



A new approach to preferred provider selection in health care

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ABSTRACT

In January 2015 Zilveren Kruis, the largest health insurer in The Netherlands, engaged in a new three-year, unlimited volume contract with five carefully selected providers of cataract surgery. Zilveren Kruis used a novel method, designed to identify the top expert providers in a certain discipline. This procedure for provider selection uses the principles of Best Value Procurement (BVP), and puts the provider in charge of defining key performance indicators for health care quality. The procedure empowers the professional and acknowledges that the provider, not the purchaser, is the true expert in defining what is high quality care. This new approach focuses purely on provider selection and is thus complementary to innovations in health care reimbursement, such as value-based hospital purchasing or outcome-based financing. We describe this novel approach to preferred provider selection and show how it makes affordable quality the core topic in negotiations with providers.

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1. Introduction

In the Netherlands, health insurers play an important role in a health care system of regulated market competition [1]. Since the introduction of the Dutch Health Insurance Act in 2006, private health insurers are responsible for keeping health care accessible, affordable and of high quality [2]. To fulfil their responsibility insurers assume a role of healthcare purchasers: they select providers and contract care on behalf of their enrollees [3,4]. Selection of providers is a fundamental step in the purchasing process [3]. Insurers and health care providers negotiate on price, volume and quality of care.

Current purchasing practice is still mainly focused on negotiating prices and volumes [5]. Most contracts intend to control costs of health and not to improve the value and outcomes of care. The majority of contracts for hospital care are one-year contracts and often lack agreements on quality of care or patient outcomes.

Zilveren Kruis, the largest health insurer in the Netherlands, is trying to shift its procurement strategy from a price and volume focus to a value-based focus. One of the challenges is how to select and contract providers that show high performance and are able to continuously improve value. Health insurers struggle

to include outcome measures in their procurement strategy and to select and/or reward providers based on outcomes [6,7]. Insurers and providers alike ascribe this deficit to the lack of (inter)national consensus on valid and reliable measurement of health outcomes [8].

In the absence of generally accepted health outcome indicators, Zilveren Kruis used a radically different approach to provider selection. This novel approach does not rely on the health care purchaser prescribing what constitutes health care quality. This new approach was used in five pilots to select preferred providers of cataract surgery, breast cancer surgery, maternal and neonatal care, treatments for depression & anxiety, and treatments for substance abuse. All pilots followed the same process, but in some pilots a few adjustments were made, such as the duration of the contract. In total 90 health care providers participated in these five pilots. In this paper, we describe the provider selection process using one pilot as example, and selected the pilot for cataract surgery because it was one of the first, and included the highest number of participating providers. This novel approach is relevant for all health care systems where there is a purchaser-provider split and selection of providers is a part of the purchasing process [3,4].

1.1. Best value procurement

In traditional procurement practice the buyer designs and specifies the product before he invites sellers to make offers. Economic literature describes various procurement problems that can arise under the assumption of asymmetric information about require-

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ments, quality and costs between buyer and seller. These include problems of ex ante screening of sellers and problems of ex post adaptations when the ex ante design of the product or service is incomplete [9]. In health care, this information asymmetry between health care purchaser and health care provider manifests itself around decisions of what health care intervention is needed for a certain patient, how the intervention should be executed, and what an intervention or episode of interventions should cost [4]. Health care insurers traditionally minimize risks of adverse selection and moral hazard through the specification of minimum (quality) requirements for providers, extensive specification of health services through protocols, price-and-volume agreements or lump sum contracts, and extensive monitoring of provider behavior. The overarching approach for insurers is to solve the problem of information asymmetry by developing and collecting as much information as possible and investing time and effort in trying to prescribe provider behavior through contracts that are as complete as possible.

There are various downsides to this approach [10,11]. The first is the high transaction cost involved in developing health care quality indicators, designing minimum requirements, provider screening, contract design, and monitoring of providers [12,13]. The second problem is related to the behavior it stimulates at the providers. There is a risk when the purchaser designs and specifies the product or service that the provider will become reactive. There is no reward for proactive thinking, when minimum requirements are defined, behaviors are prescribed, and hence, decision rights for providers are heavily restricted [14,15]. This approach treats providers as a homogeneous lot, and it does not recognize the exceptional expertise that some (or many) providers possess.

Best value procurement has been used for many years already in various countries (including the Netherlands) mainly to select contractors for infrastructure projects in construction and IT. Recently, this approach to supplier selection has branched out to other sectors, including human services [16]. BVP is based on the following principles [17]:

- 1 It is not the purchaser who specifies how the assignment should be fulfilled, but the provider, based on its own expertise;
- 2 The provider takes maximum responsibility for the end result of the assignment;
- 3 The purchaser does not set any minimum product requirements in the selection process of suppliers;
- 4 The selection of (the) provider(s) is based primarily on objective and quantified evidence of past performance and not on lowest price or costs.

The purchaser should only formulate its purchasing intent, either as a problem which has to be solved, or as an objective that should be realized. The purpose of BVP is to put providers in a position where they can become more proactive in their behaviors and attitudes. When BVP is used, the purchaser abandons the idea that providers should be managed, directed and controlled [18].

1.2. The BVP pilot for cataract surgery

Using BVP for the selection of preferred providers in health care means that in contrast to current practice no quality standards or indicators are imposed on health care providers. It literally means that the provider has to convince the insurer why he qualifies himself to be a preferred provider, using evidence of past performance. The provider chooses what outcome indicators to use as convincing evidence.

The best value providers were identified on the basis of four documents and two interviews with key personnel from the provider. Each provider was asked to show his capability by submitting

four documents: the level of expertise (LE) document, the risk assessment (RA) document, the value added (VA) document, and the document on how to prevent under- or overtreatment (UO). Providers were restricted to two pages for the first three documents and one page for the fourth document.

The most important challenge for the providers was to show their ability to fulfil the intent of Zilveren Kruis, which was formulated as: “Zilveren Kruis wants to offer a three-year, unlimited volume preferred provider contract to health care providers who:

- 1 Have a transparent and verifiably high level of health care quality
- 2 Provide and maintain maximum patient satisfaction
- 3 Uphold an active policy on patient safety
- 4 Verifiably prevent under- or overtreatment of patients
- 5 Work efficiently.”

Zilveren Kruis was aware that not all providers were familiar with the BVP approach. For this reason, Zilveren Kruis organised two training days for providers and during the process providers were invited to ask questions. The answers were shared with all participants to create a level playing field.

1.2.1. The review procedure

The BVP process was strictly organized around several deadlines. There was a tender protocol in which the conditions and outlines of the tender were specified. The tender protocol created a level playing field between providers in which bilateral discussions were not allowed. The review took place in two phases. First, every member of the review committee (4–5 members, including the first author) reviewed the documents individually. Each document (four per tender) was given a grade (0, 2, 4, 6, 8 or 10 points). Then the members of the review committee discussed their findings to reach a consensus grade for each document of each tender.

The tenders were reviewed based on five questions, which were known to the providers:

- 1 Does the provider support his quality claims with performance information on the level of outcome measures?
- 2 Does the provider show ambition on improving quality of health care, efficiency and business process (continuous improvement)?
- 3 Does the provider show that he understands what the purchaser wants to achieve?
- 4 Does the provider show a vision on what health care should look like in the future?
- 5 Is the tender of the provider sufficiently SMART (specific, measurable, attainable, relevant and time-bound)?

The selection phase also consisted of two interviews per provider. For the interviews two staff members of the provider were invited and were separately interviewed. All interviews were conducted by the first author. The others in the review committee observed and listened. The types of staff members to be interviewed were not specified. The only advice was to send employees who know the care process from beginning to end and who have a direct role in that process. In many cases the provider sent a medical specialist, a nurse or a head of department. This was new for providers because negotiations typically take place between purchasers and sales managers. The reason for this choice is that Zilveren Kruis really wanted to talk about the content of the plans, the care process and health outcomes.

The interviews were also graded by the members of the review committee, based on the same framework as the reviews of the written documents. Because the two interviews, as well as the LE and OU documents were considered more important indicators of provider expertise, these elements were given a weight of 1.5 times

the weight of the RA and VA documents. The weights were determined after consultation with the providers. A total of 80 points could be attained for evidence of provider expertise.

1.2.2. Provider participation

Zilveren Kruis selected four regions for this pilot: two urban and two rural. A total of 31 cataract surgery providers (hospitals and private clinics) were invited for the cataract surgery pilot. All providers not participating in the pilot or not being selected for a preferred provider contract would still be eligible for a normal one-year contract following traditional negotiations. Of the 31 providers who were invited, one provider did not participate because cataract surgery was not a key treatment in their portfolio, and therefore the provider did not want to invest time and effort in this pilot. A second provider was excluded by the review committee because the provider only submitted a price offer without any of the requested tender documents. In total, 29 providers submitted 204 pages in which they showed evidence of past performance, how they would manage and mitigate risk, how they would prevent under- or overtreatment and which added value they wanted to realize.

1.2.3. Review of the documents

A key element in the review of the documents was the extent to which the claims made by providers were supported by performance metrics based on outcome measures.

In the LE document, the provider is asked to explain his performance on the intent set by Zilveren Kruis. The only requirements are that the provider uses outcome measures to support its performance. No other technical requirements or conditions are imposed by the purchaser. So the provider is free in choosing its own outcomes measures. The review showed that in only 38% of all LE documents performance claims were supported by performance metrics. Performance metrics were mostly presented in terms of input, process or output quality indicators. Only 11 of the 29 providers who participated were able to support their claims by showing outcome quality indicators, for example sight improvement.

In the RA document, the provider has to show that it acts in the best interest of the buyer by identifying, mitigating and minimizing the risks that the provider does not control. The provider has to define and prioritize risks and explain how risk is being managed. In this document it is important for the provider to show its capability of risk mitigation in terms of potential time, cost, and value. Few RA documents received high scores from the review committee. Out of the 29 documents, only five documents were rated 'good' (grade 8) and none of the providers received an 'excellent' grade. In the evaluation it became clear that providers had difficulties defining risks that lie beyond their control, listing risks instead that they can control. For example, the risk of inflammations of the eye (ophthalmia), the risk of surgical complications, or the risk of insufficient qualified personnel. An example of a risk that is beyond the control of the provider is production problems at the lens manufacturer. An expert provider will be able to acknowledge such a risk and show a risk mitigation plan.

The objective of the VA document is to enable the provider to improve the value of the project or service by applying innovations. If the provider has such ideas, it has to show that these innovations or added services increase value and exceed the primary intent of the purchaser. The submitted VA documents showed that providers had great difficulty in showing the effects of value-adding innovations and opportunities on health outcomes. Providers also had great difficulty in showing additional costs of innovations and opportunities. Providers showed more abstract ideas or dreams than well-elaborated business plans. Of the 29 VA plans, 26 plans received a neutral score. These plans did not show the aimed effects

of innovations on health outcomes or did not estimate additional costs. Only one provider was able to show the added value (outcomes and costs) of the opportunities they submitted. The provider was able to translate the use of an innovation into an expected outcome and expected additional costs.

Another important element of the intent is that Zilveren Kruis wants to contract providers that work efficiently, as evidenced in the UO document. Zilveren Kruis seeks providers who know how to guarantee an optimal fit between health care needs of single patients and the treatment that is given by the provider. Most providers answered this question by describing their process from beginning to end, but without any support of performance metrics to show that their processes are actually efficient and under- or overtreatment of patients is avoided. Two providers were able to support their claims with performance metrics. These providers started an internal discussion on how to verifiably prevent under- or overtreatment. This discussion resulted in the development of new indicators, for example the number of cataract surgeries on patients under the age of 59 (a high number could be an indication of overtreatment).

1.2.4. The interviews

After assessing and scoring the documents, the names of the providers were linked to the documents and providers were interviewed about their proposals. Zilveren Kruis held 58 interviews with staff members of the 29 providers. A standardized questionnaire was developed and was used for every interview. The questions were not only about verifying performance claims but also on elucidating the ambition and vision of the provider on cataract surgery. Providers did not receive the questionnaire in advance. The standardized questionnaire was complemented with questions about specific parts of the tender documents. At the end of each interview the provider was given the opportunity to ask questions or to give an additional explanation on specific topics in their proposal. Each interview was rated by the committee according to the same framework as used for reviewing the tender documents. The providers were free to choose the staff members who they wanted to be interviewed. The interviewees were interviewed separately from each other. Different, yet complementary answers were received in the interviews, but not contradictory answers. In 32 cases the interviewee was a medical doctor who performed cataract surgery. In thirteen of these cases the medical doctor was also head of department or even medical director. In fifteen cases the interviewee was not a medical professional but an operational manager. In a few cases the interviewee was a sales manager or a member of the executive board.

Out of the 58 interviews, 32 received a neutral grade (i.e., 6): this meant that interviewees were not able to provide a clear vision on how to realize better health outcomes and were not able to show a realistic and clear ambition on the performance of their own organization. Roughly a third (20 interviewees) received a 'good' score. These interviewees explained how their organizations measured performance and how they improved themselves. They had a clear vision on performance and in some cases plans for introducing better performance measures. Six interviewees received the highest score. These interviewees showed that they continuously improve themselves using performance metrics on the level of outcomes that matter to patients. Even when there was a lack of consensus within the medical profession on which outcome measure should be used, these interviewees did not hesitate to develop their own outcome measures or use measures that are implemented in other countries.

Fig. 1 shows the score of all 29 participating providers for each submitted document and interview. Many providers receive an average score, and only a few manage to distinguish themselves with a score '8' or '10'.

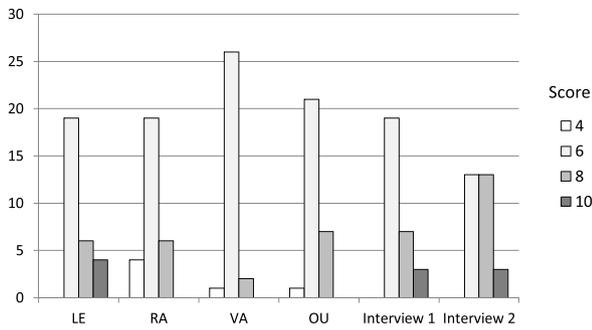


Fig. 1. Scores given by the review committee to the documents and interviews.

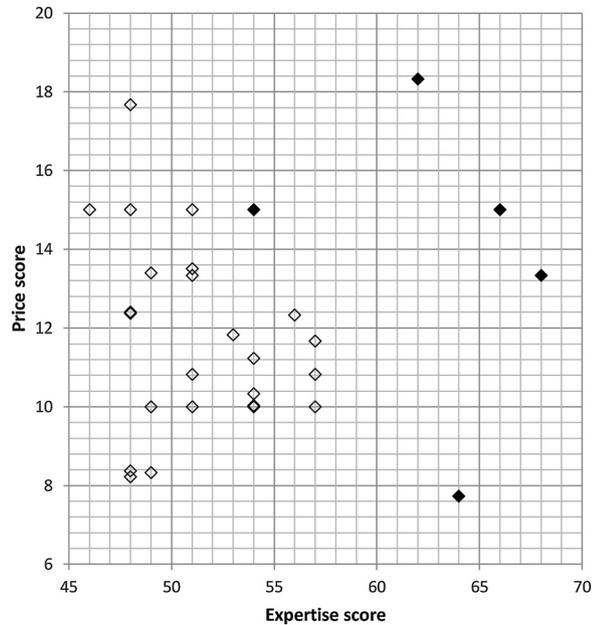


Fig. 2. Scatter plot of Expertise scores and Price scores for the 29 participating providers (selected providers in solid dots).

Providers were asked to submit a price offer which remained undisclosed until all documents and interviews were scored. With the price offer the provider could earn an additional 20 points, based on a rewarding scheme. Zilveren Kruis promised not to negotiate with selected providers about the price. This meant Zilveren Kruis was exposed to a financial risk that normally is mitigated via price negotiations with providers. Experiences with BVP in other sectors show that expert suppliers typically do not ask the highest prices.

Fig. 2 shows the results of the review process. It shows that no provider offered the lowest or highest price of the price range (800–1400 euro for outpatient cataract surgery), or beyond. This meant that no provider received the maximum or minimum score for their price offer. Of the 29 providers who participated five providers received the three-year preferred provider contract (the solid dots in the scatter plot). Combined with the expertise scores the figure shows that four providers distinguish themselves in a dominant way from the majority of the participants. On the other hand one provider does not distinguish itself based on price nor expertise.

The inclusion of price in the selection process and the use of a threshold can result in selecting providers that do not really dominantly distinguish themselves as exceptional experts. In other words, lower quality may still be rewarded with a preferred provider contract [19]. This observation strengthens the idea that a

Table 1

Example of key performance indicators in preferred provider contract for cataract surgery.

Example cataract performance report Hospital X	
Quality performance indicator	Agreed performance level
Perioperative complications	Max. 1%
Postoperative complications	Max. 1.2%
Conducted front vitrectomy	Max. 0.2%
Corrected visual acuity $\geq 0,5^a$	$\geq 96\%$
Patient satisfaction of outpatient visit	$\geq 90\%$
Average grade by patients (0–10 scale)	≥ 8
Net Promotor Score	≥ 55
Availability of operating room	100%
Lead time first hospital visit - operation	Max. 30 days
Patient satisfaction re. waiting time	$\geq 90\%$

^a With average deviation of 0.4D.

purchaser should think carefully about how to assess price versus expertise and to what extent price should be a part of the preferred provider selection procedure [20].

1.3. Preferred provider contract

The five selected providers translated the submitted documents (LE, VA, RA and OU) into a performance contract that contained agreements for the key performance indicators. Zilveren Kruis only checked if the proposed level of the key performance indicators did not deviate from the indicators that were mentioned in the submitted documents and if the proposed indicators were sufficiently specific and measurable. In other words, the selected providers actually wrote their own performance contract as an addendum to the regular contract that providers negotiated for delivering health services. The selected providers were also asked to propose their own program for performance monitoring. Zilveren Kruis wanted performance monitoring to coincide with the regular process of the provider and did not want to increase transaction costs by imposing a separate monitoring scheme. As a result, in some cases a monthly frequency was chosen and in other cases a three or four month frequency. Table 1 shows an example of key performance indicators as agreed with one of the selected providers.

After the review phase of the cataract pilot each participant received written feedback on why they were or were not awarded the preferred provider contract. The providers were also individually visited to provide additional explanations. The first author participated in all feedback meetings. Amongst others, Zilveren Kruis asked whether the provider preferred BVP or the regular purchasing process. The majority of all participants (25) preferred the BVP approach instead of the more traditional way of purchasing with a focus on price and minimum quality standards, and scored the pilot an ‘8’ (better than the traditional approach) or a ‘10’ (much better). Health care providers mentioned that this procedure made them more aware of the performance of their own care process, and inspired them to think about process improvements. Second, this procedure put them in the lead to define health care quality. And third, some medical professionals mentioned they were grateful that this procedure allowed them to show their expertise directly to the health insurer.

2. Discussion

Zilveren Kruis conducted the best value procurement (BVP) pilots not only to select preferred providers when standardized outcome measures are lacking, but also to learn how to reshape the relationship dynamics between health care providers and health care purchasers. The pilot had a major impact on both providers and Zilveren Kruis. First of all providers and medical specialists

became aware that it is not only important to know how to improve processes, but also to make health outcomes more transparent. With more transparency about outcomes it is much easier to improve processes, to convince health insurers about provider level of expertise, to enable value-based payments and to show patients the effectiveness of certain treatments. BVP made providers proactively define health outcomes and not wait for either directions from health insurers or (inter)national consensus about health outcomes.

One major impact on Zilveren Kruis was that health care quality, both in terms of quality differences between providers, and what indicators to use, became more transparent in a very short timeframe. The discussion arises whether this method results in a 'let a thousand flowers grow' strategy and therefore poses a threat to the standardization of quality outcome measures, like ICHOM [21]. Ultimately, Zilveren Kruis favors the development of standardized quality outcome measures. The question is how to get there. BVP represents a 'bottom-up' approach from the level of individual health care providers with a high level of professional engagement [cf. 22], instead of a institutionalized perspective based on consensus.

Best value procurement is first and foremost a tool for provider selection. It can be combined with pay-for-performance (P4P), but it does not have to. In the pilots of Zilveren Kruis, the providers essentially wrote their own contracts, defining the performance indicators related to input, process and outcomes themselves. Payment was not contingent on performance, however. It is very well possible to combine BVP with P4P, but this would require that the P4P program is designed according to the evidence on P4P effectiveness, for instance that rewards are based on providers' absolute performance, and that the program is designed collaboratively with providers [23].

Recent reviews of the Dutch health care system reforms since 2006 have noted that the health insurers, as purchasers of care, have made only limited progress in taking up their role as strategic purchasers of care [2,3,5,6,8]. Among various other things, the concept of strategic purchasing includes a focus on health care quality and health outcomes, dealing with information asymmetries other than through contract completeness, and eliciting provider responses to purchasing that have a positive impact on health systems performance [4]. The BVP pilots have to be seen as a step towards more strategic purchasing of health care [cf. 3]. To the best of our knowledge, this best value procurement approach has not been used anywhere else for the selection of health care providers. For policy makers working in health care purchasing or commissioning in countries or regions with a purchaser-provider split (such as Germany, Finland, Switzerland, England), these pilots could serve as an example of how to enrich the health care purchasing toolbox.

3. Conclusion

The pilots aimed to change a purchasing strategy characterized by price, volume, contracts, monitoring and control towards a purchasing strategy characterized by outcomes of care, shared value, dialogue and empowerment. Whether this objective is being realized is too early to tell. For each of the five pilots, the first phase was successful in the sense that Zilveren Kruis was able to identify providers that distinguish themselves as expert providers. But the effects on health care quality, safety, patient satisfaction, efficiency, volumes and relationship quality can only be evaluated after the pilots are completed. The evaluation of the selection phase showed that health care providers are very enthusiastic about this approach to provider selection. Even those that participated but did not get a preferred provider contract, generally preferred this process over the traditional process. The providers who participated asked Zil-

veren Kruis to continue this approach to health care purchasing. Best Value Procurement is no panacea, but is to be seen as an additional tool in the toolbox of health care purchasers. With this series of pilots in different health care domains, knowledge can be generated about when to apply BVP, and when not. The longer-term effectiveness of this approach and the boundary conditions for its applicability will be tested in the years ahead.

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Conflict of interest

At the time of this research, Peter Dohmen was policy adviser for Zilveren Kruis (Achmea) and project manager for the pilot described in this article. Currently, Peter Dohmen is a part-time PhD student and part-time purchasing consultant.

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