation of VBHC.

Data Analysis

Both, the content from the frameworks and the information shared in the conversations with participants, were considered for the analysis phase. The objective of this study was to explore the domain and generate pointers for follow-up studies. Therefore, an inductive approach for data analysis was taken using Grounded Theory Methodology (Glaser & Strauss, 1967). The three authors analyzed the data from the interview recordings collaboratively. Also, the answers in the 'Future Persona' template and the other two frameworks were transcribed. Moreover, dialogic engagement (Ravitch & Mittenfeller, 2015) with the project coach helped us reflect upon the quality of the research design and the analysis.

Process

The data analysis consisted of several steps. First, the interviews were transcribed by the interviewer. Second, a part of each transcript was coded by each of the authors individually and then discussed and compared on dimensions and properties to create an agreement on the use of codes, strengthening the validity (Ravitch & Mittenfeller, 2015). In-vivo codes and the preservation of gerunds were used to stay close to the interviewee's answers. Alongside the transcribing and coding, Memo writing (Birks & Mills, 2015) was used to write down emerging thoughts, experiences and doubts to discuss within the team.

After that, each transcript was coded by the researcher who performed the interview. The codes relevant for answering the research question were selected and added to the codebook, supported with a quote. Then, the codes were categorized using the five behaviours of negotiation, which are Attack, Evade, Inform, Open and Unite, and we subdivided them into the corresponding negotiation behaviours labels (Raider et al, n.d.). For example, the initial codes 'being consistent' and 'repeating yourself' were used for the purposes of aligning, setting priorities and having shared understanding. These purposes were placed in the negotiating style of 'establishing common ground'. The codes that did not fit the framework were provided with a self-created code; for instance, the code 'necessities for negotiation' was created.

During a group session with the three researchers, the structure of the codes and supporting quotes

were laid down visually. The authors immersed themselves in the data and created overarching clusters of the codes and explored the relationship between the clusters. For example, the authors explored how the focussed codes 'establishing common ground' related to the behaviour styles 'Inform' and 'Unite'. An insight was that the code 'establishing common ground' contained information about how stakeholders inform and convince each other to form an agreement and use this agreement as a base for further steps. Therefore, the code 'establishing common ground' seemed to use communication to inform and convince people with the purpose of uniting. These initial and focussed codes were grouped and formed the cluster 'communication and convincing'.

As a next step, the research question was re-examined and iterated upon to enhance the connection between the data and the question. Last, the clusters were analyzed regarding their contribution to answering the research question. Five clusters were identified, that explore how professionals in the medical field negotiate. The clusters were 'players in the transition towards VBHC', 'challenges in convincing others', 'Absence perception of negotiation', 'communication styles' and 'the power of peers'. The emerging insights in these clusters were noted down as directions and considerations for further research and possible implications for practice were derived.

FINDINGS

The findings are organized in a narrative structure, divided into five main sections. First, the stakeholders in the transition to VBHC are introduced. Then, the insight mentioning that participants do not perceive they are negotiating in the implementation of VBHC. The third insight reveals several challenges in convincing others. The fourth section describes how participants convince their colleagues to establish agreements. This study reveals that achieving agreements are done in different ways. Therefore, we describe three communication styles, 'Arguing with Benefits and Consequences', 'Using Examples' and 'Let Others Experience Themselves' Last, we integrate the finding about the role of peers in convincing others.

Players in the transition towards VBHC

During the interview, the participants were asked to reflect on their perceived influence in the implementation of VBHC. It was found that all the participants except the medical design intern, perceived themselves as having high influence. For example, the medical design research student explained, *'that's why I think I'm in the high influence [level] because I think I am kind of a bridge*' (P1). Being a bridge for her means that she is the connection between the doctor and the patient to help them provide the best service to the patient.

However, the study reveals that although the participants feel that they have a high influence, they are not perceived as key players by others due to the fact that they are not decision makers. The organisation advisor pointed it out, *'...they often say, you have a lot of influence without much power'* (P2). With this comment, we interpret that the participant can influence the outcome, but has no power to make decisions. The participants mentioned the board of directors, the doctors, the managers, the people responsible for defining a budget and priorities, as the decision makers.

We can derive that to achieve implementation of VBHC, it may be important to convince people who consider they don't play a relevant role and the stakeholders that have high influence and power. This will boost the implementation because the transition requires shared efforts and a shared mindset, as is explained below.

No Perception of Negotiation

Participants are not considered key players, and may, therefore, be less involved in negotiations about implementing VBHC. None of the participants perceived to negotiate while working in the implementation of VBHC. For example, the IT manager responded, *'Negotiation? What is there to negotiate about, I am just doing my job'* (P5). Even though participants do not perceive that they negotiate, the analysis of the data revealed how they communicate. These behaviours are different ways of convincing, which we considered to be a way of 'establishing a common ground' as part of the negotiating styles (Raider et al, n.d.) to work towards the implementation of VBHC.

Challenges to Convince Others

Due to the fact that participants are not key players, we identified that they need to convince other stakeholders of their influence in providing quality and value to the patients. All the participants were willing to adapt their way of working to reach that goal. This ambition gets difficult for them because they need to collaborate with some stakeholders who are not willing to change their current way of working. The medical design intern gave a reason for this behaviour: *'[...] many stakeholders, they just want to stay in their comfort zone, because if they need to change, they will have more risks or even have less benefits'* (P6).

The participants want to convince these stakeholders that a change is needed. One of the problems we noticed is that negotiations in multi-stakeholder collaborations are entangled due

to individual interests, as was illustrated by the organisation advisor. '[they should discuss] *who does what in the care, without thinking too much about your own purse*' (P2). Therefore, it seems relevant to make stakeholders aware of the benefits for themselves and also about the benefits for the patients and other stakeholders.

Other restrictions mentioned were the scarcity of time and resources. For example, a participant indicated that care providers find it difficult to combine daily care activities with new activities that contribute to VBHC. We believe that this lack of time slows down the implementation of VBHC because it seems that their short term agenda is perceived as more important than the future aim of VBHC. Since VBHC may not be a top priority for the stakeholders, it may be harder to convince them to add activities to their workload that would contribute to the implementation of VBHC.

Three Communication Styles

These limitations drive participants to look for effective approaches in their way of communicating with others. We summarized the ways of communicating in three communication styles (see Figure 3), being: 'Arguing with Benefits and Consequences', 'Using Examples' and 'Let Others Experience Themselves'. In their daily work, participants use these styles for the purpose of convincing others to achieve the implementation of VBHC.

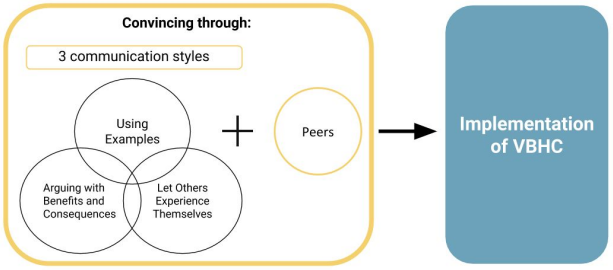

Figure 3. Overview of how convincing is achieved in the implementation of VBHC.

1) Arguing with Benefits and Consequences

When arguing to convince someone, two aspects were revealed. First, it seems important to show the beneficial consequences of implementing VBHC. For instance, the medical design intern explained: *'And if the project could really help both [parties] in improving the staff experience, or helping lower the cost, then you have some strong arguments to speak about those benefits for the hospital'* (P6). Second, also sharing the negative consequences can be valuable. For example, the organisational advisor stated that she threatened other stakeholders by saying for example: *'[if we take no action] we place ourselves outside the market, and it stops with the quality of the care that we currently have. Would you like that to happen to your parents, or your child?'* (P2). By presenting the consequences, medical professionals help others reflect on future scenarios. This communication style may result in convincing other stakeholders to place VBHC higher on their agenda.

When showing the benefits and consequences repetition seems to be key to create a shared mindset and avoid confusion. Conveying the message once is probably not enough to make people change. When the IT manager wants to implement a new technology he: *'[...] communicates it through different channels, like the newsletter, the website and in meetings to keep repeating it'* (P5).

Thus, presenting the benefits and consequences in a reinforced way by repetition is one of the ways how different medical professionals convince others to implement VBHC.

2) Using Examples

Another approach to convince others of implementing VBHC is by using examples. The participants referred to examples with terms like 'best practices', 'tangible examples' and 'teaching examples'.

We noticed that using examples could have two main benefits: creating a shared understanding and creating a learning opportunity. First, from the interviews we derive that professionals in the medical field need to establish a shared understanding with people outside their professional expertise since they have different levels of knowledge on certain topics. The IT manager explained: *'A lot of nurses have little understanding of IT so I try to explain it as accessible as possible to show it isn't that difficult by explaining it with examples'* (P5). It is important that the different medical professionals understand each other, so they can collaborate and help others to implement VBHC. The study suggests that by using examples they simplify the message and demonstrate why it is relevant.

Second, the study reveals that sharing both 'good' and 'bad' examples of care approaches can be used as a learning opportunity. The examples can come from internal departments or from external care organizations. The medical design intern explained that she looks at other collaborations between hospitals and healthcare organizations and uses that to reflect at her current work context: '*It is useful to explain those cases [examples of other hospitals], to show why it is important to adopt VBHC and to show what are the things they are not doing and what we*

should do' (P6). It seems that because the other stakeholders see results in the real world, they can project it to their own working context, enhancing the convincement.

An obstacle mentioned by the organisation advisor was that examples of VBHC approaches are shared through literature and symposiums. These channels may not be optimal, as it demands search skills, time and accessibility to attend these events.

3) Let Others Experience Themselves

The third, and last, communication style suggests that it may be beneficial to create and stimulate people to experience VBHC to convince them. These experiences could be built around how the value-based treatment or care approach works and the benefits it could bring to the stakeholders involved. Therefore, participants suggest convincing other medical professionals by allowing them to experience the treatment. According to the mesologist, scepticism about her therapy only decreases when people experience it, because: *'Just telling about the therapy does not work'* (P3), so she tries to prove the treatment to other medical professionals.

This study suggests that medical professionals need to prove their treatment or care approach by showing how it works and making the other person experience it. This may facilitate convincing their colleagues of their treatment or approach, the relevance of it and the ability of the treatment to improve the quality of care. The same phenomena of convincement through experience seems to apply to caregivers who initially may be hesitant to change towards VBHC approaches. By experiencing the benefit for the patient and the benefit for themselves, they are more easily convinced. The organisation advisor mentions that *'It probably works best if they [caregivers] discover themselves that this is nicer for the patient.'* (P2). As a result of experiencing the treatment, medical professionals will be convinced intrinsically, which enables the person to spread the word to their peers.

The Power of Peers

From the analysis of this study, it was found that medical professionals seem to be more easily convinced when the message comes from their peers. Similar to patients who take advice from other patients, care providers take advice and insights from their peers more seriously. The organisation advisor is aware of this and uses it in her mission to implement VBHC. She tries to: *'[...] have some ambassadors and a supervisor or unit head who believes in VBHC with full conviction*' (P2). The nurse student adds that peers help each other to provide good quality care *'if one nurse is low in the quality measurement system, we try with the team to increase it again and then we try to remind each other to take care of our values'* (P4).

Another aspect mentioned was that decision makers suggest 'unrealistic' ideas. The nurse student explained it by saying: *'Unit heads come up with changes in the hospital, but they usually don't even have a medical background and they are suggesting stuff to change at the workplace that is actually not feasible. They can't estimate it because they don't know the way we work'* (P4). It is perceived some decision makers ask for changes without considering the opinion of the people who will implement them, for example, the nurses. Also, they don't consider the feasibility and how that could affect the nurses. In consequence, nurses perceive the new changes as unrealistic and they are reluctant to accept them, causing the implementation of VBHC to slow down.

A way to deal with the reluctance, mentioned by the nurse, is to have the key decision makers walk along with the other medical professionals to understand their way of working. Another solution was offered by the IT manager, namely to have inter-disciplinary meetings *'[...] so the nurse looks at functionality, I at the feasibility and others at for example fire safety, everybody in their own expertise'* (P5). This implies that different perspectives are considered to enhance the implementation of VBHC, but the stakeholders need to have a basic understanding of each other's needs and context.

These insights suggest that convincement from peer to peer takes less effort. A possible reason for this is that they talk in a common language, which enables shared understanding and makes communication and collaboration easier. Likewise, peers working together over a longer period of time increase their trust in one another. This results in an enhanced acceptance of suggestions from peers.

Subconclusion

To summarize, professionals in the medical field do not consider to negotiate in implementing VBHC. However, due to challenges in implementation reluctance to change may be developed in stakeholders. Therefore, convincement of the value and necessity of VBHC seems to be important to achieve working together towards the implementation of VBHC. In order to convince them, we defined three communication styles based on the participants' behaviour, being: 'Arguing with Benefits and Consequences', 'Using Examples' and 'Let Others Experience Themselves'. Finally, it seems that convincing others is easier when it comes from peers because there is more trust involved.

DISCUSSION

This paper contributes to the fields of negotiation, convincement and Shared Value Creation in the health care context, and may be of use to accelerate the implementation of VBHC. We identified that professionals in the medical field do not perceive to negotiate in the implementation of VBHC. First, we assume that their shared intention to provide the best care for the patient may explain why they do not perceive to negotiate. Second, the findings suggest that convincing communication contributes to the establishment of a shared mindset. Also, it was found that peers are more effective in convincing others. The shared mindset and peer-to-peer strategy seem to enhance the establishment of Value Networks, which we assume can speed up the implementation of VBHC. This reasoning is elaborated below.

Shared Intention Prevents Perception to Negotiate

Pruitt (1981) claims that negotiation is a process by which two or more parties with unaligned interests try to establish agreement about one or multiple issues. In the health care context, we noticed that stakeholders have a shared intention to provide the best care for the patient. Having the same intention contradicts the opposing interest in a negotiation. Possibly, this reasoning explains why professionals in the medical field do not perceive to negotiate. An example to illustrate this: an IT manager and a nurse share the intention to provide the best care for the patient. Hence, the IT manager only needs to convince the nurse that a new technology supports their shared intention. This shared intention may speed up the process of implementing VBHC and enhances positive relationships between the stakeholders.

Creating and Spreading a Shared Mindset

As a result of the analysis, we defined three communication styles, being 'Arguing with Benefits and Consequences', 'Using Examples' and 'Letting Others Experience Themselves'. To continue with the previous example, the IT manager wants to convince the nurse of using new technology, a smart wristband to track patients. He presents to her examples of how those wristbands are used in other organizations. Then, he points out the benefits of using them and the possible threats of not implementing the technology. Finally, he gives her a smart wristband to try it out and experience it herself to gain confidence about the benefits.

The three communication styles are used by professionals in the medical field for the purpose of convincing others. We noticed that convincing others could be beneficial for organizations, as it facilitates establishing a shared mindset and therefore unity. Ulrich (2002) states that a shared mindset helps in reducing costs, increasing ownership and leading stakeholders to take action. This shared mindset about the importance of implementing VBHC, may enable professionals to look further than the possible short-term financial pains due to unaligned reforms in care delivery and insurance (Lee & Kaiser, 2015), reducing the current cost barriers in the implementation. Furthermore, we assume that the mindset facilitates professionals to take ownership of implementing VBHC and be motivated to take action. Having the VBHC mindset will foster change initiated by individuals, which is one of the ways to create change according to Beer, Eisenstat & Spector (n.d.)

The analysis of the interviews suggests that peers are more effective in convincing their colleagues, compared to external people or managers. Convincing is described by Perlman (2009) as making a person believe something. From the findings, we derive that once a person is convinced and shares the same mindset, this person can act as an ambassador to convince other colleagues. For example, once the first nurse is convinced by the IT manager, this nurse can convince other nurses about the use of the smart wristband, acting as an ambassador. She will again use the same communication styles, but it will take her significantly less effort as her colleagues will believe her because they trust her as a peer. Therefore, we presume that the use of ambassadors can speed up the implementation of VBHC.

Creating Value Networks to Speed Up VBHC

However, professionals also need to collaborate with stakeholders outside their peer group to prevent, and reduce the existing, fragmentation (Lee & Kaiser, 2015) and thus follow the needs of the patient across disciplines. We consider that multi-stakeholder collaborations are required inside organizations and externally with other care providers. To optimize collaboration, each of the stakeholders is expected to share the same patient-centred mindset and the willingness to change and contribute to the implementation of VBHC.

According to Stoimenova & De Lille (2017), establishing an agreement has positive consequences on the relationship between stakeholders. To continue with our example, the nurse and the IT manager collaborate in a different way now, because they create value together, enhancing their mutual benefits, referred to it as 'Shared Value Creation' (Porter & Kramer, 2011). These stakeholders who collaborate to create value give birth to Value Networks, proposed by Bocken, Short, Rana, & Evans (2013). Their study suggests

that stakeholders should create mutual understanding and expectations of each other to facilitate the generation of agreements. Our study suggests that a shared mindset may also be important in establishing Value Networks, besides the aforementioned mutual understanding and expectation.

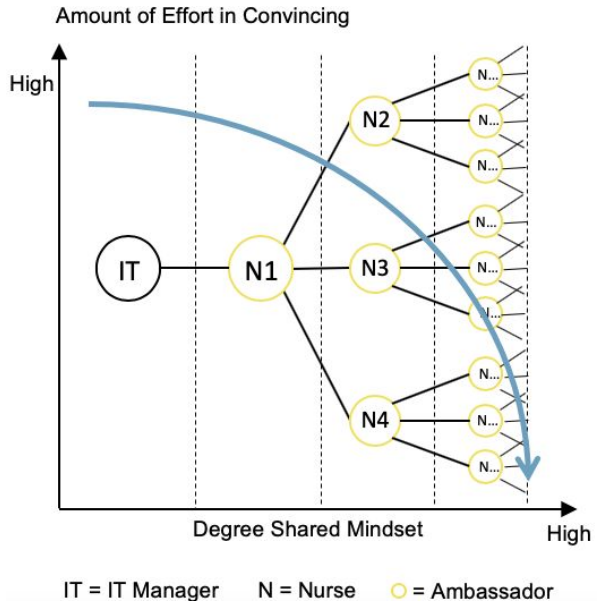

Figure 4. Expanding Value Networks and a shared mindset through ambassadors; illustrated using the example of the IT manager and the nurse.

We presume that if Value Networks are established and stakeholders are aligned in mindset, this will reduce the time and effort that professionals in the medical field spend in convincing others about the 'what' and 'why' of VBHC. For example, the IT manager will invest less time in talking about examples, benefits and consequences of the implementation of the smart wristband. Consequently, he will have more room to actually negotiate about 'how' to implement the smart wristbands. Therefore, we suggest that a shared mindset in Value Networks can speed up the implementation of VBHC. Finally, we consider the role of peers in convincing others would contribute to expanding the Value Networks (see Figure 4) and accelerate the implementation of VBHC.

Implications

Based on the findings and discussion, some implications for care organisations and future research are presented below.

For Practice

The findings suggest that caregivers are best-convinced of new care approaches if they experience and see it themselves. However, care providers seem not to be optimally facilitated to explore VBHC alternatives, as they need to combine the exploration with performing their daily work in a scarcity of time and resources. A suggestion is to train medical professionals by reflecting on how they work now and giving them the resources to experience the changes suggested for the implementation of VBHC, for example providing them with the smart wristbands that derive from the example mentioned earlier. The implementation of a training program could allow them to discover and unlearn old-school behaviour as suggested by Carlgren et al. (2016). Moreover, the training program could help the professionals to experience the benefits themselves and prepare them as ambassadors. Another suggestion is to arrange 'walk along' sessions in which caregivers can learn from their peers who provide care in different contexts.

As mentioned by Bocken, Rana & Evans (2013), stakeholders should aim for mutual understanding and expectations of each other. Stoimenova & De Lille (2017) mention using design tools to achieve a shared mindset. Therefore, we suggest using the tools mentioned in this paper to guide groups of practitioners to share their views, ambition and expectations to create an understanding and a shared mindset. One of the participants, the organisation advisor, also mentioned the value of the tools to evoke discussions during team-days, for example in exploring what causes resistance in implementation. Therefore, we designed some tools (see Appendix A) and created a workshop guide to facilitate individual or group reflection in professionals about VBHC.

For Future Research

The Negotiation Styles Framework (Raider et al., n.d) mentions the behaviour labels 'Attack, Evade, Inform, Open and Unite'. From the interviews, we found that convincing plays a role in achieving unity. We also learned that, for example, threats are used to convince others, which is a behaviour from the style 'Attack'. For future research, we suggest complementing this study by exploring these five behaviours levels from the convincement perspective. With this suggestion, we aim to get a deeper understanding of the role of convincement in the behaviour styles and the way the styles are connected.

Limitations

With regard to the study set-up, there are three limitations that we assume have affected the outcome of the study. First, convenience sampling was used, causing a random mixture of care providers to participate in the study. Also, among the interviewees, there were three students. These students may have less working-experience and observations since they are novel in the field. Also,

they may have a different relationship with the other professionals, possibly influencing their negotiation approaches and performance. Convenience sampling fits the exploratory nature of the study, which is not aiming for generalizable results. However, the exploration could have been improved by integrating key players working in the medical field, such as doctors, people from the government focus on healthcare and people working in medical companies.

Furthermore, as six interviews were carried out, the number of perspectives taken into account is limited. Therefore, the study reveals some insights that may be used to guide future research. More interviews are needed to explore these findings more in depth and discover the nuances and subtleties in dimensions, properties and relationships. Thus, the study should be complemented by interviewing more professionals in the medical field, in which the researchers can be guided by the method, findings and discussion presented in this paper.

With regard to the study set-up, the interviews were carried out by three researchers individually using a semi-structured questionnaire that focussed on negotiation. It was remarkable that none of the participants experienced to negotiate at their work. Instead, the participants mentioned the need to convince others during their work. Therefore, each of the researchers had to adjust the interview guide to enable the participants to explain more about how they convince others. Therefore, the consistency of questions across the interviewees was reduced. For a future study, it is important to check the interpretation and perception of the topic with the participants before doing the study. We suggest doing the pilot session with people that are similar to the actual sample.

CONCLUSION

The study suggests that professionals in the medical field do not perceive to negotiate in the implementation of VBHC. However, they described how they established agreements with their colleagues. This study reveals that achieving agreement is done via three communication styles, being 'Arguing with Benefits and Consequences', 'Using Examples' and 'Let Others Experience Themselves'. Additionally, convincing seems to be most effective when it comes from a peer. Therefore, this study suggests care organisations create and educate ambassadors to spread a shared mindset about VBHC. A shared mindset is expected to contribute to the establishment of Value Networks and to speed up the implementation of VBHC. Finally, the study demonstrated how generative tools can be used to evoke discussion amongst professionals to reflect upon their role in the implementation of VBHC.

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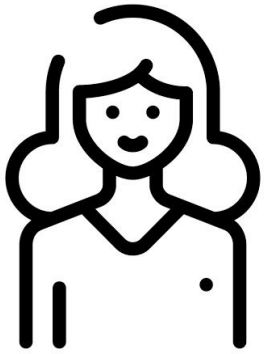
APPENDIX A: Tools used in interviews

Future Scenario



Rebecca

Scenario

It is May 2030, Rebecca was diagnosed with breast cancer 3 weeks ago. She is a teacher for 8-year-old kids which brings her much joy. She has four kids, two of them are still living with her and her husband.

To get her treatment, she chose her communication channel with the hospital to be web-based, so she can continue with her work and receive personal advice and support online. This channel is also available for her caregivers, her husband and kids, so they can provide optimal support to Rebecca.

At home, she wears an activity tracker which monitors her health and will be helpful for the caregiver to tailor the care.

She already had a surgery, and the removed tissue was immediately tested. An additional cancer tissue was found which was immediately removed, eliminating a next surgery, which is valuable for Rebecca.

Transition to Value-Based Health Care
The story above gives an example of Value-Based Health Care in 2030. The care is fully centered around the patient. The quality of the care is key.

Your Future Persona

Fill in the questions below as detailed as possible.
Think about your current role, now imagine yourself working in the future context of Value-Based Health Care. As in Rebecca's case, the quality of the care is key.

Year: 2030	Age:	Future job title:

Please describe your role in the year 2030 (use Rebecca's case as a reference). *What are your main tasks?*	What is the primary purpose of your role? *What is your objective? What will you be willing to achieve?*	What motivates you to carry out your activities? *What are your main drivers? What keeps you positive?*

Competencies *What do you need to know? What skills should you develop? What attitudes will help you to do things at their best?*	**Responsibilities** *What are you in charge of? To what extent are you involved?*	**Constraints** *What limitations do you have?*	What resources do you need?

Identify Stakeholders and Dynamics Among Others

Part 1
Identify Stakeholders

Objective: Locate on the map all the medical professionals that are considered relevant to achieve the transition in health care.

1. Read the objective written down in the smallest circle. Is it clear?
2. Position yourself on the circle, notice that the circles refer to the level of power you have in the project. Would you have a significant influence on the project? Would you have limited influence?
3. Place other stakeholders that you consider would be relevant for the realisation of the objective (maximum 10 stakeholders).

Part 2
Identify Dynamics Among Others

Objective: To identify who you will communicate with.

1. Take a look to the map, think with which stakeholders would you collaborate in the future? (select 3-5)
2. Draw an arrow towards the stakeholder(s) you need to communicate with.

Speculative Design in Health Care
Reference: Stakeholder Circle, FAM (Fast Arragement Mapping) and Net-Map
Print in A3

TU Delft

Engagement Plan

Think about today, year 2019, what can you do now to drive towards your future role?
Objective: Define a list of activities in which you can start working today as first steps to achieve the transition into a future where medical professionals deliver value and quality to Rebecca and all patients.

Brainstorm
Which activities do you consider are key? What needs to be improved? What needs to be changed? Which ones are similar? Which ones are a priority? Write down your ideas and share your thoughts.

What can you start doing now?
Make a plan, list 3 to 5 main activities. What responsibilities will you have? What competencies do you need? Are there any constraints?

1.

2.

3.

4.

5.

Why is it relevant?
Describe in what sense the activity will contribute to your future role.

1.

2.

3.

4.

5.

Other comments:

Speculative Design in Health Care
Reference: Stakeholder Circle, FAM (Fast Arragement Mapping) and Net-Map
Print in A3

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