TSUNAMI WARNING: FROM BABY-BOOM TO WANTED SENIOR ROOM

An explorative study into the expectations and requirements for public-private partnerships in the Dutch healthcare real estate market

VU VRIJE UNIVERSITEIT AMSTERDAM

CUSHMAN & WAKEFIELD

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Internship report

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Colophon

This document concerns an internship report for the Master of Science program in Management, Policy-analysis and Entrepreneurship in Health & Life Sciences at VU University Amsterdam, The Netherlands.

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Preface

In front of you lays the result of my internship research project, which took place at Cushman & Wakefield during a five-month period in 2018. The internship is part of the Master of Science program in Management, Policy-analysis and Entrepreneurship in Health & Life Sciences at VU University Amsterdam. Throughout the whole research process, I have been greatly supervised by Emma Emily de Wit (Athena Institute, VU University, Amsterdam).

This research has been conducted for Cushman & Wakefield under the very effective supervision of Eric Scheijgrond and Geertje Besier. Together we have designed the research project and I have been fortunate to be part of a multinational company and to meet many inspiring people. It has been a true challenge, working in the personal undiscovered field of healthcare real estate. The internship process helped me realise how important it is to connect the two involved fields of interest for the benefit of improving healthcare in the future. I want to thank all my colleagues at Cushman & Wakefield for teaching me more about real estate and helping me with gathering participants for my data collection.

In the past several months, I have learned very much, and this experience has been enriching for me to an extent that it has increased my passion for healthcare even more. My gratitude goes to my Cushman & Wakefield supervisors Eric Scheijgrond and Geertje Besier for this great opportunity and their warm-hearted support. I want to thank my VU University Amsterdam supervisor Emma Emily de Wit for teaching me new research insights, for the feedback, and for the continuous help with my report, knowing that this topic was previously unknown to her.

The aim of this report is to provide insights into the expectations and requirements for public-private partnerships in the Dutch healthcare real estate market, viewed from both the public and the private sector. These insights will contribute to the knowledge of Cushman & Wakefield in this field. I also hope that the knowledge resulting from this research will contribute to the improvement of healthcare and senior housing.

Thank you!

Amsterdam, July 2018.

Executive summary

Keywords: *double ageing process, healthcare real estate, public-private partnerships.*

Introduction: The population of the Netherlands is going through a double ageing process. This demographic change is very likely to cause an increased shortage of suitable elderly housing in the near future. Anticipating this trend, a possible solution is public-private partnerships (PPPs) in the healthcare real estate market. However, little is known about how to establish such PPPs. Therefore, the aim of this research is to contribute to the establishment of PPPs in the healthcare real estate market by collecting insights from multiple stakeholders with regards to what is expected and required for PPPs.

Methods: Qualitative research was conducted, deriving knowledge from 15 semi-structured interviews. Based on a conceptual framework, an interview guide was developed, tested, and used for data collection. Data was collected from (semi-)public stakeholders (n = 8) and private stakeholders (n = 7). All interviews were transcribed verbatim and analysed through open, axial, and selective coding.

Results: Based on the data analysis, various themes were derived. Firstly, there was disagreement in the outcome expectations for PPPs about the scope of projects. In addition, diversity in target population combined with care provision was an important expectation. Risk expectations included time-varying risks, conjuncture risks, and opportunities: social added value for the public sector and financial growth for the private sector. Secondly, regarding required perspectives on roles, public roles mostly comprised policy transparency and contractual flexibility, although public respondents also emphasized limitations due to regulatory restrictions. Private roles involved innovation and financial and technical project management. However, results demonstrated agreement that not all stakeholders should have equal responsibility in the partnership. Mutual roles were defined as the development of a strategic PPP vision and the formation of a transcending steering group.

Discussion: The adopted conceptual framework was valued. The findings of this study were comparable with existing studies. The strengths of this research were, among others, that this was the first study to describe the views of all key stakeholders in healthcare real estate on PPPs. In addition, data saturation was reached with the number of participants, strengthening the validity of the study. Limitations of this study were that results are not generalizable nor are they able to be put in perspective. Also, stakeholders were not confronted with each other's opinions through focus groups. Further research is needed and should focus on the engagement and enablement of a PPP structure in the healthcare real estate market.

Conclusion: The research objective was reached, as insights into the establishment of PPPs in the healthcare real estate market were gathered, creating a better understanding of the involved expectations and requirements for the healthcare real estate market. The main expectation is the strong potential of PPPs in the Netherlands, demonstrating that, if requirements are in place, diverse and flexible living environments can be created. The most important requirement comprises flexibility in contractual agreements and a shared strategic vision of PPPs. Additional insights were found on the great potential of the Dutch healthcare real estate market in comparison with the Belgian market.

Acronyms and abbreviations

Table 1. List of acronyms and abbreviations.

AWBZ	Algemene Wet Bijzondere Ziektekosten (Exceptional Medical Expenses Act*)
CAK	Centraal Administratie Kantoor (Central Administration Office*)
CBS	Centraal Bureau voor de Statistiek (Central Bureau for Statistics*)
CBZ	College Bouw Zorginstellingen (College for Building Healthcare Institutions*)
CIZ	Centrum Indicatiestelling Zorg (Care Assessment Centre*)
GDP	Gross Domestic Product
LTC	Long-term Care
NHC	Normatieve Huisvestingscomponent (Normative Housing Component*)
OECD	Organisation for Economic Cooperation and Development
PPP	Public-private partnership
WHO	World Health Organisation
Wlz	Wet langdurige zorg (Long-term Care Act*)
WMO	Wet Maatschappelijke Ondersteuning (Social Support Act*)
Zvw	Zorgverzekeringswet (Healthcare Insurance Act*)

*English translation.

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1. Introduction

1.1 Background

As in most Western countries, the population of the Netherlands is increasingly ageing. In 2018, the baseline year of this study, 3.1 million people were aged over 65, which is 18 percent of the Dutch population. This number is expected to rise up to 4.6 million over-65 people by 2040; equal to 26 percent of the Dutch population (CBS, 2018). Therewithal, the expected average life expectancy is rising sharply from 81.6 years today, up to about 88.6 years in 2060. This dual development is known as the "double ageing process," leading to a significantly increased demand for long-term care (LTC) (Eggink, Ras, & Woittiez, 2017). Faced with the problems associated with an ageing society, innovative policies are increasingly sought to achieve a better balance between the need to expand LTC and the imperative to control public spending (De Jong et al., 2018; Pavolini & Ranci, 2008).

In the Netherlands, the expenditure for LTC accounts for about 5 percent of the GDP. This is similar to other Nordic countries, but higher than most Southern European countries. The emphasis and expenditure on residential care, however, is considerably high (Da Roit, 2017). The Netherlands is the second highest spender on LTC after Sweden in the OECD-countries, which has evoked ongoing national debate about public expenditure (OECD, 2018). As of 2015, major reforms in Dutch LTC have been introduced, mainly to regain control over expenditure growth and improve quality of LTC by making the approach more client-tailored. The reform is based on four related assumptions: a controlled reorientation, a focus on non-residential care, decentralization of healthcare, and expenditure reduction (Maarse & Jeurissen, 2016). The national government has abolished the Exceptional Medical Expenses Act (AWBZ) by reducing its scope and renaming it to the Long-term Care Act (Wlz). Important tasks from the AWBZ were partly transferred to healthcare insurers through the Health Insurance Act (Zvw), and partly to municipalities through the Social Support Act (WMO). As a consequence, measures are being taken to control use of care, for instance, by restricting access to publicly financed care (Eggink et al., 2017)

In line with these developments, LTC reforms have been introduced for the financing of residential care (Ipso Facto, 2016; Rijpstra & Janssen, 2013). Until 2012, the government financed capital costs to an approved healthcare institution if it had a permit from the College for Building Healthcare Institutions (CBZ). In this way, healthcare institutions were not real estate risks (Veuger, 2016). From 2013 until 2016, the Dutch government introduced reforms concerning the financing of healthcare real estate, the separation of financing residence and care, and the decentralisation of responsibility and risks (Rijpstra & Janssen, 2013).

Since these reforms, capital costs are no longer reimbursed directly, and healthcare institutions have become responsible for the funding of these costs. The institutions must pay for this from the income generated through the care they provide. Healthcare real estate is thus funded through the demand for care. Furthermore, legislation and regulation have changed for the care recipient; financing of residence and care are separated. From 2013 onwards, people with a low-level care need are no longer entitled to stay in a residential care institution. The goal of separating residence and care for people with a low-level of care need is to stimulate people to live longer at home and to receive non-residential necessary care and support (te Brake & Moolhuizen, 2017).

Over the last few years, an alarming number of municipalities in the Netherlands have signalled an increased shortage in appropriate senior housing. Previous research has shown that the main task is to adapt existing homes and real estate, and to take into account future demand when developing new real estate (Ipso Facto, 2016; Skipr, 2018). In addition, managing healthcare real estate has become increasingly complex due to the above-mentioned changes in residence and care regulations, which requires a new way of thinking and working (Skipr, 2017). How the healthcare real estate market currently operates, the market may not be able to provide the increasing number of elderly with suitable housing in the future. For efficient restructuring of the healthcare real estate market it is indispensable that public and private parties collaborate. Such public-private partnerships (PPPs) suggest a cooperative arrangement between two or more public and private sectors, usually of a long-term nature (Grimsey & Lewis, 2002). Good cooperation between these two sectors forms a basis for a future-proof vision of healthcare real estate.

1.2 Problem statement

The Dutch healthcare real estate market faces an important task in developing adequate real estate for the growing group of elderly. There will be an increasing demand for care in the coming years. The vast majority of existing real estate was created when the elderly could easily move to appropriate care institutions, regardless of their level of care need. For instance, there was little incentive or demand to make real estate or a living environment suitable for receiving non-residential care. In the coming years, the existing living environment must adapt to these changing circumstances. As people continue to live longer independently and the ageing population is growing, a greater need for innovative care concepts is necessary, along with suited real estate. Private actors, such as investment companies and property developers, have already begun to design new non-residential concepts, yet the current healthcare real estate market cannot meet the increasing (future) demand. This puts pressure on both the public and private sector in anticipation of the shared task of providing the elderly with suitable housing. There is an imminent need for introducing public-private partnerships in the healthcare real estate market.

1.3 Problem justification

Previous research has shown that urgent action and the establishment of PPPs is necessary to anticipate the growing need for LTC and senior housing. However, there is little to no knowledge of the expectations and requirements for such partnerships in the Dutch healthcare real estate market (Ipso Facto, 2016; Skipr, 2018). Thus, Cushman & Wakefield, as the commissioner of this study, has requested more information about how PPPs should be established.

The objective of this study is to contribute to the Cushman & Wakefield mission statement to support PPPs in the Dutch healthcare real estate market by exploring the expectations and requirements for PPPs in this market. Therefore, the research question of this study is *"What is expected and required for public-private partnerships in the Dutch healthcare real estate market?"* Seeking answers to this question generates insight into the establishment of PPPs in the Dutch healthcare real estate market. This insight is necessary to make recommendations to Cushman & Wakefield on the establishment of PPPs, which will hopefully ameliorate the problem of lack of suitable senior housing to meet the needs of the increasing ageing population.

2. Contextual background

This chapter offers background on the research topic and describes the context in which this study was conducted. First, the double ageing process will be discussed with a focus on the Netherlands. Next, the organisation of long-term care (LTC) and its relation to senior housing in the Netherlands will be explained, and multiple previous reforms in these sectors will be elaborated. Finally, information is included about the commissioning company and a stakeholder interaction map is provided describing all relevant stakeholders.

2.1 Double ageing process

According to Gavrilov and Heuveline (2003), the *double ageing process* is "the demographic trend where people are living longer while fewer babies are being born, describing the synergy between the increasing life expectancy and the increasing over-65 population" (p. 3). Population ageing is a global demographic trend causing the age structure to shift from younger to older ages (von Humboldt, 2016). Worldwide, nearly every country is facing an ageing population. The world's population has been growing for many centuries; however, this growth has accelerated over the last few decades (Kinsella & Philips, 2005). In particular, this growth is dependent on the post-war baby boomer generation who is now entering the golden age of their sixties (Midgley & Pawar, 2017). The average life expectancy has dramatically increased during the 20th century; one of society's greatest achievements in human development. Although most children born in 1900 did not pass the age of 50, life expectancy has now extended to nearly 85 years in developed countries (Kinsella & Philips, 2005; WHO, 2011). The ageing is the largest in Europe and North America; in these high-income countries, continuing growth in life expectancy is primarily due to declining mortality among the over-65 population.

In the Netherlands, the over-65 population is expected to rapidly increase in the coming years (CBS, 2016). As can be seen in figure 1a, the distribution of the demographic pressure, which is the sum of the under-20 population and the over-65 population relative to the population between 20 and 65 years old, is changing in the coming years (Schalk et al., 2014; CBS, 2016). Green pressure (percentage of inhabitants under-20) will remain stable, whereas the grey pressure (percentage of inhabitants over-65) will increase sharply (Auping, Pruyt, & Kwakkel, 2015; CBS, 2016). Shown in figure 1b, the number of seniors in the Netherlands will rapidly increase in the coming years. The over-65 population will increase; in 2012, there were 2.7 million people over 65, which will expand to 4.7 million in 2041. Until 2060, this number will remain around 4.7 million. The proportion of people aged between 65-79 years old will likewise rise severely. From 2025, the group of over-80s will also increase. In 2040, the number of people over 65 is estimated to be about 26 percent of the total Dutch population; of whom one third of this group will be over 80. To illustrate, in 2012 there were nearly 700.000 people aged 80 or older. In 2040, this will be around 1.5 million people (CBS, 2016).

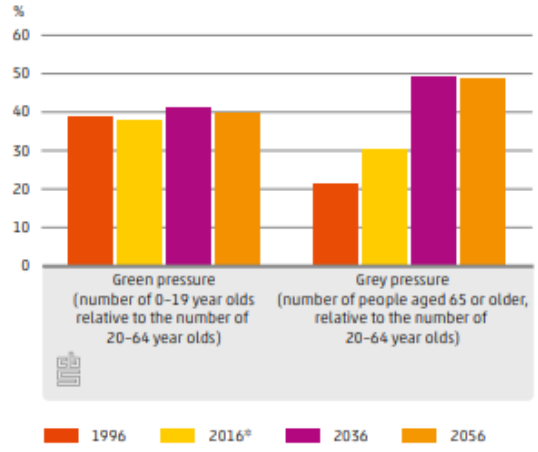

Figure 1a. Demographic pressure (CBS, 2016).

	2016	2040	2060
	x 1,000		
Population, 1 January	16,974	18,108	18,175
younger than 20 yrs	3,815	3,916	3,825
20-39 yrs	4,166	4,248	4,395
40-64 yrs	5,909	5,142	5,183
65-79 yrs	2,336	3,166	2,762
80 years or older	749	1,637	2,010
	years		
Life expectancy at birth			
men	79.9	84.0	86.8
women	83.3	87.5	90.3
	%		
Population, 1 January			
younger than 20 yrs	22.5	21.6	21.0
20-64 yrs	59.3	51.9	52.7
65 yrs or older	18.2	26.5	26.3

Figure 1b. Population forecast (CBS, 2016).

2.2 Dutch healthcare

2.2.1 Long-term care

The values of the Dutch healthcare system are based on several universal principles: access to care for all, solidarity through medical insurance mandatory available to all, and high-quality healthcare services (Ministry of Public Health, 2016). Healthcare in the Netherlands is organised in three different ways (Paley, 2010), referred to as a system in which the right care begins at the right place:

1. Primary care includes directly accessible healthcare without referral. The largest group is general practitioners. Thereafter, referral of a general practitioner is required for access to secondary care and tertiary care.
2. Somatic and mental healthcare, differentiating between physical and mental illness. General practitioners function as a gatekeeper for accessing specialists.
3. Short-term "cure" and long-term "care." Cure is medical care and is usually compensated through the Healthcare Insurance Act (Zvw). Care refers to LTC and is primarily funded through the Long-term Care Act (Wlz).

The Dutch healthcare system is known to be effective, especially compared to that of other Western countries, but it is not the most cost-effective. Costs are high because of over-use of in-patient care, institutionalised psychiatric care, and LTC. Expenditure on LTC comprises spending on residential and non-residential care, which is covered by social long-term insurance (Bakx, O'Donnell, & Van Doorslaer, 2016). As a percentage of the GDP, expenditures on cure and on care have increased since 1972. In 2013, expenditure on medical care reached 8.9% of the GDP and LTC spending rose to a substantial 4.4% of the GDP (figure 2a). According to the OECD Health at a Glance Report (2017), the Netherlands spends the most on LTC of all OECD-countries and more than average on total care. Since 2001, per capita expenditure on both medical care and LTC has risen by 40 percent (figure 2b).

Personal healthcare expenditure

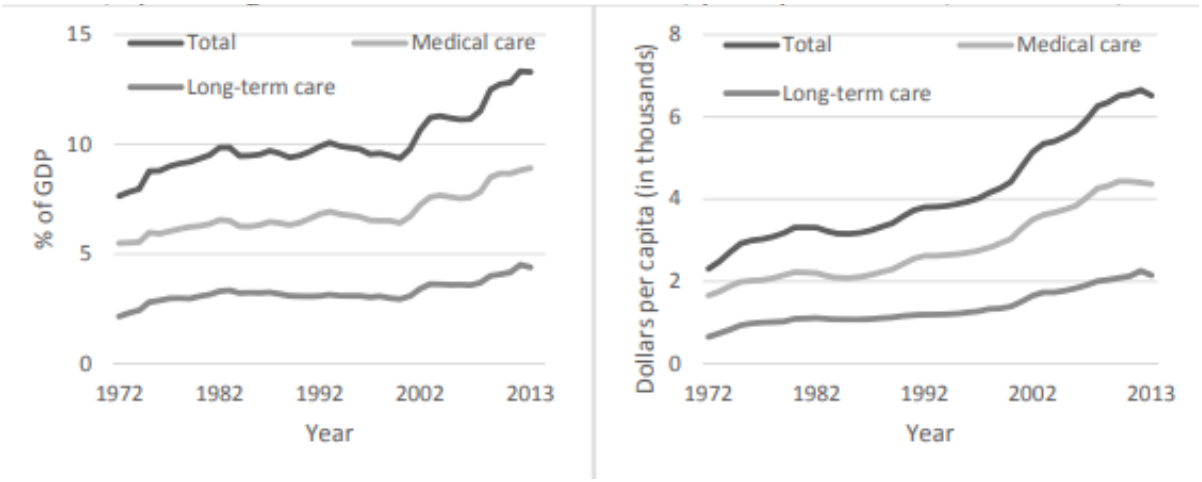

Figure 2a. Percentage of GDP (CBS, 2015).

Figure 2b. Per capita amount (CBS, 2015).

2.2.2 Healthcare reforms

A number of historical trends and developments have shaped the Dutch healthcare system. Since the start of the 21st century, two major reforms have been realised (Kroneman et al., 2016). The newly implemented LTC reform is a shift from publicly provided care to more citizen independence, and a larger role for municipalities. Previously, LTC was organised in the Exceptional Medical Expenses Act (AWBZ), however, during the reform, it became the Long-term Care Act (Wlz). During this reform, a central focus was transformation in how the government and LTC work together (Maarse, Jeurissen, & Ruwaard, 2016).

The first major reform in healthcare was the replacement of public and private insurances with a universal social health insurance package. This insurance covers most typical expenses, like general practitioner visits and hospital stays. In addition, insurers have the possibility to offer additional coverages for physiotherapy, dentistry, and other expenses. With this reform, managed competition became the incentive for improvement in the healthcare system. Although it was introduced in 2006, its step-by-step implementation continues, including adaptations in the system and in the role of key actors (Leistikow et al., 2016). The system is efficient: the most necessary healthcare is currently within reach and waiting times have decreased since implementation. To prevent excessive healthcare expenditure, a basic health insurance is mandatory for all, and low-income citizens receive several reimbursements. Out-of-pocket payments are low from an international perspective, and Dutch citizens appreciate the quality of the health system and their health as upright (Batenburg, Kroneman, & Sagan, 2015).

2.3 Healthcare real estate

As a result of the double ageing process, the demand for residence and care facilities has significantly increased over the last decades and will continue to increase in the future. Hence, real estate in healthcare has gained more importance and is currently viewed as an essential part of healthcare. Healthcare real estate is an umbrella term comprising all concepts of residence in healthcare. In this study, healthcare real estate is referred to as “senior housing.” However, healthcare real estate traditionally distinguishes multiple real estate forms for cure and care (figure 3). Both healthcare

segments have their own sub-segments, dividing care into residential and non-residential care, and cure into primary, secondary, and tertiary care. LTC residence is covered in the care segments of healthcare real estate. Whether a patient receives residential or non-residential care is determined by the level of care need assessed by the Care Assessment Centre (CIZ). This will be elaborated upon in the following sub-chapter (Tummers, Groeneveld, & Lankhaar, 2013).

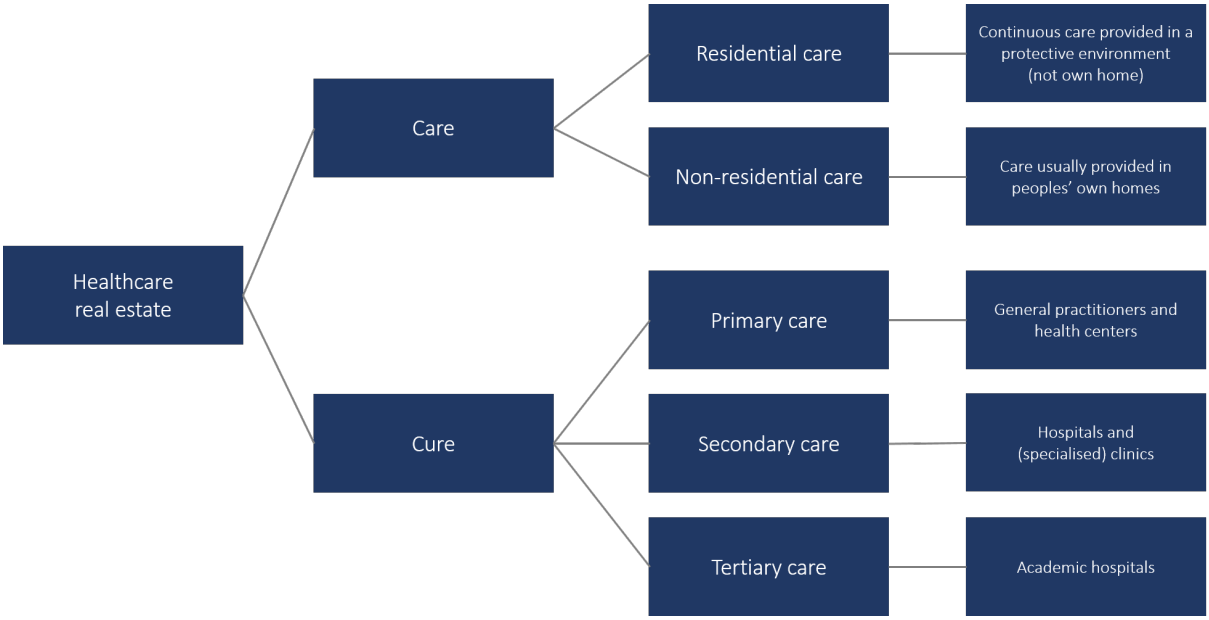

Figure 3. Overview of healthcare real estate segments, translated from Van Oostvoorn (2014).

The elderly in the Netherlands are expected to live at home for as long as possible and, if necessary, with the support from the municipality or healthcare financed through healthcare insurance (Maseland & Berends, 2018). By making healthcare more client-tailored and as self-reliant as possible, people make decisions about their own lives, and healthcare can continue to be affordable in the future. The tendency to live longer independently has been going on for several years; however, the increase of suitable senior housing is low. There is a lack of national vision on senior housing. The shortage of suitable senior housing will force the elderly to stay too long in unsuitable homes. When living at home is not possible any longer due to increasing need of care, several forms of housing are possible. The demand for suitable senior housing is increasing in all types of housing, however, the supply of suitable senior homes is decreasing. The shortage of housing is increasing up to 81.000 units in 2021 (CBRE Research, 2017). Consequently, more suitable healthcare real estate is needed to meet the growing demands. Until 2021, 44.000 suitable homes for seniors will be needed every year (Rijksoverheid, n.d.).

2.3.1 Housing reforms

The trend to stay at home for as long as possible has been present over the last decade. However, since 2013, this number has been accelerating (Verbeek & Van Campen, 2017). There are two causes: reforms in LTC and the separation of financing between residence and care for people with a low-level care need. From 2013 to 2016, this separation in financing has gradually been realised. In general, the reform implies that residence and care are financed separately and are no longer reimbursed under the Wlz. The client pays for residence via rent or purchase. The care is financed separately via the Health Insurance Act (Zvw), Social Support Act (Wmo), or Wlz, and possibly with own resources. The separation

of residence and care has several goals, including promoting longer independent living of the elderly with a care need, and also offering more freedom of choice to people with a care need. Moreover, increasing the diversity of living situations is a main objective (Aedes-Actiz, 2017).

2.3.2 Funding streams

If permanent care is needed, residence for the elderly in need of care is financed through the Wlz. As part of the Wlz, the Care Assessment Centre (CIZ, Centrum Indicatiestelling Zorg) receives requests for intensive patient care. Patients' eligibility of care is assessed by this independent organisation. In the case of domestic help, the assessment lies with municipalities. The CIZ decides how much care patients are entitled to, and if they are eligible for care in an institution or at home. Once assessed, patients can choose either to receive in-kind care or a personal budget equivalent to 76% of the cost of in-kind care (Maseland & Berends, 2018). The financing of residence for the elderly in need of care can be roughly divided into two categories:

1. Residential care, given in care institutions where the care provider provides all day supervision and intensive care to residents, if necessary. The *resident* pays a co-payment with a maximum of €2312,60 per month to the Central Administration Office (CAK) and receives residence and care from the care provider. The *care provider* delivers residence and care to the resident and receives a reimbursement from the care office or healthcare insurer.
2. Non-residential care, given in peoples' own homes, with possibilities for private care apartments or shared small-scale villas. In shared facilities, the elderly receives care, residence, hospitality, and additional services. The *resident* pays a co-payment with a maximum of €842,80 per month to the CAK and pays for residence, care, and additional services from the care provider. The *care provider* delivers housing and care to the resident and receives a rate from the resident and a reimbursement from the care office or healthcare insurer.

2.3.3 Partnership possibilities

Before the previously described reforms in the Netherlands were introduced, there was a stable supply of senior housing for the elderly population, mainly consisting of nursing and care homes. However, due to the many changes in the healthcare system, increased opportunities for innovative living situations and partnerships have emerged (Maarse, Jeurissen, & Ruwaard, 2016). The separate financing of residence and care, the increased number of people needing non-residential care, and the decentralization of responsibilities due to legislative changes have had a major impact on stakeholder involvement in the housing supply for the elderly population. Together with the demographic changes and changes in the housing market, stakeholders should seek new cooperation partners. Due to the increasing demand for suitable housing, it is of great importance that all key stakeholders are known, and partnerships can be formed with clarity around responsibilities and decision-making (Maseland & Berends, 2018). However, to date, it has not been determined how to shape partnerships in the healthcare real estate market. This study aims to collect the perceptions of all stakeholders on innovative partnerships in this market.

2.4 Cushman & Wakefield

Cushman & Wakefield is the commissioning company behind this study. It is an American commercial real estate services company and among the largest real estate services firms in the world. The firm operates in more than 70 countries with 48,000 employees. In 2016, the company merged with the Dutch real estate services company DTZ Zadelhoff, to become Cushman & Wakefield v.o.f. The Cushman & Wakefield Healthcare Group is a new and upcoming department in the organisation and provides healthcare organisations with strategic and transformational real estate services. Specifically, the Healthcare Group helps organisations reinforce their mission and brand, improve margins, improve patient and provider experiences, optimize investment value, increase business flexibility, and facilitate regulatory compliance (Cushman & Wakefield, n.d.).

2.5 Stakeholder analysis

This study contains various stakeholders who interact with each other in the Dutch healthcare real estate market. A stakeholder analysis is important to generate insight into the relations between the most important stakeholders of this market. To acquire knowledge about the changing roles of stakeholders, the *governance triangle* is used as a methodology to analyse the participation of different stakeholders. As is illustrated in figure 4, the points of the triangle indicate three types of stakeholders, and seven total areas can be distinguished in the triangle. The points of the triangle represent situations in which an individual stakeholder is active and does not involve any other actors. The areas edged between the points (area 4, 5 and 6) are viewed as cooperation between various stakeholders. Lastly, the middle of the triangle (area 7) represents the situation in which the public sector, private sector, and civil society all participate.

The symmetry of the area indicates that the three actor types are equal in interest; however, there is in fact inequality in interests, power, and capacities. Historically, the public sector has been seen as an effort of the national government to create a space for the interests of private stakeholders, and where the public interest would be served. However, according to Abbott & Snidal (2009), the national government is not necessarily a stakeholder with own interests but instead balances different interests. Classic governance theory argues that the government plays an important role in shaping the economy through legislation and regulation. The government is expected to express the concerns of the majority of the population in their policy, serving the public interest (Alexander, 2002). In addition, the government gains influence by imposing laws, rules, and political will (Yeung, 2006). The private market, on the contrary, divides scarce products among society with the primary goal of profit, which makes price an important factor (Abbott & Snidal, 2009). Lastly, civil society has a mostly non-commercial interest (Abbott & Snidal, 2009). They bring knowledge and commitment and their aim is to find good solutions to problems without involving state interests. They therefore function independently of the state and market parties (Abbott & Snidal, 2009; Yeung, 2006). To conclude, this division into three stakeholder groups does not mean that every actor has the same interests. When viewed closely, the groups consist of different actors with their own characteristics. Some actors do not only belong in one group but are on the boundary of two actor groups.

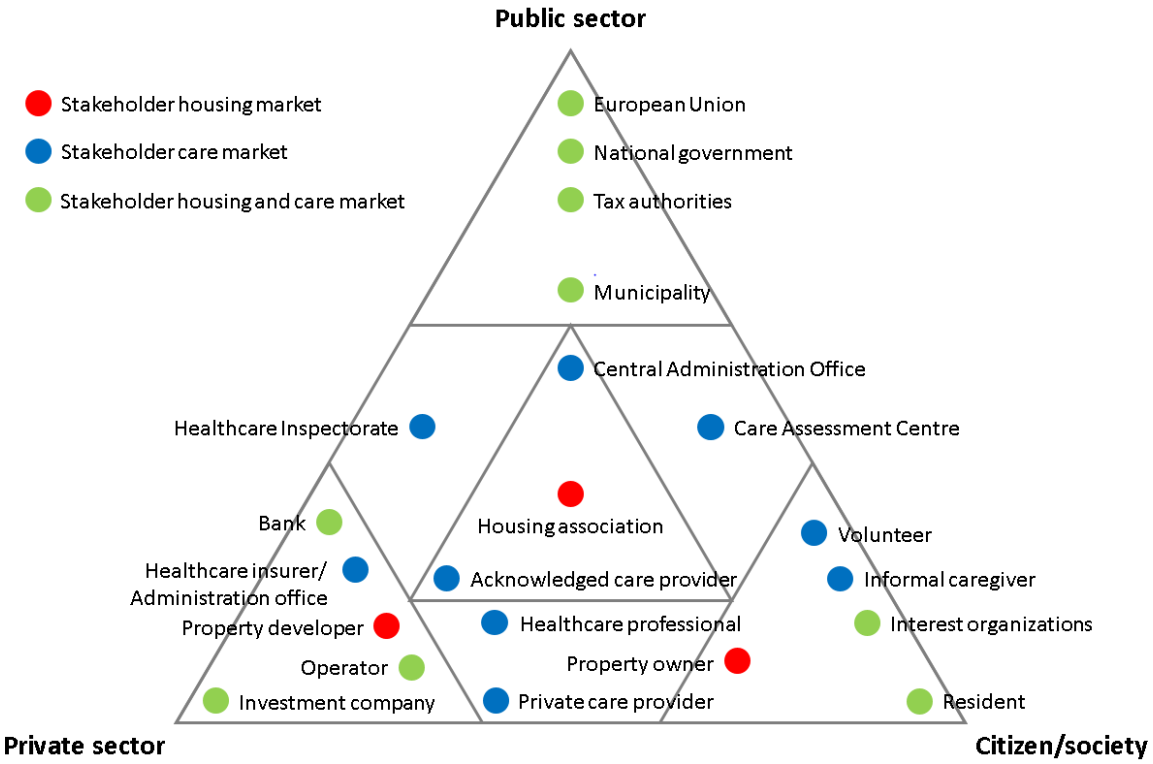

Figure 4. Stakeholder analysis presented as governance triangle.

3. Theoretical background

This chapter explains the theories and concepts relevant to the research question. The change management model by Kotter will clarify the research question and will give a better understanding of the subsequent discussed concepts. Thereafter, the public-private partnership (PPP) risk management framework will be presented and adapted to the context of the research topic.

3.1 Public-private partnerships

Samuelson (1954) defined a public good in economics as "a good that is non-excludable and non-rivalrous, where no one can be excluded from its use and where the use by one does not diminish the availability of the good to others" (p. 387). That said, he suggests that a public good is a product, i.e. a good or service, that anyone can consume as much as desired, without reducing the quantity accessible to others (Galea & Annas, 2016). As opposed to public goods, private goods are products where one person's consumption reduces the availability for others, at least until more is produced. Both terms are not automatically linked to the public nor the private sector and should thus be approached depending on the good or service. From an economic perspective, the provision of public goods may lead to a market failure, as a free market economy can lead to an imbalance in supply and demand, often caused by the "free rider issue," which suggests that someone opts for a public good benefit without willingness to pay for the price of the benefit. Therefore, the government rather than private companies often controls public goods.

It is an accepted reality that governments often search for companies in the private or the non-profit sector to help finance projects when they are, for instance, short of financial resources, technological requirements, or efficient management skills (Roth, 1987). Such collaborations are called public-private partnerships (PPP) and should be viewed as "a spectrum of possible relationships between public and private actors for the co-operative provision of traditionally public-domain services" (Li, Akintoye, & Hardcastle, 2000, p. 229). There is no universal definition of the term PPP; however, a widely used description from Gentry & Fernandez (1997) defines the construction of a PPP as "private participation in the design, financing, construction, ownership, and operation of a public purpose facility or service" (p. 19). In general, the main reason for using PPPs is to deliver higher quality and more cost-effective public services. Through PPPs, the private sector is encouraged to be involved in the provision and management of public sector services (HM, 2004).

3.2 Kotter's change management model

In order to understand the ways in which PPPs can be established in the Dutch healthcare real estate market, it will be important to appreciate that change can be embedded within a system. It is also important to understand how PPPs in the Netherlands could be evaluated according to change models. The process of change generally requires a willingness to change from both the public and private sector (Biedenbacha & Soumlderholma, 2008; Armenakis & Harris, 2009). John P. Kotter (1995) developed an eight-step model for change, which to date is a key reference in the field of change management. Initially, Kotter designed the model usable only for organisations not larger than 100 employees. At present, in a world where organisations tend to be much larger and more complex, Kotter's model has become an example as to how a system can change, given enough support. According to Kotter (1995), eight steps must be followed to realise change in a system (figure 5).

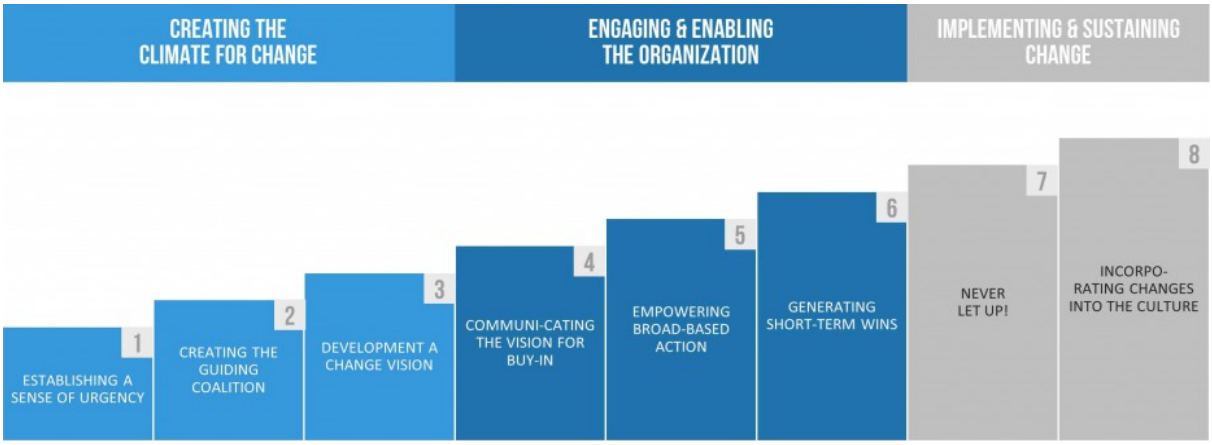

Figure 5. Kotter's change management model (1996).

The first three steps include creating an environment where change can be established. Successful change efforts must always begin with a sense of urgency. When urgency to change is experienced, a coalition for change can be established, which should include stakeholders with power, knowledge, credibility, and leadership skills. Next, a vision and strategy must be developed, in order to coordinate actions and motivate others. The subsequent three steps cover the engagement of involved stakeholders. When a vision and strategy are created, these must be accepted by members through continuous sharing. It is then that the change may be introduced. Short-term wins need to prove that the change is effective, which will reduce resistance. The final two steps cover implementation and sustainment of the proposed change. The second to last step aims to leverage wins and sustain the acceleration of improvements by maintaining a learning-without-end culture. Finally, the change needs to be embedded in the culture of both the private and public sector, as people will only change if they see the connection between new values and behaviour combined with improved results.

PPPs can be viewed as change management projects, as their aim is to trigger change in society (Stadtler et al., 2010). Moreover, ongoing interactions between the public and private sector may change relationships. For instance, from a private sector perspective, public engagement may change the external relationship and influence the way in which both sectors operate and behave. From a public perspective, on the other hand, engagement and involvement of the private sector can be beneficial for a more structured approach of public problems. Eventually, PPPs may lead to adapted cultures, structures, and processes, similar to the outcome of Kotter's change management model.

PPPs in the Dutch healthcare real estate market are currently evolving through the first stages of the Kotter's change management model. The initial step to create urgency, move people out of their comfort zones, and convince them of the importance to change is widely felt among both public and private stakeholders according to the literature (Aedes-Actiz, 2015; Zorgvisie, 2016; Skipr, 2017). This indicates that partners acknowledge the current situation and realize that if individual efforts have failed, these are likely to fail or are not sufficiently comprehensible to solve the problem in the long term (Bryson et al., 2006). Kotter's model rests on the idea that it is vital for the progress of change for partners to agree on the problem and on a shared definition of what causes the issue. Only then, a systematic solution is feasible. However, the establishment of PPPs in the Dutch healthcare real estate market has currently stagnated in the process of forming a guiding coalition: a group with enough

power in resources, qualifications, information, expertise, and relationships. Furthermore, a direct and clear vision is lacking, which dissolves transformation efforts into a list of incompatible actions. Creating a shared vision based on an inclusive understanding of the problem helps to harmonize and coordinate partners. As a result of this sub-chapter, the research question of this study focuses on the first phases of Kotter's change management theory.

3.2 Conceptual framework

Several conceptual frameworks were considered and assessed for applicability, including the framework for the construction of PPP by Li, Akintoye, and Hardcastle (2000) and the framework for risk management in PPP for housing development by Sanda and Anigbogu (2016). The first conceptualizes a PPP based on how it is used, what the conditions are for successful practices, and what the major risks are. This study is one of several studies that have led to frameworks aimed at managing risks, determining success factors for risk management in PPP, or considering risk management in general (Awodele, Ogunlana, & Akinradewo, 2012; Li, Akintoye, & Hardcastle, 2000). Sanda and Anigbogu (2016) built further on these models trying to fill the research gap concerning an inadequate approach. Their model identifies the important roles and responsibilities, real estate characteristics, expected risks in PPP, and establishes a systematic procedure for managing risks with particular reference to PPPs in real estate. As this conceptual framework is the most up to date, most complete, and most suitable for the particular context of the Dutch healthcare real estate market, the framework by Sanda and Anigbogu (2016) forms the backbone of this study.

3.2.1 PPP risk management framework

The basic assumption behind PPPs is that, in collaboration, the strength of one sector will help overcome the weakness of another sector, while increasing efficiency in the delivery of basic services. To illustrate, research has revealed that the bureaucratic and hierarchical nature of the public sector often presents a challenge in the real estate market; it also lacks the flexibility and ability to innovate and to respond quickly to new opportunities and circumstances. However, the public sector performs well in the overall regulatory framework that allows stakeholders to act more effectively (Payne, 1999). The private sector, on the other hand, operates based on adequate returns of investment. Furthermore, the commercial private sector is, and always has been, the main provider of real estate; there is a real comparative advantage to this (UNCHS, 1993). PPPs therefore are expected to produce results that neither of the parties can achieve on their own given the same amount of resources (Payne, 1999).

Understanding risks is at the core of understanding PPPs. A study by Carbonara et al. (2011) revealed that PPPs have more inherent risks than the business-as-usual method due to the involvement of many stakeholders with varied interests. Hence, understanding risks is a necessary condition for a successful PPP. The conceptual framework by Sanda and Anigbogu (2016) identifies PPPs with some variables related to PPP arrangements such as the characteristics, operating environment and PPP outcome, and variables concerning risks and risk management in PPP projects (figure 6). Before adapting the conceptual framework to the context of this study, each component of the framework will be explained and subsequently assessed for applicability to this research.

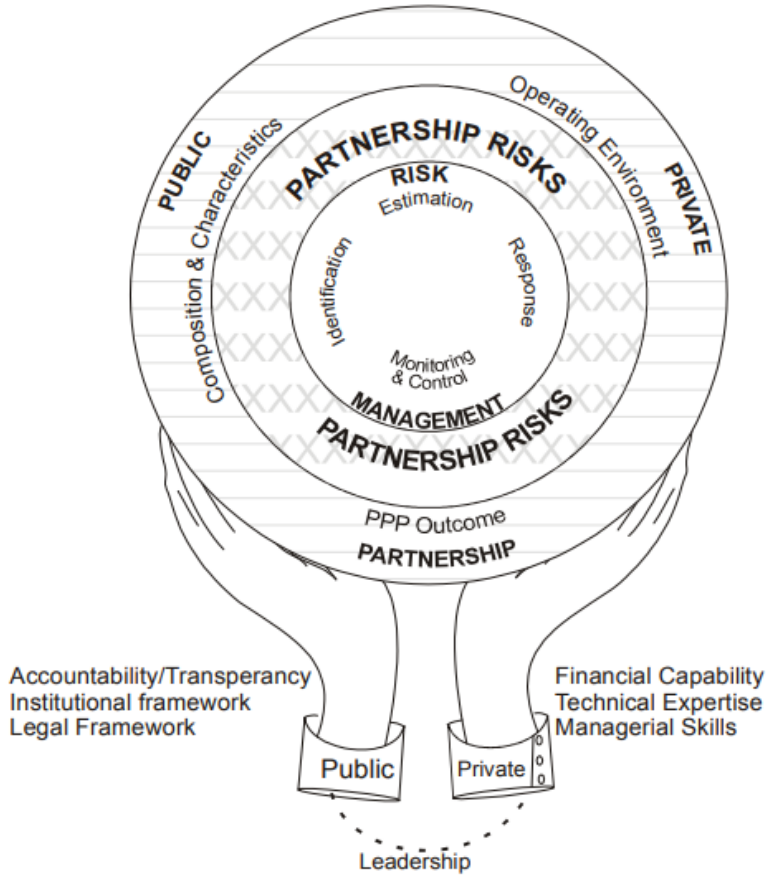

Figure 6. Conceptual framework for managing risks in real estate PPPs (Sanda & Anigbogu, 2016).

Leadership

Effective leadership from both the public and the private sector is required to ensure accountability from all involved stakeholders. According to Leon-Manriquez & Moyo (2017) "it is important to recognize the differences and to understand which roles are needed, at what stage and for what purpose. It is equally important to ensure the best person is allocated to a particular role" (p. 268). In this way, effective leaders can maintain the partnership and ensure that goals are reached in the agreed-upon period and hold those accountable for mistakes (Forrer et al., 2010).

Accountability/Transparency

Refers to open data: making content and progress accessible and understandable to everybody and ensuring that this translates into strong and sustainable development outcomes (Pongsiri, 2002).

Institutional framework

The institutional framework of PPPs comprises establishing appropriate capacities, institutional settings, and regulatory frameworks. A PPP institutional framework is the structure of a PPP agency or unit: an organisation, within or connected to the government, that provides services related exclusively to PPPs and other governmental bodies. This includes municipalities, ministries, federal agencies, departments, and special districts (Chou, Tserng, Lin, & Huang, 2015).

Legal framework

Successful implementation of PPPs depends largely on the development of legal procedures and agreements that clearly define the relationship between the public and the private sector. Without thoughtful and professional legal frameworks, disagreements are likely to happen, and projects may be postponed or terminated. Legal frameworks aim to reduce opportunistic behaviour and to align the interests of the involved stakeholders (Pongsiri, 2002).

Financial capability

The financial capability of the private sector includes the combination of knowledge, skills, and attitudes, and ultimately, behaviours that translate into financial decisions and appropriate use of financial services. This includes, among others, minimizing financial risks, the net present value of a PPP, and the internal rate of return (Zhang, 2005). The net present value refers to the difference between the value of cash inflows and outflows over a period. Internal rate of return refers to a capital budgeting method used to estimate the profitability of an investment.

Technical expertise

PPPs allow the public sector to take advantage of the technical and professional expertise of the private sector. Some projects are highly technical and require specialised knowledge. Many governments, especially local governments such as municipalities, do not have this in-house expertise. The most important technical skills are qualifications and experiences of personnel, competencies, design standard, and following clients' requirements (Zhang, 2005).

Managerial skills

One of the aims of the private sector is to bring expertise into the provision of facilities and services traditionally delivered by the public sector. Real estate specific management skills include project management skills, allocation of responsibilities and a working relationship between participants (Sanda & Anigbogu, 2016).

PPP outcome

Outcomes of PPP arrangements explain the overall expectations that are held by stakeholders regarding a PPP agreement. An essential aspect of all PPP negotiations is the project output. All stakeholders agree on who is responsible for what and targets are set for all stakeholders to achieve at the end of the arrangement. To illustrate, PPPs in real estate development have outcomes like the number of built houses, the characteristics of the housing units, and the targeted population (Ibem, 2010).

PPP risks

The second layer of the framework (Figure 6) includes the risks associated with PPP projects. This is necessary to the framework because not all PPP projects are successful; unexpected problems can arise during any stage of the project that risk the accomplishment of the project objectives. Tadayan, Jaafar, and Nasri (2012) summarized the most serious effects on project objectives as: failure to keep within cost estimate, failure to achieve the required estimation time, and failure to achieve the required quality.

The risks associated with PPPs can be grouped into two broad categories of risk: endogenous, directly related to the project; and exogenous, outside the scope of the project and caused by external factors.

Most risks are exogenous, which means that the private partner is never better informed about a risk than the public partner is. It is advisable that the risks are shared based on the benefits perceived and should be assigned to the stakeholder that is most competent to manage them (Carbonara, Costantino, & Pellegrino, 2013). Traditionally, risks are viewed as damages, dangers, and negativity that affect the project negatively (Zou, Zhang, & Wang, 2007). However, several studies emphasize that risk is a double-edged sword; most risks are threats on one hand and opportunities on the other hand (Flanagan & Norman, 1993; Bolai & Price, 2003). In other words, the impact of risk is not necessary negative; it can also bring positive influence.

In addition to these concepts, the conceptual framework of this research project also includes less relevant concepts; the non-applicability of these variables will be explained in the following sub-chapter. They include:

- Composition and characteristics: For example, contract type, contract duration, and financial structure; including funding sources, capital structure, repayment schedules, currency of loans, and payments (Li et al., 2000).
- Operating environment: The presence of laws and anticorruption mechanisms. Gives private partners certainty, ensuring their interest and ensures a complete legal system.
- Risk management: Includes risk identification (risks affecting the arrangement), risk estimation (calculating degree of uncertainty), risk response (identifying solutions to assessed risks) and risk monitoring and control (process of identifying newly arising risks and keeping track of identified risks). Ensures success in projects.

3.2.2 Framework applicability

Before the conceptual framework by Sanda and Anigbogu (2016) can be used, the conceptual framework must be adapted to the context of this study. The proposed framework presents multiple variables for a successful PPP in a traditional real estate project. However, as mentioned above, not all factors are relevant to the research question of this study. Given the specific area of this study, some alterations must be made in the model before the framework is applicable. The conceptual framework by Sanda and Anigbogu (2016) creates a structure for managing development in a traditional real estate project, which often operates within well-defined frames. However, as explained by Kotter's change management model, the Dutch healthcare real estate market is still evolving through the first stages of establishment. Variables such as specific contractual agreements, the operating environment, and risk management are therefore not yet as important (Kämink, 2017). The explorative character of this study aims to identify the expectations and requirements on a more abstract level, by identifying the distinct roles and responsibilities of the public and private sector separately, roles and responsibilities they share mutually, and the expected risks and outcome of a PPP. Hence, these concepts are used for answering the research questions in this study.

3.2.3 Final framework

The final conceptual framework for this study was shaped after a thorough literature review and careful analysis of the model of Sanda and Anigbogu (2016). Figure 7 illustrates the final framework. The model is fundamentally similar to the model by Sanda and Anigbogu and includes the roles of both the public and private sector, the mutual roles and responsibilities, the PPP outcome layer, and the partnership risks layer. As described before, composition and characteristics, operating environment, and risk management of PPPs are left out of the final conceptual framework.

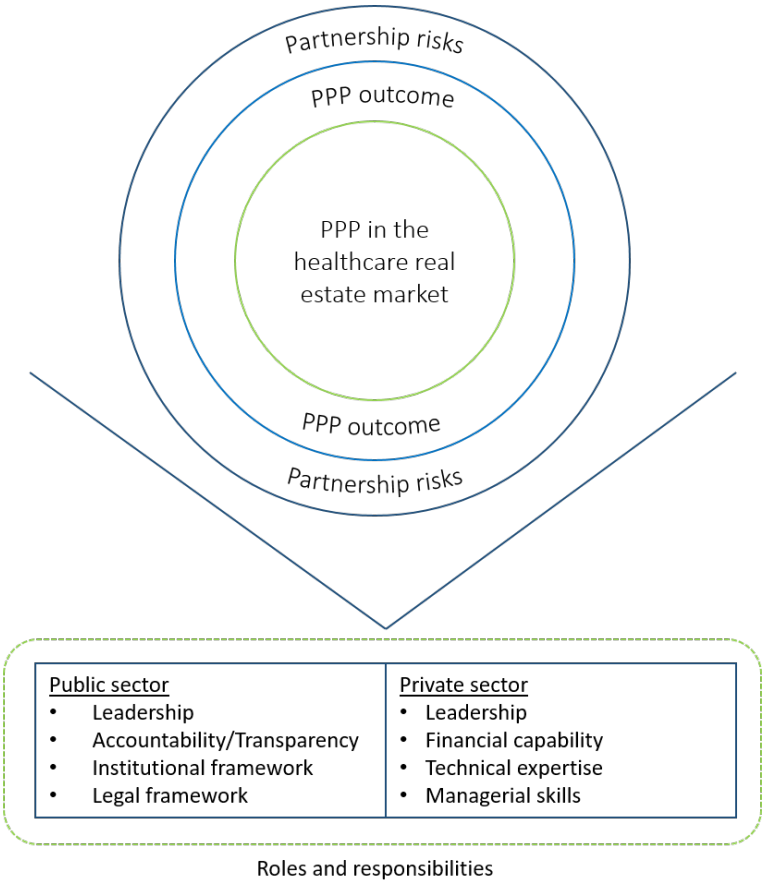

Figure 7. Proposed framework for PPPs in the Dutch healthcare real estate market, adapted from Sanda and Anigbogu (2016).

In this research, the expectations and requirement concepts for PPPs in the Dutch healthcare real estate market are defined as the required roles and responsibilities and the expected risks and outcome. The required roles and responsibilities comprise three public sector sub-concepts, three private sector sub-concepts, and one mutual sector sub-concept. Appendix II shows the explained concepts and sub-concepts, which are operationalised for the context of this research.

3.3 Research sub-questions

In order to answer the main research question *"What is expected and required for public-private partnerships in the Dutch healthcare real estate market?"* the following sub-questions were composed based on the described theories and concepts:

3a. What *risks* are expected for public-private partnerships in the Dutch healthcare real estate market?
3b. What *outcomes* are expected for public-private partnerships in the Dutch healthcare real estate market?
3c. What *public sector roles and responsibilities* are required for public-private partnerships in the Dutch healthcare real estate market?
3d. What *private sector roles and responsibilities* are required for public-private partnerships in the Dutch healthcare real estate market?
3e. What *mutual roles and responsibilities* are required for public-private partnerships in the Dutch healthcare real estate market?

4. Methods

In this chapter, the methodology of the research will be described. Argumentation and explanation will be provided regarding the research strategy, including how the data has been gathered and the methods used. Furthermore, an explanation of how the data is analysed is offered.

4.1 Research design

A qualitative research approach was used for this study, as qualitative methods have been proven useful in gaining a better understanding of complex societal problems (Fadda et al., 2015). An explorative case study was chosen to study PPPs within the context of healthcare real estate. According to Baxter and Jack (2008), a case study approach should be used when the focus of a study is to answer "how" and "why" questions and when contextual conditions need to be considered. The research methods used include a combination of desk research and field research. Internal and online desk research were used as the starting phase in this study, in order to fetch data from existing resources and to describe the context of the study. Next, semi-structured interviews were used as a field research method to elicit information from important stakeholders in a conversational, informal setting. The study was executed during a period of five months in 2018 and conducted by one researcher accompanied by two supervisors.

4.2 Study sample and recruitment

A stakeholder analysis was developed in order to identify and select the study population, leading to a selection of stakeholders from both the public and private sector, which were targeted as participants: investment companies and property developers from the private sector (N = 7) and care providers, housing associations, municipalities, and an interest organization from the (semi-)public sector (N = 8). These stakeholders were chosen because they represent a mixture of public sector and private sector stakeholders, and because they have the greatest influence on future real estate development. It is important to select the sample in a systematic way to ensure that the respondents represent a credible and indicative group. As such, a purposive sampling method was used. This means the participants were selected based on their probability to generate useful data for this study (Gray, 2014). Based on this, participants were all information-rich cases with many insightful perspectives and knowledge of healthcare real estate (Gray, 2014). All participants, prior to participation, signed an informed consent allowing the researcher to audio-record the interviews.

4.3 Data collection tools and process

Data was derived through a series of semi-structured interviews. Semi-structured interviews help to elicit information from another person in a conversational and informal setting. One researcher, who is also the main researcher of this study, executed all interviews. No language barriers were observed, as all respondents spoke Dutch. An interview-guide provided a fixed list of topics, which are based on the key concepts of the conceptual framework of this study.

The interview-guide was written in English and afterwards translated to Dutch with a team of involved experts to prevent errors in translation and interpretation. Prior to executing the interviews, a pilot version of the interview guide was tested on two subjects who were not part of the target group. This

was done to develop questions that are unambiguous and accurate. Moreover, the pilot was used to accurately measure the timeframe needed to complete the full interview. Finally, the pilot version was tested for accurate wording, clarity of instructions, and formulation of questions. For instance, observations from the pilot study led to changes in the sequence of questions, in order to make the flow more logical.

After the pilot was tested and the necessary adjustments were made, respondents were contacted. Interested respondents received a brief explanation of the study aim and procedure. Before the interview started, respondents were informed about confidentiality, and informed consent was sought. Interviews were audiotaped and conducted by one researcher, who simultaneously took notes for later comparison. All interviews were conducted in Dutch, as this was the preferred language of the researcher and all respondents. The respondents could indicate where they wanted the interview to take place. If no preference was given, interviews took place at the workplace of the respondents. All interviews were transcribed immediately after they were conducted.

The average length of the interviews was 45 minutes. The questions in the interview guide were mostly open-ended. By conducting semi-structured interviews, it was possible for the researcher to depart somewhat from the pre-formulated questions, enhancing a natural dialogue during the interviews. Questions were designed in a way to elicit further discussion. Examples of questions used: “Can you tell me what your organisation’s role could be in a public-private partnership?” and “What do you think are the biggest (in)direct efforts which need to be made for public-private partnerships?” By using the interview guide, the researcher used the same topic list, which led to an increased uniformity of data collection (Gray, 2014).

4.4 Data analysis

All interviews were transcribed verbatim and analysed after the interviews. Open coding was used directly from the transcripts in order to interpret the statements of respondents. Coding categories were generated directly from the transcripts without relating to a conceptual framework. This method was used as the aim of this study was to explore expectations and requirements, rather than testing the conceptual framework. By having the conceptual framework as reference, the chances of finding expectations and requirements outside of the scope of the framework would decrease. However, although open coding was aimed for, pure open coding was not possible in this study, as the study and its research questions were largely derived from a theoretical background and consecutive framework, therefore broadly directing the outcomes and their respective codes. Hence, data analysis was a process of going back and forth between transcripts and the framework in order to come to a final coding schedule.

As a result of this first coding phase, the codes derived from the transcripts became the initial coding schedule. Thereafter, axial coding was used to cluster the initial codes. This process was based on observed relations between the codes. Finally, selective coding was applied to identify the main themes of the results. The coding sheet illustrates the different concepts based on the conceptual framework. It was not completed until all interviews were transcribed and coded, which is referred to as an iterative method (Gray, 2014). The final coding schedule can be found in the appendix section. Finally, the most

illustrative quotes were qualified as meaningful and relevant for the results and were thus translated from Dutch to English.

4.5 Ethical considerations

According to Gray (2014), it is important to not harm those who participate in research. Hence, all respondents were asked to sign an informed consent form before the interview. By doing so, the anonymity and confidentiality of data was ensured (Gray, 2014). Respondents were therefore not obliged to answer a question and had the right to exit the interview at any time. Likewise, by signing the informed consent, the respondents gave the researcher permission to use the data for possible publication (Gray, 2014). All audio tapes were securely digitally stored, accessible only to the researcher and supervisor of this study. Names of participants are not used in this report.

4.6 Validity and reliability of the methodology

To increase validity, person triangulation was reached by interviewing stakeholders from different interaction levels. Moreover, interviews were not performed simultaneously, which allows for constant comparison to identify emerging themes within the interviews. The moment contradictory evidence was discovered, the researcher involved experts to ensure that researcher bias had not interfered with the interpretation of the data. The researcher aimed to transcribe the interviews highly objectively, to increase the validity of the study. A second expert reviewed the codes to increase the inter-subjectivity and internal validity. After analysing the transcripts, the researcher determined whether all quotes from the interviews were accurately categorised according to the coding sheet. Furthermore, the translation of quotes from Dutch to English was done by a group of experts, to make sure the translation process was reliable. By means of sending member checks, perceived accuracy and reactions were validated, increasing transactional validity (Cho & Trent, 2006).

In addition, trustworthiness of the qualitative methodology is determined by the credibility, transferability, confirmability, and dependability of findings (Shenton, 2004). Credibility, related to internal validity, was ensured by paraphrasing during the interviews as a method to confirm the statements of the participants. Transferability, related to external validity, is limited as qualitative findings are specific to a small sample. Furthermore, dependability, related to reliability, was ensured by using an interview-guide. Lastly, confirmability, related to objectivity, was also limited due to the inevitable emergence of researcher bias. Nevertheless, person triangulation increased the confirmability by collecting data from different types of stakeholders.

5. Results

This chapter presents the main findings derived from the semi-structured interviews executed for this study. The findings of the interviews include the perceptions of both public and private stakeholders to provide a clear insight into the environment in which PPPs can be established. For a clear overview, results are presented in two sections: first, the expectations regarding PPPs in the Dutch healthcare real estate market are discussed, highlighting how participants envision a successful establishment of a PPP. Second, the required roles and responsibilities for PPPs are described. Participants' quotes are anonymized and are used to illustrate the findings. First, a short description of the participants will be given, followed by the results of the interviews.

5.1 Description of participants

In total, 15 participants were interviewed for this study. Table 2 shows the most important characteristics of the respondents, including the type of stakeholder, in which sector and country the respondent operates, and if the respondent has previous experience with PPPs. The characteristics were gathered based on closed questions. As previously discussed in the stakeholder analysis and verified by the respondents during the interviews, housing associations and care providers did not view themselves as either purely private or public stakeholders and are therefore classified as semi-public participants. Concerning the respondents' experience with PPPs, any level of experience was classified as "Yes," which could range from an experience of direct involvement, or involvement as an outside observer. Documents related to the interviews, including the interview guide and informed consent, can be found in the appendix section.

Table 2. Description of the interviewed study population.

Participants					
Participant number	Type of stakeholder	Abstract job title	Operating sector	Operating country	PPP experience?
1	Municipality	Manager	Public sector	NL	Yes
2	Property development	Director	Private sector	NL	Yes
3	Interest organisation	Advisor	Public sector	NL	No
4	Investment company	Manager	Private sector	NL	No
5	Care provider	Director	(Semi) Public sector	NL	No
6	Housing association	Advisor	(Semi) Public sector	NL	No
7	Housing association	Director	(Semi) Public sector	NL	Yes
8	Property development	Director	Private sector	NL	Yes
9	Property development	Director	Private sector	NL	Yes
10	Care provider	Director	(Semi) Public sector	NL	No
11	Care provider	Director	(Semi) Public sector	NL	No
12	Care provider	Manager	(Semi) Public sector	NL	No
13	Municipality	Manager	Public sector	NL	No
14	Investment company	Manager	Private sector	BE	Yes
15	Investment company	Director	Private sector	BE	Yes

In the following sub-chapters, the findings of this study will be presented. Six main themes emerged from the data analysis, which are largely in-line with the concepts discussed in the theoretical background: roles and responsibilities for the public sector, roles and responsibilities for the private sector, mutual roles and responsibilities, risks, outcome, and market potential as a newly emerged theme. The order of the concepts was adjusted to benefit the narrative of this chapter.

5.2 Expectations

In order to realise PPPs in the Dutch healthcare real estate market, actors who have previously never cooperated are now required to partner for the benefit of the future elderly population. Through analysis of the data, it became clear that the respondents have divergent expectations about PPPs in the healthcare real estate market. In what follows, deeper insight will be provided as what these stakeholders envision in the establishment of PPPs.

5.2.1 Outcome

As described in the theoretical background, the outcome of a PPP arrangement reflects the specific output of the partnership, in which stakeholders agree on project arrangements, the target population, and characteristics of housing units.

During the interviews, it became apparent that among the public and private sector, expectations strongly differ as to the **scope of project agreements**. For instance, a fixed partnership contract, as is often suggested, involves a new field of partnership, which for half of the respondents triggers apprehension about the extent of the partnership, particularly among the more inexperienced partners. Most of the more experienced respondents believe that project-based agreements are the only way in which PPPs can realistically be established, as the success of a project is dependent on many factors, which will be discussed in the sub-chapter 'risks'. According to more experienced respondents, long-term agreements with fixed financial targets increase the level of uncertainty for the private sector and increase the likelihood of partnership failure. On the other hand, most of the less experienced respondents expressed concern about collaborating on a short-term basis with relatively unknown partners and stated that, to build a strong and trustworthy partnership, and to prevent actors from opting-out prematurely, it is indispensable that there are clear long-term agreements about the specific outcome:

"You do not know how such partnerships will work out in the beginning. You start by making agreements for each project, not for a whole series of projects. That strongly depends on, for instance, location and size of the real estate" (Respondent 2, property development, experienced with PPP).

"I have not worked with private companies before, but to offer certainty to both parties, I believe the public and private sector will and should make long-term agreements in advance" (Respondent 3, interest organisation, inexperienced with PPP).

Furthermore, many respondents agreed that **diversity in target population** is a much-desired outcome of PPPs. Prior to asking about this topic, multiple respondents mentioned that a distinction must be made between the rental market and the selling market. They agreed that the rental market is the most valuable and suitable for PPPs, as care in many cases is provided in combination with rented accommodation. Therefore, the selling market is less relevant in this case. One respondent explained how the rental market is clearly divided, with the housing associations focusing on the lower-income population in the social rental market, and investment companies covering the private rental market. In this arrangement, care providers rent real estate from either stakeholder and rent this out to residents. Unanimously, respondents expect an increasing gap in the middle-class rental market if stakeholders will not collaborate more efficiently. Leaving this large group untargeted will create a serious shortage for suitable housing in the future. Therefore, it is important that public and private stakeholders acknowledge and collaborate their strengths.

"Good partnership for the private sector means a good financial return with acceptable risks and for the public sector a significant social contribution" (Respondent 7, housing association).

Similarly, the same respondents mentioned that a diversity in target strategy will allow for a **diversity in care provision** within the same real estate context, creating a product that accommodates the needs

of the target population. When asking why a diversity of care provision has not been established before, the respondents mentioned that the Dutch healthcare system in the past was regulated and financed in a public way so that such innovative concepts were not possible. One respondent explained that in the 1950s and 60s it was clear where the elderly moved to when they were in need of healthcare. These traditional residential facilities were built with the intention that the elderly could grow old in a pleasant, publicly provided way. Different housing concepts with, for instance, interference from the private sector was unimaginable. Currently, according to the respondents, with the financing of residence and care provision separated, there is more space for innovative thinking and collaboration.

Moreover, the respondents agreed that a strong movement has been observed around eldercare and residential needs. In terms of the living environment, residential homes have become much less attractive to the elderly over the past decades. LTC shows a movement in which the elderly seem to prefer a tailor-made solution to their living environment when they require continuous care. According to housing associations and care providers, an efficient way to respond to this shift is to change the way real estate is rented out, by creating a mixture of residential and non-residential care provided in the same real estate context. This way, real estate can be individually rented out to residents with the possibility of non-residential care or rented out under a residential contract. In return, this gives residents the opportunity to live in a diverse setting and the possibility to switch care provision without the need to move to another living environment. By making the real estate "flexible" and thus more attractive, multiple respondents expect that a younger population will be targeted (60-65 years old), which will enhance the need for a diverse living environment. This way, when residents become very dependent on care and need to move to a residential facility, different levels of care can be established within the same building:

"Suppose you have an apartment complex with 90 apartments, of which 70 are directly rented out to residents by investment companies and 20 are rented to a care organization with residential facilities. This way, all tenants can take advantage of the available care providers, while simultaneously you avoid vacancy, which has happened often in the past" (Respondent 8, property development).

According to the Concept Developer from a property development company, developing fixed real estate for a specific target group is an outdated plan and is not future-proof. He states that the problem lies in existing real estate, which ought to be transformed but this has not happened yet. Respondents from Property Development Companies and Investment Companies agreed that guidelines for developing future-proof estate should be created. One respondent working at an Investment Company said his company already adjusted their own terms of reference but wished for universal guidelines.

Two respondents offered a similar, and striking, discussion of the implications of such a target strategy. One the one hand, as stated before, the elderly demonstrate a transition to increased needs in their living environments; this requires that developing actors **fulfil the needs of the target group by making real estate life-course proof**. As one respondent mentioned:

"Fulfilment of needs starts with the living environment, which should be safe with facilities nearby such as shops, public transport, and parking. The real estate itself must have an area for meetings. Of course, elevators are needed, and houses should be without sills. The turning radius in the shower and around the toilet must also be accessible for disabled residents" (Respondent 4, Investment Company).

When real estate is constructed to be life-course proof, the elderly who are required to transform their homes to accommodate their increased needs, are instead tempted to move to a suitable living environment, thereby leaving their previous single-family house unoccupied and suitable for another target group. In other words, the creation of life-course proof housing bolsters a **sustainable moving flow on the housing market**. As a result, the elderly can move to new a living environment with sufficient care and a safe environment. This strategy, however, is doubtful to work in the long-term. As both respondents explained, having an increased elderly population with an increased life expectancy will have repercussions on the moving flow in the future.

"The elderly do not want to move. Actually, the problem lays in the fact that the generation that is now 30 to 40 years old, will not be able to move to a suitable home in the future because the elderly continue to live longer, and they will not move. It is in this way that the housing market suffers from the ageing process" (Respondent 6, housing association).

In line with these implications, various public respondents mentioned that the **social impact of moving** should be valued significantly more when considering PPP target strategies. As is illustrated in textbox 1, public respondents agreed that moving is not only a matter of defining how suitable the current housing situation is for one, but also the perceived need to move from the perspective of the elderly.

Textbox 1. The social impact of moving.

"If I may tell a personal anecdote: my father is an average elderly man. He is a widow, but still happily living in the house where I grew up. He owns a single-family house, nothing special, middle class. However, the house where he lives has a staircase and an upper floor. For the past year, he has been totally dependent on his wheelchair, but he wants to stay in his house, because he has nice neighbors and a large social network in his neighborhood, with all those people helping him with, for instance, his garden, which he loves. Should he then move because his house in theory is not 'suitable' for him anymore? My father consciously chooses to stay where he lives, and I think that is what is best for him and makes him the happiest. Maybe one day he will fall down the stairs, but so be it. At least he then has spent his days comfortable and with a high quality of life, instead of being forced to move to a new home with new people and a new living environment, if it does not even feel necessary to him. Do not forget what kind of impact these types of changes may have on people that age" (Respondent 10, care provider).

When respondents were asked a verifying question, to confirm their perspective on the social impacts of moving, they displayed a rather indifferent attitude, stating that retaining a healthy moving flow was more important. Although the importance of the social impact of moving was not mentioned specifically, several private respondents were clearly more focused on solutions that tempt the elderly to move elsewhere than they were on how the needs of elderly best could be met.

5.2.2 Risks

Risks are categorized into endogenous risks (internal or project related) and exogenous risks (external or environmental related). It has been discussed above in the theoretical background that risks are a double-edged sword: a threat on the one hand, an opportunity on the other. Risks are not necessarily negatively associated with each other. In terms of endogenous and exogenous risks, both were

expressed in the interviews. In general, three types of expected risks were perceived and distinguished throughout the interviews. It should be noted that risks in general were predominantly felt by more experienced respondents regarding PPPs. Nearly all respondents who had less experience with PPPs did not initially expect any important risks. However, when the conversation continued, nearly all less experienced respondents brought up risks on their own.

Time-varying risks, both endogenous and exogenous, were frequently mentioned as a major risk for the establishment of PPPs in the healthcare real estate market. In terms of endogenous risks, all respondents believed that risks in terms of progress and quality of projects are crucial to the success of the PPP. These risks include technical setbacks. Moreover, a respondent from a property development company stated that projects usually have a duration of five to seven years from start to realisation. During this period, all involved stakeholders invest a significant amount of time and capital into the realisation of a project. In this context, according to the same respondent, he saw many projects fail due to time-related difficulties:

"A public-private partnership starts on an abstract level but eventually takes place on a practical level. During and after realization, various obstacles might be encountered. Technical setbacks for instance, as things simply turned out differently than you thought" (Respondent 8, property development).

With regard to exogenous time-varying risks, multiple respondents, especially public and semi-public respondents, mentioned that governmental alterations in regulation and legislation in healthcare and housing policy were a core risk, especially with regard to reimbursement changes in these systems. In particular, the public respondents mentioned that the financing of healthcare is very vulnerable and complex, where governmental authorities do not make multi-year agreements.

"I once experienced a project with great potential, which eventually failed because of changes in care financing. The care provider had a great vision, but nearly went bankrupt because they no longer received extramural funding. I then started thinking: is it even possible to make a future-proof plan for healthcare real estate?" (Respondent 15, Investment Company)

Next, exogenous conjuncture risks were frequently mentioned and perceived as impactful, referring to the change in growth of the real estate market. Although nearly all respondents observed these risks, private respondents, especially property developers and investment companies, emphasised these risks more strongly. According to these respondent groups, the conjuncture of a market determines how willing stakeholders are to partner with each other, as a respondent said:

"In general, risks are underestimated in an upward economic climate and always overestimated in a low economic climate" (Respondent 7, housing association).

In reaction to this behaviour, the same respondent groups noted that establishing a PPP is more attractive in a low economic climate, as the dependency of the sectors grows with a negative trend of the market. However, a respondent from a property developer believed that this tendency does not always function as it should, mentioning how he had already seen several PPPs fail, even in a low economic climate. The mistake made by many partnerships, he stated, is basing financial starting points and agreements on a slightly rising economic climate, which he described as false opportunism.

Thereby, economic boom or downturn also determines if prices increase or decrease for the private real estate sector. Nearly all private respondents mentioned inflation as an example of how to deal with significant price increases and its impact on a project. According to them, the associated risk should not only be carried by the private sector, which was often experienced in previous cases. They stated that, when external factors cause prices to rise, private parties should not take all the responsibility, because the result may be billions of losses or even bankruptcy.

"A definite positive benefit is what I would like to see: that you really have a win-win situation for both sectors" (Respondent 1, municipality).

Finally, aside from risks as threats, several risks as opportunities were mentioned. There was a clear distinction between opportunities for the public sector and private sector. All public and semi-public respondents believed that offering a **social added value** was the most important opportunity; offering an expanding group of dependent people the residence and care they need.

All private respondents mentioned financial growth through positive business outcomes as the main opportunity. Half of these respondents were more specific about what the underlying opportunities of PPPs would be. According to them, regardless of their PPP experience, **non-replicability and scalability** are key opportunities for a successful partnership, leading to positive business outcomes. They defined a successful partnership as a product that is hard to copy but still scalable to a national level partnership. Concerning scalability, a respondent from a housing association mentioned how partnering works on a trial-and-error basis, starting with a small project with multiple obstacles. The subsequent projects will gradually have higher quality outcomes.

5.3 Requirements

The previous chapter discussed the expectations of PPP from both public, semi-public and private respondents' perspectives. The mind-set of respondents was considered in terms of outcome and risks expectations. However, in continuation of the narrative of the chapter, providing expectations only partially answers the research question. Aside from the question, "What do you think will happen?" the question "What do you need to make this happen?" is equally important in a thorough analysis of PPPs. The following sub-chapters answer this question, by giving an overview of the required roles and responsibilities from both the public, semi-public, and the private sector, and the mutual roles and responsibilities.

5.3.1 Roles and responsibilities public sector

Roles and responsibilities of the public sector as posed by the conceptual framework are categorized into transparency, accountability, and setting institutional and legal frameworks. Within the theme of public roles and responsibilities, two important themes arose.

First, the private respondents emphasized how **transparency of policy** from the public sector in terms of zoning plans and land prices is a key requirement for a trustworthy PPP. In this context, transparency was perceived as a role especially for *municipalities*. All private respondents with PPP experience mentioned how they perceived collaboration with municipalities as a barrier for successful

partnerships. According to these respondents, such laborious contact is due to a **sense of distrust** among the different sectors. In fact, PPP requires the unifying of two opposite interests in the healthcare real estate market:

"My experience has shown that all stakeholders have their own agenda, their own way of working, their own company culture and their own vision of property development. This leads to divergent interests, which often can cause more hassle than friendly cooperation" (Respondent 3, property developer).

The respondents from municipalities, in their turn, agreed that a certain level of transparency is inevitable for a PPP; however, they noticed how certain decisions within municipalities are not always received positively by the private sector. For instance, as one of the two respondents mentioned, municipalities make their own prognoses about demographic changes and their impact on the supply of healthcare real estate. These prognoses are directly related to the distribution of zoning plans and land prices. Hence, this leads to certain decisions about approval of proposals from the private sector:

"Municipalities arrange the distribution of land and zoning plans. At the same time, our core focus is the social and middle rent class. In my opinion, that is where our [public and private sector] interests clash. Their target group, mostly the private rental market, has less priority for us because it is an independent small group" (Respondent 13, municipality).

In addition, it is noteworthy that the other respondent from a municipality was critical about how elderly housing is regulated within municipalities. As healthcare real estate is a rather new field of interest for a municipality, there is not yet a clear structure of which department should focus on which area. Within municipalities, multiple departments currently target healthcare real estate: the Care department, the Housing department, and the Land & Development department. According to the respondent, communication and collaboration between these departments is likewise a great challenge within municipalities, which might influence the apprehension towards PPPs.

Secondly, all public, semi-public, and private respondents stated that setting frameworks is the task of the public sector, as they decide on the legal and regulatory agreements for a PPP. In particular, **framework flexibility** was noted by experienced private respondents as a core role and responsibility for the public sector and a key to success, as they had experienced PPPs failing due to too-strict contracts. For instance, experienced private respondents mentioned that agreements on time, size, and thus price, should be adaptable when the economic climate of a market would change significantly. Other framework arrangements included considering the first right of purchase, the ability to terminate the rental contract between care provider and housing association or investment company, and a thorough **exit clause**. The respondents refer to an exit clause as the permission to legally get out of a partnership without any consequences.

"Flexibility should exist in two places: first, flexibility in contractual agreements strongly determines how willing the private sector is to partner. However, it is just as important that investment companies or housing associations are flexible when they want to discuss changing zoning plans or prices of land" (Respondent 15, Investment Company).

5.3.2 Roles and responsibilities private sector

Roles and responsibilities of the private sector are defined as financial capability, technical expertise, and management skills. Within this theme, three sub-themes arose during the interviews. As mentioned before, a distinction has been made between public, semi-public, and private stakeholders. However, throughout the interviews, it became apparent that the roles and responsibilities of semi-public and private stakeholders were perceived as similar. Therefore, they are both discussed in this sub-chapter.

The first emerged sub-theme comprises the **technical innovation** of the private sector, which was mentioned by members of all respondent groups. Many private actors have a commercial interest, which enhances the entrepreneurial drive in this sector. According to some public respondents, this is a core added value of partnering with the private sector, because they often have very high expertise in their field of interest and thus are able to produce highly innovative projects.

Next, all respondent groups mentioned that the private sector is responsible for the **financing and technical management of projects**, as the investment companies and housing associations have the real estate finances and expertise, and the care provider holds the specific healthcare expertise. Thereby, property developers, including architects, were perceived as the stakeholders with the most technical expertise and thus as essential for PPPs. However, some respondents argued that a division should be made between the partnering roles of the stakeholders. According to a respondent from a housing association, PPPs comprise both partnering stakeholders and facilitating stakeholders. Although property developers are viewed as indispensable stakeholders, the respondent mentioned that property developers are rather executive stakeholders who are able to facilitate or hinder the realisation of healthcare real estate. This also accounts for municipalities being able to either facilitate or hinder the process with ground allocation and zoning plans. A visualization of this structure is shown in figure 8.

"As a municipality, I do not think I would want to participate as much in a public-private partnership as, for instance, a care provider and housing association would. I think we have a more supporting role, but it also depends on how you define partnership" (Respondent 10, municipality).

"Housing associations, investment companies, and care providers: those are the core three. View it as an interactive model with partnering actors and facilitating actors. If the partnering actors join forces, then municipalities and property developers can be easily convinced" (Respondent 7, housing association).

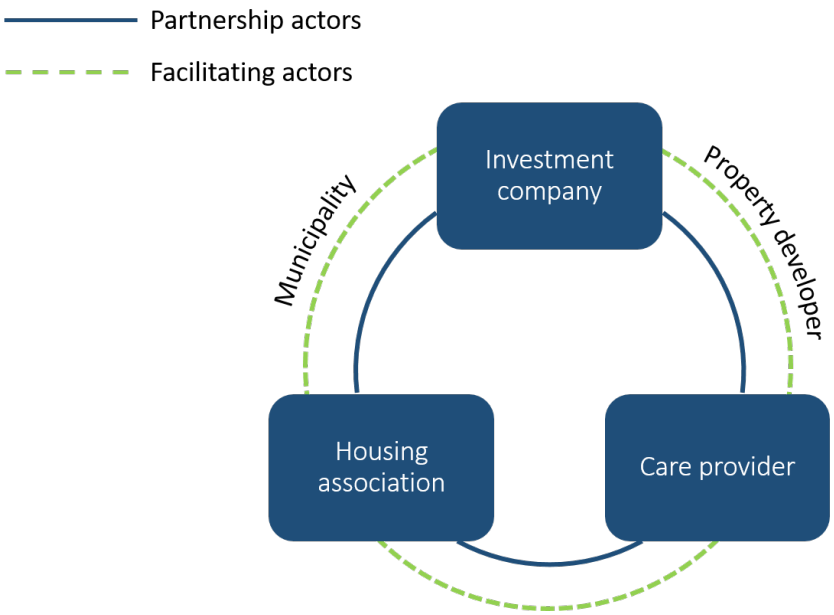

Figure 8. Proposed PPP structure visualized by a respondent.

5.3.3 Mutual roles and responsibilities

Aside from roles and responsibilities for the public and the private sector, the conceptual framework also presents leadership as a core mutual role and responsibility for both the public and the private sector. Throughout the interviews, two leadership related themes emerged.

First, all respondents mentioned that all involved stakeholders should have a **shared strategic vision** of the proposed partnership. The public and semi-public respondents especially emphasized that the private sector should acknowledge the broader perspective of a partnership in the development of a vision. According to them, the strategic vision of the private sector only focuses on financial benefit. For the benefit of the PPP, it is inevitable that private stakeholders attempt to combine the interests of both sectors. As a response, several private respondents noted that a strategic PPP vision should be viewed as two-way traffic: the public sector should also not solely focus on the social benefits in their vision development regarding PPP, but also be aware of the commercial interest of the private stakeholder, as that is what makes a PPP interesting for private stakeholders.

Moreover, the respondents unanimously agreed that some form of project regulation was required for the efficiency of PPPs, which could be created through a **transcending steering group**. Both sectors have a responsibility for composing such a steering group. According to several respondents from both sectors, a steering group should consist of experts from both the public and private sector. One respondent believed that one expert should be sought as a project director, with wide experience in both the public sector, private sector, and preferably PPPs. When verified with other respondents, it was mentioned several times that such a director is welcome but not necessary.

"A steering group like this, separated from both sectors, is very important. It can be one person or a group of experts who both have an eye for the commercial interests as well as the social interests. From there on, a shared vision can be created" (Respondent 4, Investment Company, experienced with PPP).

5.4 Market potential

Aside from acquiring knowledge on how to establish PPPs in the healthcare real estate market based on the concepts derived from the conceptual framework, one new theme emerged throughout the interviews. It became surprisingly apparent that multiple respondents saw great potential in the Dutch healthcare real estate market, which can be explained by the differences between the Dutch and Belgian market.

According to several respondents from property development and investment companies, the **separation of residence and care** is a primary reason why the Dutch market is viewed as having potential. To illustrate, the respondents from investment companies compared the Dutch to the Belgian healthcare market. In Belgium, the separation of residence and care was introduced long before it was implemented in the Netherlands. Since then, the respondents saw the Belgian healthcare real estate market rise very quickly, as the market started privatizing rapidly. Care providers were forced to develop a real estate strategy to prevent vacancy. Therefore, care providers needed to either sell off or transform their real estate, leaving a strong incentive for private investment companies. Likewise, the respondents expected this trend to be triggered in the Netherlands when the separation of residence and care was introduced in 2013. However, to date, the respondents mentioned that the Dutch market is lagging behind Belgium. Dutch care providers still doubt their real estate strategy and are uncertain about selling or transforming their real estate. As the respondents continued, this trend is unfortunate for the maturity of the healthcare real estate market, because all ingredients for a high potential market are present. For instance, the consolidation of care providers and housing associations is low in the Netherlands, which increases the partnership possibilities. Besides, according to the respondents, the elderly show a stronger preference for renting rather than owning houses, in contrasts with the Belgian population. This increases the potential for PPPs.

"We entered the Dutch market because we saw great investment opportunities. The market is growing; however, not in the way we expected. Stakeholders do not understand the complexity of healthcare real estate, which hinders the growth of the market" (Respondent 14, Belgian Investment Company).

6. Discussion and conclusion

This chapter provides a critical reflection on the results of the study by placing the key findings into context and comparing the findings to the existing literature and the conceptual framework. Furthermore, recommendations will be offered to Cushman & Wakefield and for future research. The theories and methodology used will be critically reflected upon by discussing their strengths and limitations. Finally, the study will be concluded.

6.1 Key findings

The main research question of this study was: *"What is expected and required for PPPs in the Dutch healthcare real estate market?"* This question aims to explore the expectations and requirements of PPPs from both the public and private sector. Based on the collected data, it can be stated that many different expectations and requirements from all sectors have been gathered. Out of 15 interviews, six key themes emerged, which are considered to determine the success of PPPs in the healthcare real estate market. First, a summary of the key themes is provided (table 3), followed by an explanation of how the themes are related to existing literature and the conceptual framework.

Table 3. A synoptic overview of the expectations and requirements found in this study, distinguished per concept.

MAIN THEMES		EMERGED THEMES	
	Expectations	**Outcome**	• Scope of project agreements • Diversity in residence and care provision • Fulfilment of needs with life-course proof real estate
		Risks	Threats • Time-varying risks: quality of project and changes in regulation and legislation • Conjuncture risks: changes in the economic growth of the real estate market Opportunities • Social added value public sector, financial growth private sector • Non-replicability and scalability
		Market potential	• Impact of residence and care separation on the potential of the Dutch healthcare real estate market
	Requirements	**Roles and responsibilities public sector**	• Transparency of policy in terms of zoning plans and land prices • Contractual flexibility with exit clause and flexibility in zoning plans and ground allocation
		Roles and responsibilties private sector	• Technical innovativeness • Financial and technical management • Alignment of partnering and facilitating actors
		Mutual roles and responsibilities	• Development of a shared strategic vision • Forming a transcending control group

6.1.1 Comparison with existing literature

This study focused on the expectations and requirements for PPPs in the Dutch healthcare real estate market. It represents one of the first attempts in the Netherlands to obtain information from all key stakeholders on their perceptions towards PPPs. Therefore, very few similar studies regarding PPPs specifically for the healthcare real estate market can be used to comparatively understand the current findings. Nonetheless, an in-depth comparison can be made with existing literature focusing on PPPs as a whole.

In general, it can be concluded that operationalising and defining the term "partnership" to view the relationship between public and private actors is challenging in all sectors, as it suggests an equal status and authority of involved stakeholders. Wong et al. (2015) carried out a study from an *international* perspective and evaluated how PPPs were viewed in different countries. They stated that the definition of a PPP fails to be specific and consistent, as its perspective remains different in every political, economic, and social environment or context. Similarly, the results of the current study suggest an inequality in PPP roles and responsibilities, as presented and visualized by several respondents. Rather than forcing a partnership by means of contractual governance, a PPP should work towards cooperation and shared objectives. Complementarily, a literature review by Roehrich et al. (2013) studied 1400 publications from a wide range of disciplines about the usage of PPPs and concluded that too few in-depth empirical studies have been conducted to be able to agree on the definition of a PPP. This might explain why respondents of the current study did not agree on the extent, characterization, and operationalization of a PPP.

In addition, Klijn and Teisman (2002) earlier questioned on a *national* level whether the practice of PPPs match the idea of actors cooperating with achieved benefit. They tested their hypothesis on three cases in the Netherlands, not including the healthcare real estate market. It was concluded that practical reality was far from ideal; The authors stated: "Actors have difficulties in achieving actual joint decision-making and tend to organize their interactions in a traditional way: by contracting out and by separating responsibilities" (Klijn & Teisman, 2002). These findings complement the results of the current study. Contracting and separating responsibilities are seen as a somewhat awkward solution to difficulties related to PPPs, such as the allocation of roles and sharing of risks. Through such fear-driven practices, both the public and private sector cease to embrace and make effective use of the power of a partnership.

Moreover, regarding the requirements for PPPs, other studies suggest that roles and responsibilities likewise differ for each PPP context and cannot, therefore, be approached from a traditional PPP perspective. To illustrate how the results of the current study reflect this, a comparison can be made to projects for real estate sustainability in the Netherlands. Similar to the healthcare real estate market, this market concerns projects with a shared task from both the public and the private sector and thus cannot be viewed as a traditional real estate situation. Deloitte Real Estate (2017) developed a partnership approach with multiple stakeholders and identified innovative ways of introducing PPPs in real estate projects, similar to the results of the current study. Their study examined the need for flexibility in PPP agreements. They noticed a movement in which fewer legal agreements and increased flexibility are required. According to Deloitte, the market functions less efficiently with fixed long-term programmatic agreements. Thereby, in line with these conclusions, Teisman, van Buuren, and Gerrits (2009) also appointed these trends in the field of area development: a movement from supply control

to demand control and the increased need for a shared strategic vision on PPPs. Both existing studies stress the need for increased flexibility in cooperation, contract, and operating environment (Teisman, van Buuren, & Gerrits, 2009; Deloitte Real Estate, 2017).

6.1.2 Reflection on conceptual framework

For this study, the PPP risk management framework by Sanda and Anigbogu (2016) was favoured over the PPP construction framework by Li, Akintoye, and Hardcastle (2000), as the first model built on the latter and provides a more extensive explanation of establishing PPPs. However, the adopted framework still has several limitations.

The conceptual framework is intended for traditional real estate projects, suggesting a traditional situation in which the public sector aims to attract and encourage the private sector to participate in a publicly-provided sector. This is not the case in the context of the Dutch healthcare real estate market and thus limits the suitability of the framework for this study. In a traditional real estate development project, the operational structure of a PPP is clear, and agreements can be clearly made. In the context of the healthcare real estate market, however, the public and the private market face a shared task in a non-matured market; the Netherlands is facing an increased shortage of suitable elderly housing and PPPs may be a possible solution to this trend. The findings of the current study and existing literature suggest that the public and the private sector should collaborate on a more flexible level. As explained by Deloitte Real Estate (2017), structure and the operating environment of a PPP are of less importance and were thus left out of the adopted framework. A flexible approach is key to a successful PPP, which conflicts with the adopted framework of this study. Nevertheless, the explorative character of this study ultimately fit well with the other concepts. The roles and responsibilities of the public sector, the private sector, the mutual roles and responsibilities, and the expected risks and outcome were applied directly to this study and very effectively answered the research questions.

One new theme emerged during the interviews that was not included in the framework. The market potential of the Dutch healthcare real estate market was found to be an important expectation for several, mostly private, stakeholders. However, the absence of this theme in the conceptual framework can be attributed to the specific context of this study. Sanda and Anigbogu (2016) endeavoured to develop a conceptual framework, applicable to all traditional real estate situations. Therefore, prior to collecting the data, there was a possibility of new themes emerging due to the exploratory nature of this study in a rather new and non-matured real estate market. Similar to the theme of this study, a study by Capital Value (2018) likewise acknowledged the potential of the Dutch healthcare real estate market. Their recent study stated that during the last few years, the growth potential of the market has increased significantly, due to the investment volume of 2017 combined with the growing ageing population and the separation of residence and care.

Lastly, the clear categorization between the public and private sector in the conceptual framework should be critically reflected upon. Throughout the stakeholder analysis and interviews, it became clear that multiple respondents did not agree with all key stakeholders, specifically care providers and housing associations, being either a public or private stakeholder. According to the respondents, both types of stakeholders do not solely operate in the public or the private sector; they all maintain a public and a private element to their business management. These organisations are bound to legal tasks, serve a public interest, and are mainly publicly financed. However, they also hold a private task as they

are expected to increase efficiency and become more market-oriented, confirmed by Kok and Driessen (2012). Therefore, the distinction between public and private, as the conceptual framework suggests, does not fit the context of this study. While transcribing and analysing the data, additional questions were added to the interview guide about the roles and responsibilities of these semi-public stakeholders. Ultimately, however, the roles and responsibilities of care providers and housing associations do not differ significantly from those of private stakeholders. Hence, it did not affect the results of this study.

6.2 Recommendations

6.2.1 Recommendations to Cushman & Wakefield

The results of this study on the establishment of PPPs in the Dutch healthcare real estate market are important for Cushman & Wakefield, the commissioning company of this study. Recommendations are directly linked to the practical relevance of this research and can be used for future improvements in the healthcare real estate market and the services of Cushman & Wakefield.

Cushman & Wakefield is advised to develop a strategic plan on strategies for establishing PPPs in the healthcare real estate market. This will result in increased awareness of the urgency and potential of PPPs and the level of knowledge that is still required. For example: this could be accomplished through improving information dissemination and accessibility of knowledge between sectors. In order to increase trust between the public and the private sector, Cushman & Wakefield could act as intermediary between these sectors and attempt to harmonize the public and private sector. The process of uniting the stakeholders is key for sustainable PPPs in the future, as is demonstrated in this report, and confirmed by the literature (Wong et al., 2015; Roehrich et al., 2013).

To illustrate, Cushman & Wakefield could, as a service-driven company, adopt the “expert consulting” approach and act as intermediary in this case (Torvinen & Ulkuniemi, 2016). By doing so, the public and private sector temporarily transfer ownership of the problem to the consulting agent. Such methods work most efficiently when the consultant is able to provide the relevant expertise. Cushman & Wakefield is able to take on this role due to many years of experience in the Dutch healthcare real estate market and their leadership in commercial real estate services. By embracing such an approach, the objectives of Cushman & Wakefield will not only be economic; but will also include aims to create genuine partnerships and unite the interests of both sectors.

6.2.2 Recommendations for future research

First, future research should include additional qualitative research. In this study, only semi-structured interviews were conducted with key stakeholders in the field of healthcare real estate. An interesting finding of this study is the conflicting visions of the stakeholders about the required roles and responsibilities for the opposing sector. For instance, private respondents viewed transparency from municipalities as an important factor; however, municipalities did not fully agree with this statement. Future research should therefore ideally include focus group discussions (FDGs), facilitated around a certain theme and including multiple participants. The purpose of FDGs is to develop a better understanding of how participants feel about a certain topic or issue and what values and frameworks underlie their emotions or perceptions (Krueger & Casey, 2014). Such methods encourage actors to openly respond to certain topics and allow for building on each other’s ideas, thereby co-creating new

knowledge and solutions. In this case, both public and private stakeholders would be confronted with each other's opinion in a setting that stimulates open discussion and collaborating towards consensus; this was not possible with the methodology of this study.

Moreover, future qualitative research is needed that builds further on Kotter's change management, as described in the theoretical background. This model lists eight steps needed to successfully establish change in a system. Within the model, three categories of change are distinguished: creating the climate for change, engaging and enabling the system, and implementing and sustaining the change. This study focused on the first category, through exploring the key stakeholders' conceptions and visions about PPPs in the healthcare real estate market. As Kotter's model suggests, future research should first study the enabling and engagement of PPPs in the healthcare real estate market, by defining how the change should be communicated and empowered in order to lead to wins for both the public and the private sector. Such studies will be indispensable for eventually implementing and sustaining PPPs in the healthcare real estate market.

6.3 Strength and limitations of the study

6.3.1 Strengths

With regard to strengths, this study is one of the first studies carried out in the Netherlands to explore the environment in which PPPs are to be established. The interviews were conducted with both public and private stakeholders, capturing the views of all key stakeholders and allowing them a convenient opportunity to voice their opinions (Baker et al., 2016). This approach provided a "bigger picture perspective" and a clearer understanding of PPPs.

Regarding the participants of this study, person triangulation is a strength of this study, as stakeholders from different interaction levels were included and multiple researchers have contributed to this study. Thereby, the number of participants is also considered a strength, as it resulted in data saturation; themes were recurring, and no new information emerged in the end. Moreover, two pilot interviews were held prior to the semi-structured interviews to determine if the questions of the interview guide were unambiguous and followed each other logically. Afterwards, the findings and recordings were sent back to the respondents by means of a member check. This transactional approach comprises the active interaction between researcher and respondents and increases the validity of the study (Cho & Trent, 2006). It is thus considered a strength.

6.3.2 Limitations

The findings of this study should also be read with certain limitations in mind. The answers reported in the interviews by the respondents might have been influenced by recollection bias and the temptation to offer socially desirable answers. This is particularly true given the potentially confidential nature of the subjects discussed in the interviews and the possibility of respondents perceiving that their answers were under scrutiny. Similar sources of bias may likewise have influenced the behaviour of respondents in the interviews, as they were audio-recorded. In addition, the perceptions of the respondents were based on their subjective interpretation of events, which may not have reflected reality (Ulin, Robins, & Tolley, 2005).

In addition, the topic familiarity of the researcher prior to conducting the study was considerably low. Real estate is a complex field and study on its own, which demands a certain level of expertise to understand how stakeholders work together in the real estate market. As a result, researcher bias could have emerged during the interviews, as answers could have been interpreted wrongly. A member check partially remedied this possibility.

6.4 Conclusion

This study was carried out due to the increased shortage of suitable senior housing in the Netherlands, caused by an ageing population. PPPs are suggested as a possible solution to anticipate this trend, and the aim of this study was to explore the expectations and requirements for such PPPs in the Dutch healthcare real estate market. Many different views were gathered from both the public and private sector. The findings indicate that PPPs in the healthcare real estate market have potential, but success will require accord between all key stakeholders on the meaning and objective of PPPs. Public and private stakeholders demonstrate divergent perspectives on how PPPs ideally should be established, and high ambiguity exists on the definition of a PPP. As a result, many views were gathered on PPPs, however, these views cannot be tied to a shared vision and an implementation strategy in the Dutch healthcare real estate market.

Concluding this report, this study provided a stepping-stone for future research to further explore the enabling and implementation of PPPs in the Dutch healthcare real estate market. When all expectations are anticipated, and all requirements are optimized, in theory, PPPs could successfully be established. Eventually, this could lead to an increased future provision of suitable senior housing for the Dutch elderly population.

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Appendices

Appendix I Interview guide

In this section, the interview guide is presented. The interview guide will increase the internal validity of the qualitative data collection. The following interview questions are used as guidance for the interviewer. When appropriate, the interviewer may elaborate on certain topics depending on the answers and responses of the interviewees. Prior to the interview guide, an example of the *interview informed consent* conversation is presented in English. For the interview, the Dutch translation was used.

Start of the interview

"First of all, thank you for having me here today and making time in your schedule to help me completing my research project. I am Master of Science student at the VU University Amsterdam and currently following my internship part of the Master studies Management, Policy-analysis and Entrepreneurship in Health & Life Sciences. This interview is part of a research project that I am conducting at Cushman & Wakefield.

The interview will take approximately one hour of our time. I will be asking you some questions about how public-private partnerships can be established in the real estate market for elderly housing. Questions will focus on the roles and responsibilities of both the public and private sector, possible risks of such partnerships in this context and possible outcomes of such partnerships. If you have any additional questions, please do not hesitate to ask me. Your anonymity will be guaranteed, and no names will be published. Do I have your permission to use this interview as data in this research project? Furthermore, do you give me permission to record this conversation, which will solely be used for the purpose of data analysis? If yes, please read and sign the informed consent form."

Interview guide

Interview topics and sub-topics	Key interview questions
1. Knowledge and Information	• What is your position and responsibility in your organization? • What do you know about the double ageing process and its influence on housing policy in the Netherlands? • What do you know about the cuts on long-term care expenditure and its relation to housing and healthcare? • Can you tell me how you think about the increasing shortage of suitable elderly housing the Netherlands?
2. Public sector and private sector collaboration	• How do you think about introducing public-partnerships in the healthcare real estate market? • Have you previously experienced partnerships with the public/private sector in your organization? • If yes, how did you experience the collaboration with the public/private sector?

3. Roles/responsibilities public sector	<u>Accountability/transparency</u> • To what extent should documents from the public sector be accessible? • To what extent should information about timeliness be available? • To what extent should mechanisms for influence from the private sector be available? <u>Institutional framework</u> • What capacities does the public sector need for composing an institutional framework? • What institutional settings should be in place from the public sector? • What regulatory frameworks are needed from the public sector? <u>Legal framework</u> • What legal procedures are necessary for successful PPP? • What are necessary agreements between government agents and private firms for successful PPP?
4. Roles/responsibilities private sector	<u>Financial capability</u> • How could the private sector minimize financial risks for PPP? • To what extent is the net present value of importance for PPP? • To what extent is the internal rate of return of importance for PPP? <u>Technical expertise</u> • What expertise/competences is required from the private sector for PPP in healthcare real estate? • What design standard is needed from the private sector? • How can requirements for the senior housing best be met? <u>Managerial skills</u> • What project management skills are required? • Wat contractual relationships are required? • How should responsibilities in the partnership be allocated? • What working relationships should be in place?
5. Partnership risks	• How do you feel about the associated risks with PPP in the development of senior housing? • How do you think about cost or time estimation failures? • How do you think about quality failures? • What treats do you think will be important for PPP in the development of senior housing? • What opportunities do you think will be important for partnerships in the development of senior housing?
6. Partnership outcomes	• How do you think about the size of the housing scheme needed? • What characteristics of housing units are important? • What is the targeted population for this partnership? • What type of housing scheme would you think is ideal?

Closing of the interview

"This is the end of the interview. Thank you very much for your answers and your time. Is there anything else that you want to tell me that might be relevant for the research project? If you think of something relevant that you are willing to share, my personal details have been provided to you so feel free to contact me. Additionally, do you have any other questions that you want to ask?

Lastly, would you like to stay up to date about this research and want to receive a summary of the research of the results when the analysis is completed? If yes, please write down your email address. Thank you!"

Appendix II Operationalisation table

Concept	Sub-concept	Definition	What does this include?
Mutual roles and responsibilities	Leadership	The ability to make thorough decisions and perform well in a PPP.	• Role allocation • Strategic vision • Leadership mind-set
Public roles and responsibilities	Accountability/Transparency	Operating in such a way that others can easily see what actions are performed.	• Fullness of disclosure • Accessibility of documents • Timeliness of information availability • Mechanisms available for influence
	Institutional framework	A system of laws, regulations and procedures that shape a PPP.	• Appropriate capacities • Institutional settings • Regulatory frameworks
	Legal framework	A set of rules through which judgement can take place.	• Comprehensive legal procedures • Clearly defined agreements between government agencies and private firms
Private roles and responsibilities	Financial capability	The economic resource measured in terms of money used by entrepreneurs and businesses.	• Minimizing financial risks • Net present value of the PPP • Internal rate of return
	Technical expertise	A technical level of work that requires specialized knowledge and skills.	• Expertise of personnel • Required competences • Design standard • Conforming to clients' requirements
	Managerial skills	The ability to make business decisions and lead others.	• Project management skills • Allocation of responsibilities • Working relationships
Risks		The potential of a PPP for gaining or losing its value.	• Cost estimate failure • Estimation time failure • Quality failure • Challenges/threats • Challenges/opportunities
Outcome		A possible result of a PPP.	• Number of houses • Characteristics of the housing units • Targeted population

Initial axial codes	Interview number																Finial axial codes	Initial selective codes	Final selective codes
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	TOTAL			
Mixing (non-)residential care	X	X			X	X	X	X			X			X	X	9	Care diversity	Diversity	Partnership outcome
Living with different people	X	X		X	X	X	X	X					X		X	9	Target population diversity		
Fulfilment of needs	X		X	X		X	X	X						X		7	Future-proof real estate		
Positive experiences PPP					X								X			2	Attitude towards PPP	Attitude	
Negative experiences PPP			X		X	X	X	X	X	X						7	Attitude towards PPP		
Long-term agreements			X		X	X					X	X				5	Scope of partnership	Scope of partnership	
Short-term agreements	X	X		X				X	X							5	Scope of partnership		
Project failure	X		X				X	X			X					5	Endogenous time-varying risks	Threats as risks	Partnership risks
Changes in legislation	X			X		X		X			X				X	6	Exogenous time-varying risks		
Return of Investment		X					X		X					X	X	5	Exogenous conjuncture risks		
Do it for society	X		X			X	X			X	X	X				7	Social added value	Opportunities as risks	
Making more profit	X			X				X	X					X	X	6	Financial growth		
Learning from Belgian market		X												X	X	3	Influence finance separation	Maturity market	Market potential
Care providers' need for new strategy		X												X	X	3	Urgency real estate strategy		
Difficulty for stakeholders		X						X						X	X	4	Complexity healthcare real estate		
Able to access documents	X	X	X	X	X				X							6	Accessibility to documents	Transparancy and accountability	Roles and responsibilities public sector
Transparency of zoning plans			X	X												2	Transparency of zoning plans		
Regulation in partnerhsip				X												1	Partnership regulation		
Contract agreements		X		X	X		X	X	X							6	Framework	Setting frameworks	
Contract flexibility												X	X			2	Framework		
Setting legal framework	X	X	X	X	X	X	X		X	X			X	X		11	Framework		
Capital availability		X	X	X		X	X	X	X	X	X	X	X	X	X	13	Financial resources	Financial capability	Roles and responsiblities private sector
Competitive environment		X						X	X					X	X	5	Financial competition		
Investment strategy		X									X	X		X		4	Financial resources		
Innovative mindset	X	X	X	X	X	X	X			X	X		X			10	Expertise	Technical innovativeness	
Entrepreneurship	X	X	X	X		X		X			X		X			8	Expertise		
In-house expertise				X	X		X				X		X			5	Expertise		
Professional people	X	X	X	X		X		X				X	X	X		9	Qualified personel	Management skills	
Experience with PPP						X						X	X	X	X	5	Project experience		
Unite each others' interests	X	X	X	X		X	X	X	X					X	X	10	Combine interests	Leadership	Mutual roles and responsibilities
Municipalities front leader				X				X		X				X		4	Leadership public sector		
Investment/Property firms leaders												X	X			2	Leadership private sector		
Broader perspective of PPP			X					X		X						3	Acknowledge broader perspective		
Context of PPP	X		X							X			X	X		5	Acknowledge social context		
Urgency needs to grow											X					1	Spread sense of urgency		
Create trust	X			X	X			X	X							5	Create trust		
Agree on the wins			X				X				X			X	X	5	Strategic vision	Shared strategic vision	
Evaluate strategy					X				X		X			X	X	5	Strategic vision		
TOTAL	16	17	16	18	12	14	14	18	12	8	13	8	12	18	14	210			

Appendix IV Informed consent

Information sheet

Cushman & Wakefield has started a research project in collaboration with VU University Amsterdam to identify under what conditions public-private partnerships can be established in the elderly housing market in the Netherlands. This research project is a result of the increasing number of suitable elderly housing in the Netherlands. The study will provide valuable information for both the public and the private sector in the real estate market, which will contribute to solving the problem of suitable elderly housing in the future.

We are asking you for your consent to be interviewed and to answer important questions about partnerships and the real estate market. The answers you give will become part of the research report, but all personal information such as your name will be kept confidential. When the research report is published or presented, your identity will not be disclosed. The personal information collected or obtained will be kept confidential and protected.

Your participation in the research will not involve any costs and there is no compensation available. You may also withdraw at any time if you change your mind about participating.

The research team includes Eric Scheijgrond (Cushman & Wakefield), Geertje Besier (Cushman & Wakefield), Emmy de Wit (VU University Amsterdam) and Oscar Klein (VU University Amsterdam/Cushman & Wakefield).

If you are willing to participate, please sign the attached consent form and give it to Oscar Klein or another member of the research team.

Thank you for helping us with this research project.

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Consent to participate

Name: _____

Organisation: _____

Job title: _____

Date of Birth: _____

Signature: _____

Date: _____

Participant

By signing this form, I confirm that:

- The research project has been fully explained to me and all of my questions have been answered to my satisfaction
- I have been informed of the risks and benefits, if any, of allowing my information to be used in this research report
- I have been informed that I do not have to participate in this research report
- I have read each page of this form

Thank you for your participation!