Introduction

Professional demands for healthcare reform

On 11 March 2015, shortly before midnight, a group of general practitioners (henceforth GPs) gather around the main entrance of the Dutch Ministry of Health, Welfare and Sports in The Hague, the Netherlands. The GPs have congregated here to tape a manifesto to the glass door of the Ministry (figure 1, previous page). They include nails as a symbolic reference to Martin Luther's manifesto, nailed to the wooden door of the All Saints Church in 16th-century Wittenberg. Luther's manifesto demanded reformation of Roman Catholic church practices.[1] Like Luther, these GPs also demand a reformation. This time, they argue, the Dutch healthcare system should be fundamentally reformed (Zurhake 2015; cf. NOS 2015).

In their manifesto, the GPs stress that politicians, policymakers and health insurers should demonstrate courage and confront reality. They should acknowledge that the introduction of market mechanisms into the Dutch healthcare system, some 10 years earlier, has failed. Collaboration amongst healthcare professionals has become impossible, whilst such collaboration is, according to the GPs, the only way to deliver continuity and quality of care (Het Roer Moet Om 2015a). Subsequently, the manifesto introduces three theses:

- Get the GPs out of the grips of the competition law and restore 'integration through collaboration' as the leading principle in primary care.
- Collaboration and negotiation on an equal basis; national and regional. No more 'false negotiations' with the health insurer.
- Trust the expertise of professionals. Stop the unlimited collecting of useless data.

1 Although Martin Luther's manifesto often symbolizes the beginning of Protestantism and the large scale religious and geopolitical struggles across Europe that followed (Mullet 2014), it was part of broader religious, economic, technological and geopolitical developments (Edwards 2004). Widely disputed is whether Luther nailed his theses to the door of the All Saints Church in Wittenberg in the first place; and whether everything somehow necessarily, magically and destined, unspun from there (as his 19th century admirers would have it). The role that the printing press played in the large-scale production and distribution of Luther's reformatory manifesto is generally accepted; this of course signifies a lot of capital, material and work invested in spreading Luther's word (Edwards 2004). With his 95 theses, Luther protested the sale of indulgences and other church practices and problematized the Pope's claim to temporal authority (Overhoff 1997). Although his theses were written in a searching manner (questioning instead of prescribing), his later work openly challenged the church and presented alternative practices of Christianity. Luther started to enact a rather radical and doctrinal strategy for change, emphasizing the restoration of godly principles, unafraid of placing himself outside the church as an institution. In doing so, he distanced himself from Desiderius Erasmus (who happens to be born in Rotterdam and after which the University at which I have written this dissertation is named). Erasmus also wanted to change church practices but followed a different strategy. Emphasizing humanism, tolerance and reasonableness, Erasmus sought to stimulate change from within the church and on an incremental basis. In this dissertation too, different ways of understanding institutional change, and the role that actors play in it, will be brought forward. Some of these understandings foreground dialogue, deliberation and reason (e.g. Jurgen Habermas; Michel Callon), others foreground othering, difference and closure (e.g. Chantal Mouffe; Niklas Luhmann). Long after Erasmus and Luther, formation and (re)formation, as well as collaboration and resistance are still dominant principles through which we theorize governance and institutional change.

The manifesto continues with a threat. If politicians, policymakers and health insurers are unwilling to listen to the GPs, it will have serious consequences for: a) agreements made regarding the organization of collaboration in primary care; b) the motivation of GPs; c) the delivery of optimal care; and d) the transfer of secondary care activities (provided in hospitals) to primary care professionals (who provide care outside hospitals). The manifesto ends with a statement that playfully builds on the Health Minister's surname 'Schippers' (which freely translates to 'Sailing Master'): '*Schippers and helmsmen, the course must change*!' (Het Roer Moet Om 2015a)

With their symbolic reference to Luther and their play with words, the GPs use wittiness to get their message across. However, they also use threats and demands, giving the manifesto a very serious and militant undertone. GPs no longer accept the system they are working in and are willing to act. They have therefore organized themselves into a faction called 'Het Roer Moet Om' (which freely translates to: 'The Course Must Change').

Next to the militant and witty references used in the manifesto, the GPs also voiced their concerns in another language; one of victimization. In a booklet published in June 2015 by the same faction, GPs share their stories; narratives about their everyday working experiences that have led them to despair. The cover of the booklet shows a drowning GP (figure 2). In his left arm, the GP holds a suitcase, desperately trying to keep it dry. This suitcase symbolically refers to the GPs' struggle to continue delivering quality of care. The depicted GP's right arm is stretched, searching for a helping hand. Indeed, the title of the booklet translates to: '*Help the GP.*'[2] At the bottom left of the cover are keywords that translate to: '*bureaucracy, distrust and inequality in everyday practice.*' As the reader turns the pages, the GP's hands slowly disappear underwater. At the end of the booklet, the GP's hands have entirely disappeared and the reader can assume that he has drowned from the daily practice in which bureaucracy, distrust and inequality sway (Het Roer Moet Om 2015b).

In the time that follows, the GPs' call for help, action and change spreads across the healthcare sector. Other healthcare professionals recognize the problems faced by the GPs and similar manifestos follow. One example from 2016 is titled 'Zelf Aan Het Roer' (which freely translates to: 'Setting Course Ourselves'). It represents the demands of healthcare professionals in general – instead of GPs alone – and stresses their need to retake control over their counselling rooms (VvAA 2016). Another example is a movement named 'Ontregel De Zorg' (which freely translates to: 'De-bureaucratize Care' but playfully hints at disorder as well [VvAA 2018]). Indeed, like Luther's 16th-century manifesto, the GPs'

2 The title and illustration are derived from a novel centered around a GP called Angelino who moves to the countryside and stirs up life in a local community with his extravagance and expressiveness (cf. Kortooms 1968).

Figure 2: *Cover of the booklet published by action committee 'Het Roer Moet Om' (2015b)*

manifesto spreads and mutates. It is adopted by – and reified to fit the demands of – a plethora of healthcare professionals who feel victimized by the Dutch healthcare system and want to change it.

My PhD project

It was in the spring of 2015 that I started working on my PhD thesis in the Health Care Governance group at Erasmus School of Health Policy & Management. My assignment was to study changing professional roles and relations in Dutch healthcare governance. Of particular concern were several policy experiments aimed at moving beyond contemporary tensions and improving collaboration amongst healthcare professionals – and between these professionals and other actors – involved in Dutch healthcare governance. In this light, I was immediately fascinated by the abovementioned manifestos. What was going on between the different actors involved in Dutch healthcare governance? Why did healthcare professionals emphasize the importance of restoring collaboration? What did they mean with bureaucratization, distrust and inequality? Moreover, how could policy experiments contribute to overcoming tensions and restoring collaboration amongst healthcare professionals and between healthcare professionals and professional others?

It was with these initial questions that I set out to explore policy experimentation in Dutch healthcare governance. On the one hand, I wanted to describe and understand how healthcare actors participated in such experiments. On the other hand, I also wanted to understand where such experiments would lead to in terms of new (or restored) professional

roles and relations, or alternative organizational formats for the provision of healthcare (more theoretically informed research aims and questions are provided on page 15). It was the start of a journey that would bring me to the boardrooms of the Ministry of Health, the headquarters of health insurers, the tower of the healthcare inspectorate, the platforms of patient and consumer organizations and the consultation rooms of healthcare professionals.

But in order to have some sense of direction on this journey – and in order to turn the abovementioned intentions and questions into more specific and theoretically informed research aims and questions – I realized that it was important to take three additional steps.

Firstly, my project required me to have some understanding of the histories and institutional intricacies of the Dutch healthcare system. For instance, in their manifestos, healthcare professionals had articulated that they wanted to *retake* control over their counselling rooms and *restore* collaboration, suggesting that there was a time when they had control and did collaborate. Articulated tensions and calls to restore collaboration thus seemed to be historically and institutionally contingent (Van Assche et al. 2014). Secondly, institutions and professionals seemed to interact. After all, a bourgeoning number of rules and regulations seemed to smother healthcare professionals, but these professionals also sought to change the very rules and regulations that smothered them. Even though this seems a straightforward observation, I did not know how to approach and interpret such a dynamic between institutions and professionals. This need for perspective prompted me to explore the literature on institutional theory (e.g. Hall and Taylor 1996). Thirdly, I wanted to better understand whether and how policy experimentation – as a phenomenon – related to such historical developments and institutional dynamics. Moreover, I wanted to know how policy experimentation could, in theory, contribute to overcoming the articulated tensions between different actors involved in Dutch healthcare governance. This urged me to study the experimentalist turn in the governance literature as well (e.g. Sabel and Zeitlin 2012).

Before further introducing my research aims and questions, I will therefore first briefly reconstruct how the roles and relations of Dutch healthcare professionals have changed over the years. Thereafter, I will introduce key strands of institutional and experimentalist literature and describe how they have informed the research questions and steps taken in this dissertation.

Professional roles and relations in Dutch healthcare governance: a historical analysis

Within classic welfare states, professionals have been approached as groups that have characteristics that set them apart from other actors in the provision of public services

(Dwarswaard 2011; Wallenburg 2012). Freidson (2001) intended to capture such demarcations ideal-typically. He describes professionals as: '*occupational groups that organize and control their own work, legitimized by an officially recognized body of knowledge and skill, made possible by an occupationally controlled division of labor and shaped by a labor market on which individuals participate that have passed occupationally controlled training programs.*' (Freidson 2001: 126 [paraphrased]) Based on such characteristics GPs, medical specialists, dentists, physiotherapists and nurses would, amongst others, qualify as professional groups.[3]

In the Netherlands, healthcare professionals have had protected status with laws that regulate their jurisdiction. This protected status can be traced back to the second half of the 19th century (Van de Ven 2015). During this time, the government sought to increase public access to healthcare services whilst simultaneously increasing its control over the quality and safety of the services provided. The government intended to do so through the introduction of Sickness Funds (of which membership became mandatory for Dutch employees in 1941) and by installing a centralized inspectorate assigned with the task to survey the quality and safety of healthcare services (de Quaasteniet 2008). In addition, the government introduced a law that protected and regulated professional jurisdiction. This law prescribed who was and who was not allowed to provide certain healthcare services (Dwarswaard 2011; Van de Ven 2015). Inclusion criteria were however determined by the professional community themselves, organized in professional organizations. Moreover, what was considered good care was also subject to professional self-regulation. Up until today, professional self-regulation remains an important regulatory principle in Dutch healthcare governance; it is shaped by regulatory instruments such as education and training, professional guidelines, peer review and disciplinary boards (Bal 2008).

Nevertheless, what being a healthcare professional means has changed significantly over the years. Such changes did not only stem from dynamics within professional groups (e.g. based on a growing and diversifying body of knowledge). They were also brought about in response to developments taking place outside of professional organization and control. Within the sociology of professions, scholars have for instance revealed how state-initiated policy reforms, patient expectations and new labor principles induced changes on the level of professional ethics, conduct and training (Dwarswaard 2011; Wallenburg 2012; Postma

3 Recent studies have described how, in everyday practice, healthcare professionals engage in activities that do not necessarily fit Freidson's ideal-typical demarcation. They engage in the management of healthcare organizations and negotiate with health insurers about the quality, volume and price of the care provided. These insights have moved scholars to coin the term *hybrid professionalism* (Noordegraaf 2007; 2015). Not only has such hybridity eroded the boundaries of professional jurisdiction, it also complicated who can and cannot be considered a professional. Below, I provide a reading of how such hybridity can be interpreted historically and institutionally.

et al. 2015). In relation to Dutch healthcare governance, scholars that discuss such external forces often mention several historical episodes. Below, I briefly highlight these episodes and the way they impacted professional roles and relations.

As medical knowledge and technologies were advancing in the second half of the 20th century, more health problems were identified and made into objects of specialized care. These developments raised public expectations and demands (Boot and Knapen 2003). Meanwhile, the costs of healthcare services were determined through corporatist negotiations between hospitals, professional organizations and the Sickness Funds. However, none of these parties had any incentive to contain costs. Consequently, healthcare expenditures rose from 3% of the GNP in the 1960s to 7% of the GNP in the 1970s (Helderman and Jeurissen 2010). To control expenditures, the Dutch government started rationing services top-down; particularly through the implementation of volume norms and expenditure caps (Schut 1995). Attempts to contain costs were thus mainly undertaken through supply-side interventions by the state (Helderman and Jeurissen 2010). Up until today, maximum prices for healthcare services are still determined for professional groups such as dentists, speech therapists and orthodontists (NZa 2019).

Coinciding with the state's attempt to contain costs was the emergence of the evidence-based medicine movement. This movement was aimed at reducing unexplained and therefore undesirable practice variation amongst professionals; particularly so by promoting a shift from authority-based decision-making to healthcare decision-making based on the best clinical evidence available (Bolt and Huisman 2015). Although this movement was initiated by professionals for professionals, the unexplained variation revealed also eroded public trust in professional authority and self-regulation (Bal 2008). On the one hand, it promoted the importance of professional guidelines and the idea that professionals should follow such guidelines (standardization over practice variance; cf. Bolt and Huisman 2015). On the other hand, it also allowed for civil society groups (such as patient organizations, quality institutes and health insurers) to become involved in the development of such guidelines. In this light, state-based regulation and professional self-regulation were complemented with a corporatist form of regulation, based on deliberation and consensus between professional, state and civil organizations on how to deliver, control and improve healthcare quality (Van de Bovenkamp et al. 2014). This movement has partly displaced (or extended) healthcare decision-making from the counselling room into the meeting rooms of professional, state and civil society organizations.

Another episode that has impacted professional roles and relations is associated with the introduction of market mechanisms (Helderman et al. 2005). Previously introduced supply-side interventions by the state led to repetitive conflicts between the government and

healthcare providers. As an alternative, several committees proposed to introduce market mechanisms (Dekker committee 1987). Competition amongst insurers would contain the price of insurances offered to Dutch citizens. Competition amongst healthcare providers would increase the quality of healthcare provided to patients. Moreover, negotiations between healthcare providers and healthcare insurers would stimulate quality improvement and contain the costs of services provided (Dekker committee 1987). The idea of introducing market mechanisms can be traced back to the 1980's. However, it took twenty more years before the Dutch healthcare system was fundamentally reformed in line with the principles of regulated competition; particularly so with the introduction of the Health Insurance Act in 2006 (Helderman and Jeurissen 2010).

In the newly established healthcare market, health insurers needed to start acting as critical buyers, patients needed to start acting as critical consumers and healthcare providers needed to start competing. In order to fulfill their roles, health insurers and patients needed to have insight into the price and quality of care provided and healthcare providers needed to distinguish themselves from others. These needs stimulated the development of quality indicators. Meanwhile, the state did not abandon the scene. Instead, the Dutch government reinforced its position by functioning as a market arbitrator and by top-down steering on the development of performance indicators and other quality instruments (Van de Bovenkamp et al. 2014).

Importantly, the regulatory frameworks associated with each episode (professional self-regulation; state-based regulation; corporatist negotiation; and market competition) did not necessarily replace one another. Instead, they were introduced beside one another over time (Van de Bovenkamp et al. 2014; 2017). This stratification of regulatory frameworks has had two major consequences. Firstly, it resulted in a proliferation of 'professional others' involved in healthcare governance (Lascoumes and Le Galès 2007). Examples are health insurers and policymakers, but also knowledge institutes, quality institutes, inspectorates, market authorities and patient/consumer organizations. Secondly, both professionals and professional others have been informed, inspired and constrained by – as well as producing themselves – an equal proliferation of rules and standards (Van der Heijden 2011), each of them introduced under specific historical conditions and framed in specific regulatory rationales (Lascoumes and Le Galès, 2007). Such rules and standards have often been developed independently. Nevertheless, in contemporary healthcare practices, they interact in unpredictable ways (Van de Bovenkamp et al., 2017; see for a recent example OVV 2019).

What has emerged is a complex institutional environment (Greenwood et al. 2010; 2011; Smets and Jarzabkowski 2013) in which professionals and professional others involved in healthcare governance have different, sometimes conflicting orientations towards what

they are, what they should and should not do and what to expect from others (Deacon 2000; cf. OVV 2019). In this historical light, the *bureaucracy*, *distrust* and *inequality* expressed in the professional manifestos are comprehensible (Roer Moet Om 2015a). They could be interpreted as the consequences of regulatory frameworks that have been added to the Dutch healthcare system over time; slowly intruding on matters that were once – at least ideal-typically and in the eyes of the rallying professionals – subject to professional self-regulation (Freidson 2001; cf. Tonkens 2013).

This historical reading however does not necessarily explain the dynamics through which the stratification of institutional arrangements occurred in the first place. At best, it paints a picture of changing institutions in response to historical challenges (e.g. supply-side interventions in response to rising costs). Moreover, it does not provide details about the mechanisms by which the abovementioned amalgam of regulatory arrangements has shaped professional roles, relations and practices. At best, alternative regulatory arrangements are approached as intruding on and corrupting professional self-regulation, creating tensions between healthcare actors along the way. This made me realize that I needed to look elsewhere if I wanted to better understand: a) the dynamics through which institutions shape professional roles and relations (for better and worse); and b) the role that policy experiments could play in improving the situation. This realization prompted me to explore the literature on institutional theory and experimentalist governance.

In the next subsection, I introduce how institutional scholars have sought to better understand institutional developments and how they shape and are shaped by professional practice.

Theories on institutional and professional change

What regulatory arrangements are, how they work and which social outcomes they produce has long been a topic of scholarship within the field of public administration, particularly so within different strands of institutional theory (Hall and Taylor 1996). Some of these strands have focused on the structuring effects of regulatory arrangements in relation to actors and their behavior (Scott 1987; 2014). Others have emphasized the crucial role of actors in the bringing into being of regulatory arrangements and the translation of such arrangements into everyday practices (Mahony and Thelen 2010). Below, I discuss these different strands in turn. This is followed by a description of how some scholars have tried to combine them to better understand the dynamics between institutions and actors.

In institutional theory, institutions have traditionally been defined as formal and informal procedures, routines, norms and conventions that structure the behavior of institutional subjects (Scott 1987; Hall and Taylor 1996; Lowndes 2010). This reading has stimulated

institutional scholars to study processes through which institutions (re)produce meaning and govern practices (March and Olsen 1995; Scott 2014). Different explanations and emphases emerged. Historical institutionalists for instance emphasized path-dependencies (institutions structure responses to new challenges) and historically emergent power asymmetries (institutions structurally privilege some actors over others). Sociological institutionalists, in turn, emphasized that institutions do not only specify what one should do (rules), but also *'specify what one can imagine oneself doing in a specific context.'* (Hall and Taylor 1996: 948)

What these historical and sociological institutionalists share is their analysis of institutions on a macrolevel. They both scrutinize how institutions help to understand, structure and respond to the world around us. Moreover, in both cases, institutions have been deemed *'relatively stable collections of practices and rules, defining appropriate behavior for specific groups of actors in specific situations.'* (March and Olsen 1998 in La Cour and Højlund 2013: 191) Historical and sociological institutionalists thus seem to produce rather stable, linear and unidirectional accounts about the dynamics between institutions and actors. Indeed, for historical and sociological institutionalists, periods of institutional stability are only rarely punctuated by moments in which institutional break-down and change takes place. But when this occurs, such moments are often defined as branching points or schisms, suddenly opening-up new paths for institutional development – and subsequently – what becomes defined as appropriate behavior or what one can imagine oneself doing. Typically, these moments are associated with external events such as crises and wars (Hall and Taylor 1996).

A different reading of the dynamic between institutions and actors emerged in rational choice institutionalism specifically and in organization studies more generally. Rational choice institutionalism emphasized that institutions are brought into existence by rational actors who search for ways to organize collective action, whilst simultaneously and calculatedly aiming to maximize individual gains (Hall and Taylor 1996). Instead of approaching humans as institutional dopes, these scholars thus approached humans as institutional entrepreneurs (cf. Dimaggio 1988). In a similar vein, organizational scholars tied the concept of institutional entrepreneurship to their observation that institutions structure social (inter) action and privilege some actors over others (North 1990; Fligstein 2001). According to these scholars, actors strategically try to create, maintain, or destroy institutions that privilege or marginalize their institutional position (cf. Lawrence and Suddaby 2006). Lawrence and Suddaby have coined the concept *institutional work* in order to refer to such practices.

Importantly, the rational choice institutionalists and organizational scholars have emphasized that institutional work is not necessarily done on a macrolevel (e.g. through open

and formalized opposition). Instead, it can also be observed on the microlevel of everyday practices (e.g. by championing and policing certain ways of acting whilst challenging, translating or modifying others) (Lawrence and Suddaby 2006; Wallenburg et al. 2019). Moreover, institutional change, according to these scholars, does not necessarily occur suddenly and is not necessarily triggered by external events (as historical and sociological institutionalists would have it). Instead, institutional change takes place incrementally and continuously (Mahoney and Thelen 2010). It is the result of endogenous processes: the way(s) in which actors reproduce institutions and the roles and positions assigned to them, whilst simultaneously challenging and modifying such institutions, positions and roles over time (Van de Bovenkamp et al. 2017). Increasingly, this microlevel and incremental approach has gained ground in the institutional literature at the expense of a macrolevel and punctuated equilibrium approach (Streeck and Thelen 2005).

Notwithstanding the above, one, on first sight rather macrolevel concept associated with institutional change, does seem to resonate well with my description of the Dutch healthcare system (previous subsection). It is called *institutional layering* (Mahoney and Thelen 2010). This concept refers to the process of introducing regulatory arrangements on top of – or beside – one another and over time. Scholars that study institutional layering emphasize that new regulatory arrangements overlie institutional arrangements already in place. Such arrangements however do not necessarily replace the previously introduced arrangements. Instead, new regulatory arrangements interact with already existing arrangements and these interactions can have unpredictable consequences (Van de Bovenkamp et al. 2014; 2017).

Even though the concept of *institutional layering* appears to fit well with macrolevel and historical institutional analyses, it has implications for all the abovementioned institutional theorists. For those that continue to focus on the structuring affordances of institutions on a macrolevel, institutional layering stresses the notion that new regulatory arrangements interact with already existing arrangements and that such interactions can lead to unpredictable transformations of an institutional system (Van de Bovenkamp et al. 2014). For those that turned to institutional work on the level of everyday practice, the concept of institutional layering has sensitized them to the idea that the effects of policy interventions hinge on the idiosyncratic ways in which a plurality of actors bring such interventions into practice whilst connecting such interventions to already existing regulatory arrangements (Van de Bovenkamp et al. 2017).

Recently, scholars have called to combine such macrolevel and microlevel approaches and study agents in their layered institutional contexts (Smets and Jarzabkowski 2013; cf. Lawrence et al. 2013; Zundel et al. 2013). Such studies should refrain from concluding

that layering has made societies institutionally complex (cf. Halffman 2003). Instead, they should provide better insight into the ways in which institutionally layered environments shape professional identities, roles and relations (cf. Noordegraaf 2015 on professional hybridization). At the same time, these studies should also pay attention to the ways in which actors relate to and translate different regulatory arrangements at different times and for different reasons.

In response to the abovementioned developments in the literature on institutional theory, I argue that policy experiments are *very* interesting sites to study institutional layering and work; although, of course, they are not the only sites where such layering and work can be observed. Policy experiments are interesting because of two reasons. Firstly, many of them are not only added to institutional layers already in place (in many ways representing a new layer themselves), but they are actually introduced into an already layered institutional contexts in order to deal with the uncertainties associated with institutional layering (thus representing a layer that should somehow remedy the problems associated with all other layers). Moreover, policy experiments are not only affected by the work of those that participate in them. Instead, they very much depend on such work in order to produce the institutional and professional changes sought after.

In the next subsection, I further develop the points raised in the previous paragraph. For now however, let me close this subsection by emphasizing that the literature on institutional theory has sensitized me to the fact that, when studying policy experiments aimed at overcoming tensions and improving collaboration, I need to pay attention to the ways in which healthcare professionals relate to, work on and interact with the governance principles introduced in such policy experiments; experiments and their principles that are, themselves, introduced into an already layered institutional context. Moreover, I should be sensitive to how such interactions might produce changes on the level of professionals participating, governance principles introduced as well as institutions already in place.

Policymaking in uncertainty: the experimentalist turn

Taking into account that new policy interventions interact with existing regulatory arrangements (as discussed in the previous subsection), political and social theorists have increasingly sought to understand how governments can continue to *do* policymaking in layered institutional contexts and the uncertainties that come with it (Lascoumes and Le Galès 2007: 15). In many ways, this is a question of policy method (Centeno 1993; Pielke 2007).

Classically, in the heydays of bureaucracy and technocracy, political theorists contended that policymaking and implementation should be *ex ante* informed by scientists and other experts, designed and controlled by state officials, implemented by field actors and *ex*

post evaluated by independent commissions (Martin and Sanderson 1999; Greenberg and Morris 2005; Pielke 2007; Wolpin 2007). In this line of thought, emphasis was placed on rationality beyond dogmatism and scientific analysis beyond ideology. Policymaking should be realistic, efficient, validated and depoliticized (cf. Centeno 1993 for a critical reflection on different readings of technocracy).

This celebration of scientifically informed and state-controlled policy implementation has however suffered several blows. Firstly, social and natural sciences can no longer uphold their privileged position as objective and unchallenged policy informants (cf. Latour 2004). Science is mobilized to produce politically convenient claims and counterclaims and in everyday scientific practice, political decisions are made too; for instance, about whom to collaborate with and which observations to highlight, background or problematize (e.g. Halffman 2003; Muniesa and Callon 2007; Bacchi 2012). Without its impartial scientific foundation, evidence-based policymaking has turned into policymaking in an uncertain world (Callon 2009; Alvesson et al. 2016). Secondly, the idea that people are institutional dopes that implement new rules and regulations has also been problematized. Instead, rules and regulations are interpreted, modified and translated to fit local contexts (see also the previous subsection). Thirdly, command and control modes of governance are no longer deemed opportune, nor legitimate (Black 2008). Consequently, they have made way for modes of governance based on the persuasion and coordination of an informed and strategic public (Lascoumes and Le Galès 2007).

In line with the above, there no longer appears to be a Minister Schippers who holds the rudder and who can change the course of Dutch healthcare governance top-down and unidirectionally. Instead, more open methods of policy intervention are being deployed by policymakers. Such methods are increasingly based on the principles of mobilization and coordination (Szyszczak 2006). Policy interventions based on these principles have several characteristics. They: a) imply the introduction of abstract governance principles (e.g. multidisciplinary collaboration or patient centeredness); b) aim to bring different actors together (e.g. GPs and other healthcare providers); c) facilitate deliberation and experimentation between these actors involved (e.g. on how to organize collaboration); and d) target more inclusive, efficient or situated formats for the organization and provision of practices (Arkesteijn et al. 2015; Regeer et al. 2016). In doing so, these methods are deemed to erode the exclusive and distanced decision-making powers of a technocratic and bureaucratic elite (cf. Centeno 1993).

In sync with more open methods of policy intervention, society itself has become the time-space in which policy questions are posed and answers are generated. Some scholars have specifically emphasized the experimental nature of this new mode of governance (Sabel

and Zeitlin 2006); referring to it as an experimentalist turn in governance (e.g. Posner 2015). In line with this experimentalist turn, many scholars – and practitioners alike – refer to interventions that fit the abovementioned characteristics as policy experiments (e.g. Sabel and Zeitlin 2006; Szyszczak 2006; Posner 2015; Regeer et al. 2016). Even so, there are others that refer to such interventions as policy pilots, design-thinking sessions, or testing grounds (amongst many others).[4]

Some scholars see policy experimentation as an important strategy to deal with complex public issues for which no solutions can be preempted (Callon 2009). Others have emphasized that policymaking is now in the hands of the many and the divided (Zuiderent-Jerak 2015; Wehrens 2018). Some scholars see merit in such pluralism and approach policy experimentation as a chance to break through vested interests; particularly so by fostering reason and deliberation between the actors involved (cf. Callon 2009). Others highlight the emotional dimensions that come with the uncertainties and politics in policy experimentation (Jasanoff 2012). Particularly the latter have put question marks behind the celebration of reason and deliberation within policy experimentation, arguing that each form of consensus and each alternative organizational format produced, will privilege some groups over others and will silence some voices whilst amplifying others (Mouffe 2005; Butler 2010; Jasanoff 2012).

In this dissertation, I will approach policy interventions that meet the abovementioned characteristics as policy experiments (Szyszczak 2006). The literature on policy experimentation furthermore strengthens my position that such experiments are good places to study institutional layering and work; particularly so, because of their open methods and the fact that actors are mobilized around – and stirred to work on – the stabilization of new or (re) furbished governance principles. Informed by institutional theory, I however also posit that the work conducted in these experiments is probably not only aimed at stabilizing new governance principles, but also aimed at challenging, modifying and disrupting institutions already in place and at improving and or maintaining institutionally privileged roles and positions (Van de Bovenkamp et al. 2017). The latter also resonates with the critical remarks of Mouffe (2005), Butler (2010) and Jasanoff (2012). It warns me that I should not only focus on what is produced, amplified or learned in the policy experimentation process. Instead, I should also pay attention to what is destroyed, silenced or forgotten. It means

4 Although there are scholars that have attempted to define clear boundaries between these concepts (Ansell and Bartenberger 2016; Ettelt et al. 2015), I have experienced that they are often used interchangeably in order to refer to policy interventions that fit the characteristics associated with an experimentalist turn. But there is a flipside to this observation. When healthcare actors talk about policy experimentation, they might also refer to policy interventions that differ significantly from one another in terms of objectives and methods. I will discuss such differences, and the consequences these can have, in chapters four and seven.

that I should be sensitive to the political and emotional consequences of more experimental modes of governance, beyond the normative contention that such experimentation is inclusive and productive.

Policy experimentation in the Dutch governance of care

This dissertation is written at a time in which policy experimentation[5] is booming in the Netherlands (Houppermans 2017). In capital P political[6] practice and policymaking, policy experimentation is typically associated with innovation, inclusiveness and relational modes of governance (e.g. RVenS 2017; Vilans 2020). Policymakers in the highest ranks of the Dutch ministries, for instance, recently published a vision statement in which they imagined an experimentalist future government that brings people together, facilitates the sharing of knowledge and stimulates field initiatives (Houppermans 2017). In this imagined experimentalist future, the government continues to formulate general objectives, but field actors have the space to experiment with these objectives, translate them to specific circumstances and to come up with local solutions for the societal problems addressed. In the end, the best policy solutions would emerge during (instead of before) the process of implementation (cf. Camps 2017; Houppermans 2017).

In Dutch healthcare governance specifically, policy experiments are often organized to reconfigure healthcare professional roles and relations in the context of new, refurbished and/or contested governance principles (RVenS 2017). Examples of such principles are patient centeredness, multidisciplinary collaboration and price liberalization. These policy experiments are ascribed with the potential to cut through vested interests, move beyond the status-quo and change the governance of healthcare for the better. In this light, policy experimentation appears to be *the* antidote to current tensions between actors involved in Dutch healthcare governance (RVenS 2017; cf. Roer Moet Om 2015b) and the uncertainties that are endemic to layering in Dutch healthcare governance (Klink 2010).

The institutional and experimentalist literature discussed in the previous subsections however also underline that, what policy experiments produce, depends on the different, sometimes conflicting orientations, objectives and desires that participating actors protect whilst engaging in policy experimentation (Lawrence and Suddaby 2006; Zuiderent-Jerak 2015). Policy experimentation is therefore not necessarily a protected time-space for actors to come together and move beyond. It can also be used as a *'smokescreen to evade or*

5 In line with the characteristics discussed in the previous subsection.

6 With this word I mean formal or informal organization and enactment of government. I emphasize this point because other kinds of politics will be described in this dissertation as well. Examples are the strategic positioning of healthcare professionals, or the ways in which different narratives displace one another (cf. Marres 2013).

postpone debates about conflicting visions of collective ordering, to hide certain values and to bypass institutionalized procedures.' (Voβ and Simons 2018: 226) Policy experimentation is thus not innocent or neutral. Instead, it is a normative and political process with normative and political outcomes (Jasanoff 2012; Voβ and Simons 2018).

Based on the abovementioned critique, I argue that it is important to understand what healthcare actors do in Dutch policy experimentation – and what this leads to – before *a priori* ascribing to such experiments the quality to bring people together and produce inclusive solutions.

Research aims and questions

Policy experimentation has become the *sin qua non* through which to solve contemporary challenges in the Dutch governance of care; such as overcoming tensions and improving collaboration (Houppermans 2017; RVenS 2017; Vilans 2020). But this status seems to be based, primarily, on a deep rooted faith in deliberative consensus and situated intervention (Jasanoff 2012; Mouffe 2006), rather than on empirical observation and critical scrutiny. In this dissertation, I intend to do the latter.

My aims are therefore twofold. Firstly, informed by the institutional literature (e.g. Lawrence and Suddaby 2006; Van de Bovenkamp et al. 2017), I want to describe and understand how healthcare professionals and professional others participate in policy experimentation and (institutionally) work on the introduction and stabilization of new governance principles. Secondly, and informed by the experimentalist literature (e.g. Sabel and Zeitlin 2012; Zuiderent-Jerak 2015), I also want to understand where these policy experiments lead to in terms of resolved tensions and improved collaborations.

With the abovementioned aims in mind – and based on the theoretical primers discussed in the previous subsections – I want to pose the following overarching research question:

> *How does policy-experimentation contribute to overcoming contemporary tensions amongst actors involved in Dutch healthcare governance?*

By posing this question, I do not want to claim that policy experimentation *necessarily* contributes to overcoming tensions and that the only question is *how* it contributes. Instead, I intend to subject both the *how* and the *contribution* to critical scrutiny. Moreover, I do not want to claim that it is primarily the policy experiment itself – or rather the policy intervention experimentally introduced – which contributes. Instead, it is the way in which healthcare professionals and professional others approach such experiments and

participate in them that might make a difference. In this light, the overarching research question is divided into three more specific questions:

I) *What do Dutch healthcare actors mean with 'policy experimentation' when organizing and participating in such experiments?*
There are many policy interventions which – in general terms – fit the experimentalist turn previously discussed. But this still leaves room for different readings of what a policy experiment actually is. Indeed, some actors that participate in such experiments approach them as controlled settings to summatively test the effectiveness of interventions. Others approach them as opportunities to identify best practices (Martin and Sanderson 1999). These approaches, however, tend to produce different kinds of experimental outcomes, potentially fueling instead of solving tensions amongst participants (Muniesa and Callon 2007). It is therefore important to identify different approaches and study what the consequences of such differences might be.

II) *What do Dutch healthcare actors do when participating in a policy experiment?*
Informed by the institutional work literature, I presume that those that participate in policy experiments might do so in different ways and for different reasons. Experimentation work that is conducted is probably not only aimed at realizing experimental objectives, but also aimed at creating or maintaining institutionally privileged roles and positions (e.g. Lawrence and Suddaby 2006). Therefore, it is important to scrutinize what healthcare professionals and professional others actually do when participating in policy experimentation. This question is aimed at foregrounding such experimentation work (Smets and Jarzabkowski 2013).

III) *What do policy experiments produce in terms of resolved tensions and improved collaborations in Dutch healthcare governance?*
Whether approached as tests or protective time-spaces, policy experiments are often described as productive. They can never fail and feed into a continuous process of institutional and organizational learning. This reading however runs the risk of turning policy experimentation into something that is always productive and appropriate to do. Some scholars have problematized this naïve reading of experimentation (Voβ and Simons 2018). It is therefore important to better understand what policy experiments produce in terms of tensions overcome and improved collaboration. Or maybe more concretely, in terms of new institutional and organization formats for – and professional roles and relations in – the provision of healthcare. Moreover, it is also important to pay attention to what is destroyed, silenced or forgotten (Mouffe 2006; Butler 2010).

These questions will be answered in the conclusion of this dissertation. I will do so by drawing from and comparing insights discussed in the different empirical chapters that follow this introduction. The questions should, therefore, be considered as my main 'points of direction' during my examination of the different policy experiments that feature in this dissertation. In the next subsection, I will introduce the methods used and cases studied to answer these research questions. Thereafter, I explain how I have structured the chapters included in this dissertation.

Methodology

In order to answer my research questions, I studied four different cases. I used these cases to highlight different aspects of policy experimentation and the institutional context in (response to) which this was done. Moreover, I used different qualitative research methods to study these cases. Some of these methods were specifically aimed at reconstructing a policy experiment that had already taken place. Other methods were aimed at observing tensions amongst healthcare actors firsthand, or at experiencing the social dynamics within policy experimentation whilst being an observing participant. Together, the cases I studied and methods I used allowed me to: a) identify different approaches towards policy experimentation (question 1); b) discuss how professionals and professional others participated in policy experimentation (question 2); and c) critically assess what these experiments produced in terms of tensions overcome and improved collaboration (question 3). Below, I provide a general overview of the cases studied and methods used. In each empirical chapter, more detailed methodological descriptions are provided.

Case 1: The first case I studied was an experiment in Dutch dental care. This experiment was introduced in 2012 and should have lasted for 3 years. However, and to the surprise of many, it was cancelled 6 months after its introduction, creating tensions between the actors involved, instead of moving beyond vested interests. As such, this experiment was an interesting case to start my project with and I set out to reconstruct what had happened. In order to do so, I conducted a document analysis and interviewed key informants. Based on this data, I reconstructed why the experiment was introduced, how the experiment unfolded and what became known as *the* lessons learned. One problem I faced, whilst analyzing and reconstructing this experiment, was the fact that I used retrospective interpretations from the respondents about their own actions and the actions of others. Such narratives were constructed around purposive and strategic lines of action. On the basis of these narratives, my own analysis followed suit (Lawrence et al. 2013; Smets and Jarzabkowski 2013; Zundel et al. 2013).

Case 2: In order to get acquainted with more messy and improvisatory narratives of policy experimentation, I moved on to a second case. This time, I conducted a secondary analysis

of a policy program called 'Primary Focus'. This program ran from 2009 to 2015 and funded 67 initiatives in which a plethora of professionals experimented with the reorganization of healthcare services. I gained access to data collected on three of these initiatives. This data had been collected by a research group tasked to evaluate the funded initiatives and to identify best practices (SMOEL 2015). Data collected included interviews, meeting minutes, field observations and organizational documents. Although I had not collected this data myself, it allowed me to move beyond retrospective narratives and reconstruct how participants were relating to, working on and coping with the governance principles introduced. Nevertheless, as I was using historical and secondary sources, I had yet to participate in any of the experiments. I had a feeling that I had gained insight into the articulated tensions between actors on paper, but I had never witnessed these dynamics in action. I had read about the emotions and controversy in between the lines, or I had heard them through the grapevine, but I had never personally observed or experienced them.

Cases 3 and 4: In order to observe such tensions between actors – and simultaneously gain more insight into the institutional context of Dutch healthcare governance – I moved on to a third case. This time, I joined the Council for Health and Society and participated in the development of controversial advice on the future of evidence-based medicine in Dutch healthcare governance (RVenS 2017). Here, I conducted interviews, organized focus-groups and observed and participated in several discussions on the role of evidence-based medicine in healthcare decision-making. In addition, I joined a design thinking experiment; which eventually became my fourth case. This experiment specifically sought to bring a healthcare provider, an insurer and a regulator together in order to design more collaborative formats for the provision of care. I participated in the design of these solutions, whilst simultaneously taking photographs and collecting fieldnotes. Whereas I had had some temporal removal in the previous policy experiments I had studied, I was now very much engaged (Clark et al. 2009).

The policy experiments studied were very different from one another. They differed in terms of actors involved, governance principles introduced and expected outcomes. Furthermore, they varied in scale, ranging from national interventions (e.g. the dental care experiment) to local initiatives (the design thinking experiment). Moreover, they had distinct internal navigation spaces, ranging from discussions amongst groups of intimae (the design thinking experiment) to the involvement of an undefined and uncontrolled number of stakeholders (the dental care experiment). Yet each of them fits within the experimentalist turn in the governance of care previously discussed. Particularly so, because they featured abstract governance principles that needed to be stabilized within an experimental time-space (e.g. price liberalization or multidisciplinary collaboration) and brought different stakeholders together in order to do so (either intentionally or consequentially). Moreover, in each case,

the idea was that results should be extrapolated in time and/or organizational space, either as lessons learned, best practices or starting points for further action (Sabel and Zeitlin 2012; Arkesteijn et al. 2015; Zuiderent-Jerak 2015).

Structure of the dissertation

This dissertation is based on five papers, each discussing one of the four cases introduced in the previous subsection (one case is discussed in two papers). These papers are reused in this dissertation as empirical chapters 2 to 6. In figure 3, I have provided a general overview of these chapters and the way in which they relate to one another. Below, I introduce these chapters – and their interrelations – in more detail.

Chapter 2: The first case that features in this dissertation is about a discussion amongst Dutch healthcare actors. This discussion had been slumbering for some time, yet suddenly intensified in the year 2016. At stake was the role of evidence-based medicine (EBM) in healthcare decision-making. I studied this discussion – and furthermore choose to begin my dissertation with it – because it helps to better understand the articulated tensions between healthcare professionals and professional others in the layered institutional context of Dutch healthcare governance. This chapter particularly highlights that different healthcare actors relate to EBM differently in order to inform their actor specific roles and decision-making. It furthermore addresses that each of these actors acknowledges that evidence should be contextualized, making the discussion about EBM's reductionism somewhat obsolete. The chapter however also recognizes that actors contextualize such evidence in different ways, relating to different governance principles and regulatory frameworks. Moreover, the ways in which some actors contextualize such evidence has consequences for the ways in which others can do the same, creating tensions amongst actors. By addressing these tensions, chapter 2 sets the stage for the other empirical chapters included in this dissertation; each of which is focused on a particular policy experiment.

Chapter 3: The second case discussed in this dissertation is a design thinking experiment. This experiment was particularly aimed at overcoming tensions between actors involved in Dutch healthcare governance. Participants were representatives of a homecare organization, a healthcare regulator and a health insurer. These representatives were supported by designers, social scientists and other experts. Together, the participants aimed to develop alternative organizational formats for the provision of healthcare. They used design thinking as a change strategy. Design thinking is typically described as a depoliticized, human-centered approach that values collaboration between practitioners, designers and researchers and stresses the importance of (re)conceptualizing wicked societal problems into organizational opportunities. In doing so, it fits well with the characteristics of policy experimentation introduced previously. This chapter however also suggests that such ex-

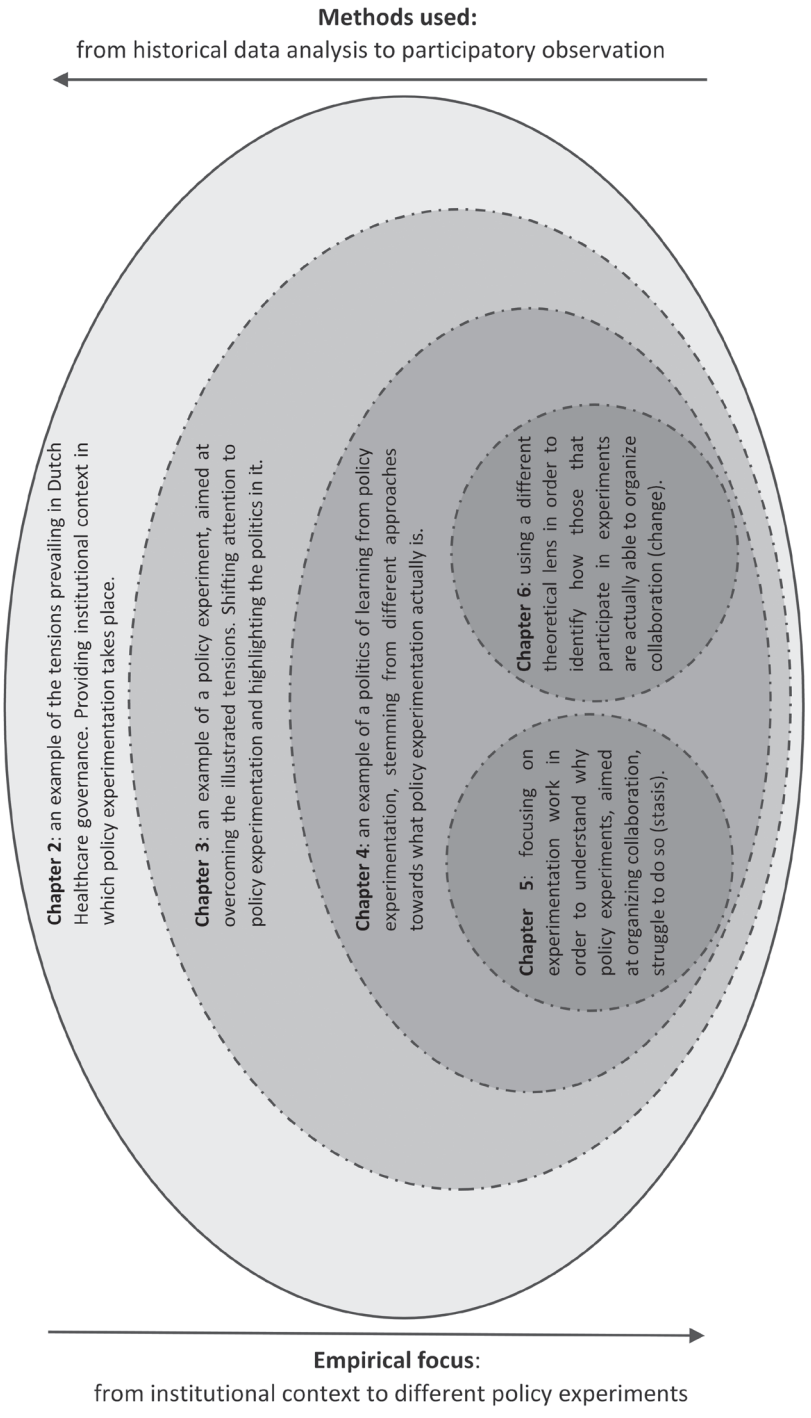

Figure 3: *Overview of the structure of the empirical chapters in this dissertation*

periments are not the depoliticized or inclusive time-spaces that some scholars consider them to be. This argument is further explored and developed in the chapters to come, particularly so by focusing on different kinds of politics in policy experimentation.

Chapter 4: The third case discussed is a policy experiment that specifically targeted the introduction of free pricing arrangements in Dutch dental care. It was introduced in 2012 and was planned to take place over a three-year period, with quarterly evaluations to reflect on the process and adjust course where and when necessary. However, 6 months after its introduction, the experiment was cancelled, fueling instead of overcoming professional distrust towards professional others. Informed by a constructivist approach, this chapter reconstructs what happened. The chapter particularly highlights that policy experiments can be just as multiple as the worlds they are supposed to bring together. To illustrate this point, it describes how participating actors had different ideas of what the policy experiment actually was and what the outcomes of the policy experiment should be. The chapter moreover describes how political opportunism influenced which approaches were reproduced – at the cost of others – and informed lessons learned. The latter is specified as a *politics of learning* in policy experimentation.

Chapter 5: This chapter shifts attention from different approaches towards policy experimentation to the work conducted within policy experiments. The case, in this chapter, is a policy implementation program called 'Primary Focus'. The program ran from 2009 to 2015. It funded 67 initiatives in which participating professionals sought to develop new formats for the provision of integrated care. Particular points of reference during the development of these formats were the governance principles 'patient-centeredness' and 'multidisciplinary collaboration'. This chapter focuses on two of these initiatives and uses the literature on institutional work to analyze how, during the development process, patient-centeredness turned from a shared objective into a contested professional quality; particularly so, because participants sought to strategically (re)position themselves within the new organizational formats under construction. Consequently, these initiatives did not lead to the patient-centered and integrated organizational formats that policymakers had been aiming for. The chapter addresses how this happened and why professionals had literally been working together alone. This observation is specified as a *politics of positioning* in policy experimentation.

Chapter 6: Similar to the previous chapter, this chapter analyzes two initiatives from the 'Primary Focus' program. In contrast to the previous chapter, however, it uses a different theoretical lens. It uses insights from geography and the sociology of professions to analyze how the participants of two initiatives used mapping techniques to develop new formats for the provision of integrated care. The chapter describes how, during the process

of mapmaking, participants differentiated between different kinds of elements and reimagined the relations between these elements. Furthermore, it demonstrates whether and how such differentiations and reimagined relations supported the establishment of new organizational formats for the provision of care. Interestingly – and in contrast to chapter 5 – this chapter foregrounds that one of the initiatives was actually able to move beyond vested interests and organize collaboration. On the one hand, this observation helps to pinpoint potentially promising approaches in workings towards professional, organizational and institutional change. On the other hand, this observation also presents a theoretical problem: how to foreground stasis and change in relation to policy experimentation and how to consider the role that theory plays therein? This problem is further discussed in the concluding chapter.

Chapter 7: In this concluding chapter, I use insights from abovementioned chapters to: a) answer the research questions posed; b) highlight different kinds of politics observed; c) reflect on the consequences of the different theoretical approaches used; and d) discuss implications for policymakers, healthcare professionals and social scientists.

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