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Effects of the reform of the Dutch healthcare into managed competition: Results of a Delphi study among experts

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ABSTRACT

Background: In 2006 a major healthcare reform was introduced in the Netherlands, implying managed competition. This study explored the level of consensus on the outcomes and desired changes of this new system, and differences between stakeholder groups.
Methods: A three-round Delphi-study was conducted among Dutch healthcare insurers, health economists, and professionals in general practice (GP) care and mental health (MH) care. In the first round, 20 experts indicated the most important advantages and disadvantages of the Dutch managed competition, and desired changes. Experts in the second (n = 106) and third round (N = 88) rated the importance of the 88 factors identified in the first round.
Results: Only healthcare insurers reached consensus on important advantages (i.e. improved efficiency; room for choice). Health economists reached almost no consensus on any factors. GP and MH-care professionals reached most consensus on disadvantages (i.e. focus on price over quality, increased bureaucracy) and desired changes (i.e. reduce bargaining power of healthcare insurers; increase attention for care of complex patients); half of them suggested abolishment of managed competition.
Conclusion: GP and MH-care professionals were most dissatisfied and suggested several changes or even abolishment of the 2006 reform; healthcare insurers mentioned some benefits. This level of dissatisfaction among health care professionals indicates that there is room for improvement, preferably developed in conjunction with stakeholders.

1. Introduction

In the Netherlands, a major healthcare reform was introduced in 2006. The traditional system no longer met requirements for access to affordable, necessary medical care of good quality for all Dutch citizens in a sustainable manner on the long-term [1]. The reform via the Health Insurance Act (HIA) implied integration of the former statutory health insurance scheme (sickness fund scheme) and private health insurance arrangements into a universal mandatory basic package scheme with competition between insurers and freedom of choice for consumers [2–4]. The new system entails a compulsory basic insurance for everyone including core healthcare reimbursements for everyone, such as general practitioner care, emergency care, specialist care, medicines and psychological care. Healthcare insurers have to accept everyone for the basic package. Insured persons can expand basic coverage with supplementary insurance policies. In the current system healthcare insurers compete on price for this additional package.

The reform resulted in a central position for healthcare insurers [2], implying: a. healthcare insurers to compete and act as prudent buyers of health care on behalf of their customers [5], and b. managed competition in which the insured, the healthcare insurers and the healthcare providers, became market players. This managed competition, in which health care providers negotiate with insurance companies, aims to increase efficiency, reduce central governance and improve accessibility of health services of a good quality at acceptable societal costs [3].

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The role of managed competition in healthcare is complex and much debated [6–11], and there is no consensus on whether the reforms reached their goals [9,12,13]. Opponents criticize its complexity, the determining role of healthcare insurers in the client – manufacturer relationship [6–13], the lack of transparency, and the power conflict between insurers and care providers [2]. Dissatisfaction has increased especially among general practitioners and professionals in mental healthcare as workload became increased due to changes in mental health care, elderly care and youth care. This led to demands for reducing bureaucracy and improving health care insurers' trust in healthcare professionals [14,15]. The Dutch Minister of Health, Welfare and Sport (*VWS*) concluded that competition in Dutch healthcare got out of hand and should be restricted to guarantee high quality care [16]. A recent conclusion from a special issue in Health Policy concluded that still much work needs to be done [17], also to restore low institutional trust [18,19]. Low levels of trust may reduce support for the new health care system among stakeholders [2]. It is therefore important to know the perceived outcomes of the new health care system of professionals related to the fields of general practice and mental health care to identify outcomes that they are satisfied with and which not, whether these perceptions are the same for relevant groups of stakeholders, and how to potentially address dissatisfaction in order to increase levels of trust.

Consequently, the first aim of this study is to explore consensus among experts on the most important outcomes, such as advantages, disadvantages as well as potential changes needed to optimize managed competition in the Dutch healthcare system by exploring this among stakeholders relevant for these two domains of health care. The second aim is to identify similarities and differences among these stakeholder groups in their opinion on the most important advantages, disadvantages and desired changes to optimize managed competition in Dutch healthcare. This identification may provide directions for optimizing the current system to achieve and maintain the overall goals of the Dutch healthcare system with regard to quality, affordability and accessibility of care [3].

2. Methods

2.1. Study design

A three-round online Delphi study [20] was conducted among health economists, healthcare insurers, and professionals in the general practice (GP) care and the mental health (MH) care to identify and prioritise advantages, disadvantages and desired changes of managed competition in the Dutch healthcare system.

2.2. Participants and sampling

An expert was defined as an informed individual [21], a specialist in their field [22], and someone with knowledge about a specific subject [23–25]. Dutch speaking professionals from health economics, health care insurances, GP-care and MH-care were selected as experts for this study. Within GP-care professionals, three types of professions were included: [1] general practitioner [2]; GP nurse specialized in chronic disease and elderly care, and [3] GP nurse specialized in mental health. Experts in the group of the MH-care professionals included psychiatrists, psychologists, psychotherapists, MH nurse practitioners and social psychiatric nurses.

Initially we approached the professional organisations for distribution of the questionnaire. As they did not respond to our invitation we decided to use purposive sampling and snowball sampling [26,27] to identify and select various different experts aiming at identifying a broad range of responses. Various national associations, (health) professional groups and professionals groups were identified to be contacted for the first round with the aim to invite a minimum of seven experts per group – a common standard within Delph studies. This resulted in a list of in a total of 21 experts. The most important selection criterion was that the researcher was currently employed in the specific area of the particular profession of the group [28]. These experts were sent an invitational e-mail. Participants in the first round were asked to suggest other experts for the second and third round. Identification of experts by the researchers and participants resulted in a list of 339 eligible experts with the same inclusion criterion as for round 1. In each round, the experts were invited to respond to the questions in an online 15-minute survey. All questionnaires were piloted by approximately five randomly chosen subjects – different from those recruited for the main study – to verify clarity of questions.

2.3. Data collection

Participants were informed about the purpose of the research, the risks associated with the research, their obligations and consequences of participation, and their right of withdrawing consent during data collection of the study. All participants were asked to provide written informed consent for the study at the start of the online questionnaire. Study approval was given by the ethics committee of the faculty of Health, Medicine and Lifesciences of Maastricht University (FHML/HPIM/2018.112).

2.3.1. Delphi first round

The first-round survey consisted of two parts. The first part assessed gender, age, current profession and years of work experience. The second part involved open-ended questions [29] assessing [1]: "What are the most important advantages of managed competition in the Dutch healthcare system?" [2]; "What are the most important disadvantages of managed competition in the Dutch healthcare system?"; and [3] "What are the most desired changes regarding the current system of managed competition?". All participants were asked to indicate a maximum of six answers per question to facilitate manageability of responses.

A selection of 40 experts was invited for round 1. Two e-mail reminders were sent to non-responders after two and four weeks. Two researchers analysed the raw data and merged similar factors via discussion. In case of ambiguities or disagreement between the researchers about a factor, a third researcher was asked for his opinion. Factors for which full agreement among all three researchers were reached were included in the second-round questionnaire. The wording used by participants – with minor editing – was used for the questions for round two.

2.3.2. Delphi second round

In the second round, demographic characteristics (similar to the first round) and the 88 unique factors were presented to 339 experts in an online questionnaire. Participants were asked to rate the importance of each factor on a seven-point Likert scale, ranging from 1 (fully disagree) to 7 (fully agree). Participants were also asked to state whether and how managed competition could be optimized. Opponents of continuation of managed competition in Dutch healthcare were asked to provide an alternative for the current healthcare system. Email reminders were sent to non-responders after two and four weeks, resulting in 106 respondents. Experts rated all factors due to the forced response format of the online survey. Results of round two were analysed per stakeholder group to identify group similarities and differences Factors with an interquartile range (IQR) of ≤ 1 were removed for the third round questionnaire.

2.3.3. Delphi third round

The third round's purpose was to finalize ranking. All respondents of the second round questionnaire (n = 106) were invited to re-rate the remaining factors for which no consensus was reached in the second round. This questionnaire differed per stakeholder group as the survey contained controlled feedback of the group's response expressed in a median (Mdn) score, so that participants had knowledge of the specific group whilst maintaining group anonymity [30]. Email reminders were sent to non-responders after two and four weeks. Experts rated all factors due to the forced response format of the online survey. Results of the questionnaire of Delphi round three were also analysed per stakeholder group.

2.4. Data analysis

The first round data was analysed using Qualtrics and content analysis by grouping similar items together [31]. Subsequent rounds were analysed to identify convergence and change of participants' views. Descriptive and inferential statistics were used to describe sociodemographic characteristics of participants and to analyse the extent of consensus [31]. As suggested by the literature, the level of agreement on each item and consensus was determined using the median and interquartile range (IQR) after three rounds of data collection and analysis [32]. Agreement was assessed by the median for each item; a factor with a Mdn score of $\geq$6 was considered important [33]. Consensus was determined as the interquartile range (IQR) being one or less. Similarity in consensus on important factors between two or more groups existed when the Mdn score was $\geq$6 and the IQR was $\leq$1 for a single factor. Microsoft Office Excel was used to calculate averages, standard deviations (SDs), percentages, median (Mdn) scores and IQRs. The results concerning the advantages, disadvantages and desired changes were used to create appendixes 1–3.

3. Results

Twenty experts (50.0 % response rate) participated in the first round, consisting of healthcare insurers (n = 5), health economists (n = 4), MH-care professionals (n = 7), and GP-care professionals (n = 4). In total, 88 unique factors were identified and used as input for the second and third round surveys, consisting of advantages (21 factors), disadvantages (35 factors) and desired changes (32 factors). A total of 106 experts were included in the second round (31.3 % response rate). The third round questionnaire was completed by 88 experts (83.0 % response rate). Sociodemographic characteristics of the experts and response rates per stakeholder group are presented in Table 1.

3.1. Health care insurers

Table 2 reveals that after three rounds healthcare insurers reached consensus on nine advantages, for instance increased freedom of choice for the insured and improved quality of care. They reached consensus on three disadvantages, for example uncertainty about the final responsible stakeholder in certain healthcare issues, and excessive bargaining power of hospitals compared to healthcare insurers). Lastly, consensus was reached regarding ten desired changes (i.e. increasing differences in reimbursement between contracted and non-contracted care; reducing cherry picking (i.e. providers who mainly try to provide care to the most profitable patients)).

3.2. Health economists

Health economists reached consensus on two desired changes: increasing the transparency of health insurance policies on quality; costs and accessibility of care; increasing investments in prevention and early detection. No consensus was reached on important advantages and disadvantages of managed competition in Dutch healthcare.

3.3. Mental health care professionals

Mental health care professionals did not reach consensus on the advantages of the current health care system. They reached consensus on 17 disadvantages, for instance focus on price over quality of care; excessive bargaining power of healthcare insurers compared to care providers. Regarding the desired changes, consensus was reached on 13 factors, such as increasing attention for care of complex patients; and increasing the transparency of health insurance policies on quality, costs and accessibility of care (see Table 3).

3.4. General practice care professionals

GP-care professionals did not reach consensus on advantages of the current system. They reached consensus on seven disadvantages, such as detrimental effects on care for the most complex patients; and the focus on price over quality of care (see Table 4 for more information). Concerning the desired changes, consensus was reached on ten alterations, such as increasing uniformity in healthcare insurers' requirements for care providers; and reducing the bargaining power of healthcare insurers.

3.5. Group similarities

GP and MH professionals reached consensus on six i disadvantages: [1] detrimental effects on care for the most complex patients [2]; focus on price over quality of care [3]; the loss of health care money as a result of competition among market players [4]; excessive bargaining power of healthcare insurers compared to care providers; [5] increased complexity of the healthcare system; and [6] increased bureaucracy. Both groups reached consensus on six important changes [1]: increasing attention for care of complex patients [2]; increasing uniformity in healthcare insurers' requirements for care providers [3]; reducing the bargaining power of healthcare insurers [4]; reducing administrative burden for care providers [5]; increasing input and control to health care professionals should regarding desired treatment pathways; and [6] simplifying healthcare regulations.

Healthcare insurers and GP-care professionals reached consensus on one desired change: increasing transparency of care provided by healthcare professionals. Healthcare insurers and MH-care professionals reached consensus on three desired changes: [1] reducing production incentives for care providers [2]; increasing trust between care providers and healthcare insurers; and [3] reducing cherry-picking.

Health economists and professionals in the GP and MH-care reached consensus on two important changes: [1] increasing the transparency of health insurance policies on quality, costs and accessibility of care and [2] increasing investments in prevention and early detection. Healthcare insurers and professionals in the GP and MH-care reached consensus on one change: a better compensation of implementation of evidence-based innovations by care providers.

3.6. Continuation of managed competition in Dutch healthcare

No consensus existed between the different stakeholder groups about continuation of managed competition. All health care insurers (n = 8) and most health economists (n = 12) favoured continuation of managed competition, with certain changes. One did not want changes; one suggested full abolishment.

Table 1
Sociodemographic characteristics study participants.

Sector	Characteristic	1st round (n = 20)	2nd round (n = 106)	3rd round (n = 88)
Healthcare insurers	Number invited	7	12	8
	Number participated (% response rate)	5 (71.4)	8 (66.7)	7 (87.5)
	Work experience in yrs. (SD)	7.4 (1.0)	5.9 (3.0)	6.3 (3.0)
	Age in yrs. (SD)	52.4 (7.9)	48.9 (8.9)	48.7 (9.5)
	Sex			
	Female (%)	–	–	–
	Male (%)	5 (100.0)	8 (100.0)	7 (100.0)
Health economists	Number invited	10	49	14
	Number participated (% response rate)	4 (40.0)	14 (28.6)	12 (85.7)
	Work experience in yrs. (SD)	23.5 (14.5)	14.5 (8.2)	13.4 (8.2)
	Age in yrs. (SD)	52.8 (11.8)	42.2 (9.0)	40.9 (8.7)
	Sex			
	Female (%)	–	3 (21.4)	2 (16.7)
	Male (%)	4 (100.0)	11 (78.6)	10 (83.3)
Mental health care professionals	Number invited	13	195	49
	Number participated (% response rate)	7 (53.8)	49 (25.1)	41(83.7)
	Work experience in yrs. (SD)	17.6 (8.7)	15.7 (11.1)	14.5 (10.4)
	Age in yrs. (SD)	47.7 (10.0)	50.9 (11.4)	50.5 (11.5)
	Sex			
	Female (%)	3 (42.9)	25 (51.0)	19 (46.3)
	Male (%)	4 (57.1)	24 (49.0)	22 (53.7)
General practice care professionals	Number invited	10	83	35
	Number participated (% response rate)	4 (40.0)	35 (42.2)	28 (80.0)
	Work experience in yrs. (SD)	3.3 (2.3)	12.7 (9.8)	14.0 (10.1)
	Age in yrs. (SD)	32.8 (7.2)	46.5 (11.7)	46.8 (10.6)
	Sex			
	Female (%)	3 (75.0)	24 (68.6)	19 (67.9)
	Male (%)	1 (25.0)	11 (31.4)	9 (32.1)

Table 2
Opinions of health care insurers.

Perceived Advantages	*Disadvantages*	*Desired Changes*
increased freedom of choice for the insured	uncertainty about the final responsible stakeholder in certain healthcare issues	increase attention for healthcare outcomes
improved quality of care	excessive bargaining power of hospitals compared to healthcare insurers and	improve the system of risk equalization
improved accessibility of care	increased incentives for over treating patients by care providers	increase differences in reimbursement between contracted and non-contracted care
reduced waiting times for patients		reduce production incentives for care providers
cost-containment		reduce cherry picking (i.e. providers who mainly try to provide care to the most profitable patients
improved efficiency of health care		develop policies to protect health data of patients and the insured
increased innovation in healthcare		increase transparency of care provided by healthcare professionals
a better balance between quality, accessibility and affordability of care		increase trust between care providers and healthcare insurers
increased awareness of healthcare costs		better compensate the implementation of evidence-based innovations by care provider
		increase regional responsibility of different stakeholders in care processes

Half of the MH-care professionals (n = 25; 51 %) agreed upon abolishment of managed competition, whereas 24 (49.0 %) agreed on continuation with changes. Of the GP-care professionals, 54 % (n = 19) agreed on abolishment, while 46 % (n = 16) agreed on continuation with changes.

Advocates of abolishing managed competition in the Dutch healthcare system (n = 45) opted for different alternatives. Most frequently suggested alternatives for the current system of managed competition were a government controlled healthcare system (n = 6), a population or regional based funding system (n = 5), the return to the former sickness fund system (n = 3) and a single payer system dubbed 'national care fund' (n = 2).

4. Discussion

Several overviews about the effects of the 2006 reform concluded that – despite benefits – the introduction of the Dutch Health Insurance Act also resulted in problems and political controversies [2,3,34–36]. We conducted a Delphi study among experts to identify the level of consensus regarding the positive and negative effects and potential adaptations of the current Dutch health care system with managed competition, and identified notable findings.

First, only health care insurers reached consensus on important advantages of managed competition in Dutch healthcare, pertaining to increased freedom of choice; improved accessibility

Table 3
Opinions of mental healthcare professionals.

Disadvantages	*Desired Changes*
focus on price over quality of care	increase attention for care of complex patients
excessive bargaining power of healthcare insurers compared to care providers	increase the transparency of health insurance policies on quality, costs and accessibility of care
the use of wrong healthcare procurement strategies by healthcare insurers	reduce the bargaining power of healthcare insurers;
increased administrative burden for care providers	reduce incentives for care providers
increased overhead costs as a result of regulation, care purchasing processes and administration	reduce administrative burden for care providers
increased uncertainty and a lack of clarity among care providers as a result of a lack of uniformity in the requirements of different healthcare insurers	increase trust between care providers and healthcare insurers; and
a poorly functioning Diagnosis Treatment Combination (DTC) payment system	simplify healthcare regulations
increased complexity of the healthcare system	increase investments in prevention and early detection
increased bureaucracy	increase uniformity in healthcare insurers' requirements for care providers
excessive focus on control	improve the DTC payment system
detrimental effects on care for the most complex patients	give more input and control in desired treatment pathways to health care professionals
inadequate time for care providers with their patients	reduce cherry-picking
inadequate attention for prevention and early detection	better compensate the implementation of evidence-based innovations by care providers
increased healthcare costs	
the loss of health care money as a result of competition among market players	
increased cherry-picking by care providers	
increased mistrust between different market actors	

Table 4
Opinions of general practice care professionals.

Disadvantages	*Desired Changes*
detrimental effects on care for the most complex patients	increase attention for care of complex patients
focus on price over quality of care	increase the transparency of health insurance policies on quality, costs and accessibility of care
the loss of health care money as a result of competition among market players	increase investments in prevention and early detection
excessive bargaining power of healthcare insurers compared to care providers	increase uniformity in healthcare insurers' requirements for care providers
increased bureaucracy	reduce the bargaining power of healthcare insurers
increased complexity of the healthcare system	reduce administrative burden for care providers
	given more input and control in desired treatment pathways to health care professionals
	better compensate the implementation of evidence-based innovations by care providers
	increase the transparency of care provided by healthcare professionals
	simplify healthcare regulations

and quality of care; reduced waiting times for patients; awareness of healthcare costs and cost-containment; improved efficiency of health care; increased innovation in healthcare; and balance between quality, accessibility and affordability of care. Several of these advantages are related to the central role of healthcare insurers in orchestrating the current Dutch healthcare [2], where health care insurers compete and act as prudent buyers of health care on behalf of their customers [5]. Yet, health economists did not reached consensus on important cost and efficiency advantages. Reports on cost reduction, increased efficiency and quality appear to be mixed and also depend per context and problem addressed [37–39]. A further in-depth study about these topics with this subgroup is therefore warranted to obtain a more detailed picture.

Second, GP-care professionals and MH-care professionals reached consensus on various disadvantages and desired changes regarding managed competition in Dutch healthcare. Just over half of them wants abolishment of managed competition in Dutch healthcare. Of the stakeholders involved in this study, GP and MH-care professionals were most dissatisfied about managed competition, which is also reflected by their initiatives to reduce bureaucracy and administrative burden, and improving health care insurers' trust in healthcare professionals [14,15], and vice versa as also shown by others (18).

Third, three desired changes were mentioned most often. The first concerned increasing the transparency of health insurance policies on quality, costs, and accessibility of care. Failing clear and timely information of insurers to their customers and a low health insurance literacy of customers tends to decrease trust in healthcare insurers [40] calling for increased transparency about procedures and quality [4,19]. Although transparency of insurers' information to its clients has increased, information about waiting times and traceability of information still needs further improvement [41]. The second change concerned increasing investments in prevention and early detection, which may foster quality of life and reduce care demands on the long run, thus increasing affordability and accessibility of healthcare [41], although evidence on its cost-effectiveness is contradicting [42,43]. These recommendations are also in line with recent actions by Dutch Ministry of Health, Welfare and Sport, such as incorporating lifestyle interventions in the basic insurance package [41] and promoting longer independent home living for the elderly [44]. The third desired change concerned compensation of evidence-based innovations by care providers. While healthcare insurers negotiate with providers about price, quantity and quality of care [4], evidence shows that quality only played a limited role in negotiations between insurers and providers [4], which are mostly cost-driven [2]. This cost-driven focus hampers

a good price compensation for the implementation of high quality evidence-based innovations in health care.

Fourth, whereas healthcare insurers regarded their bargaining power as an advantage, MH-care and GP-care professionals regarded this as a disadvantage. Although ideally balanced negotiations require comparable power positions between parties [45], the current relationship between insurers and care providers has resulted in much power for the insurers, findings also reported by other studies [2] (36). This also resulted in protests by general practitioners (GPs) and MH-care professionals concerning, bureaucracy, (too low) tariffs, complex contract conditions [46], and uncontracted MH-care providers [47].

Our study is subject to limitations. First, snowball sampling and purposive sampling may have introduced selection bias [48]. Snowball sampling leaves it to the respondent to indicate relevant experts, which may result in biases. Additionally, respondents dissatisfied with the current health care system may have been more likely to participate. The absence concerning consensus about the advantages among professionals from the general practice and mental health could reflect such a bias. Hence, study replication using other sampling techniques is recommended. Second, our sample contained only seven healthcare insurers, which is regarded as sufficient [28] although others include 10–15 experts [49] yielding no clear consensus on the optimal number of participants in a Delphi study [50]. Third, the 30 % response rate for round 2 was modest, but high (81 %) in round 3. Our response rates are similar to many Delph studies where approximately 30 % take part in the second round, and 70 % in the subsequent round [51]. Fourth, personal perspectives may have played a role in the identification of advantages, disadvantages and changes needed. The phrasing of the questions allowed participants to report on perceived advantages and disadvantages, which could also imply pros and cons for them personally. Yet, this bias is possible for all stakeholders and it is difficult to conclude whether self-interests were more leading in one group that in another. By choosing open wording to cover all angles of interest in round 1 we aimed to cover a broad spectrum of answers, and also resulting in a wide variety of topics mentionned by the participants.

Fifth, due to feasibility reasons, our study focused on the perceptions among Dutch healthcare insurers, health economists, and professionals in general practice (GP) care and mental health (MH) care, also to increase understanding and dissatisfaction and distrust among general practitioners and mental healthcare professionals. Future studies are encouraged to address perceived outcomes of the current health care system among citizens, patients, other groups of care providers such as hospitals and independent treatment centers, municipalities and politicians regarding the role of managed competition in Dutch healthcare. Sixth, our study used a bottom-up approach to assess stakeholder perspectives and thus did not use already identified criteria for efficient and affordable regulated competition in health care [11]. Finally, after the 2006-reform other health policy decisions were taken in the Netherlands (e.g. social support act, mental care reform, long-term care reform, youth care reform (see for instance [52]), that could have influenced the responses of the participants.

5. Conclusions

Views of the various groups differed significantly, which is also understandable given the different roles that the professionals have. For instance, health insurers and health economists may be more focusing on an overall perspective, whereas professionals from the general practice and mental health will be reporting more their domain specific items. This latter difference may also explain the difference between health insurers on the one hand, and professionals from the general practice and mental health on the other hand. Healthcare insurers were most positive about the role of managed competition the current Dutch healthcare system. Health economists hardly reached any consensus. GP and MH-care professionals were most dissatisfied and suggested several changes or even abolishment of the 2006 reform. Their responses provide information concerning the determinants of the dissatisfaction and distrust, and thus which items need to be taken into account in attempts to facilitate or improve the execution of the current system, preferably developed in conjunction with stakeholders. Our study provides detailed information concerning the topics that result in lowered satisfaction and trust. These items need to be taken seriously, not only via increasing transparent information, but by developing strategies to minimize the disadvantages as much where possible, and thus contributing to the already identified need for improving trust between professionals and health insurers [19]. This study offers policymakers and researchers clear directions for the items to be addressed, and to consider potential amendments within or to the current system in order to optimize it in order to achieve and maintain the overall goals of the Dutch healthcare system with regard to quality, affordability and accessibility of care.

Declaration of Competing Interest

The authors report no declarations of interest.

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Appendix A. Supplementary data

Supplementary material related to this article can be found, in the online version, at doi:https://doi.org/10.1016/j.healthpol.2020.10.010.

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