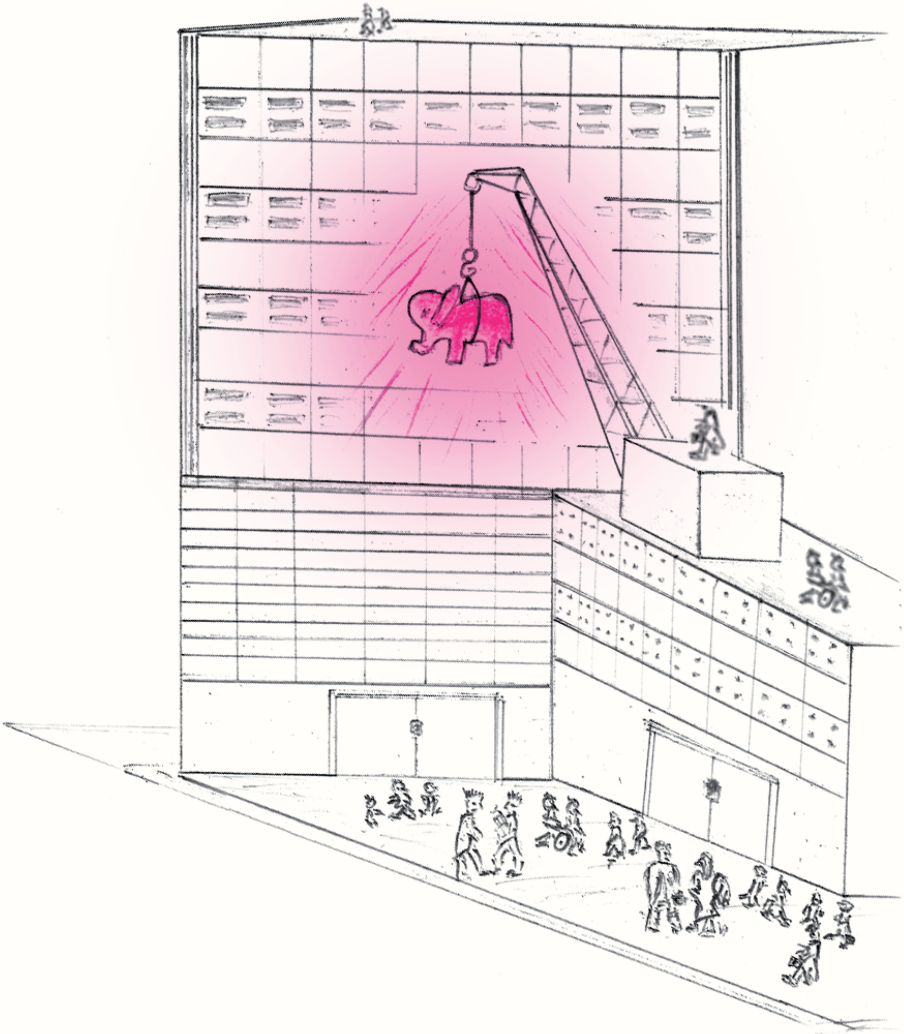

Together Alone

An analysis of policy experimentation in Dutch healthcare governance

MARTIJN FELDER

Together Alone:

An analysis of policy experimentation in Dutch healthcare governance

Martijn Felder

The research for this dissertation was conducted at Erasmus School of Health Policy & Management, Erasmus University, Rotterdam, the Netherlands.
The research was financially supported by the VvAA (Vereniging van Artsen Automobilisten), a member organization and insurer for healthcare professionals in the Netherlands.

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Together Alone: An analysis of policy experimentation in Dutch healthcare governance
Dissertation Erasmus University Rotterdam, the Netherlands

ISBN: 978-94-6361-444-3
Cover design by Victor Felder and Erwin Timmerman
Layout and printed by: Optima Grafische Communicatie (www.ogc.nl)

Together Alone:
An analysis of policy experimentation in Dutch healthcare governance

Samen alleen
Een analyse van beleids-experimenteren in de Nederlandse gezondheidzorg

Proefschrift

ter verkrijging van de graad van doctor aan de
Erasmus Universiteit Rotterdam
op gezag van de
rector magnificus
Prof.dr. R.C.M.E. Engels
en volgens besluit van het College voor Promoties.
De openbare verdediging zal plaatsvinden op
vrijdag 25 september 2020 om 11.30 uur

door

Martijn Felder
geboren te Assen

Erasmus University Rotterdam

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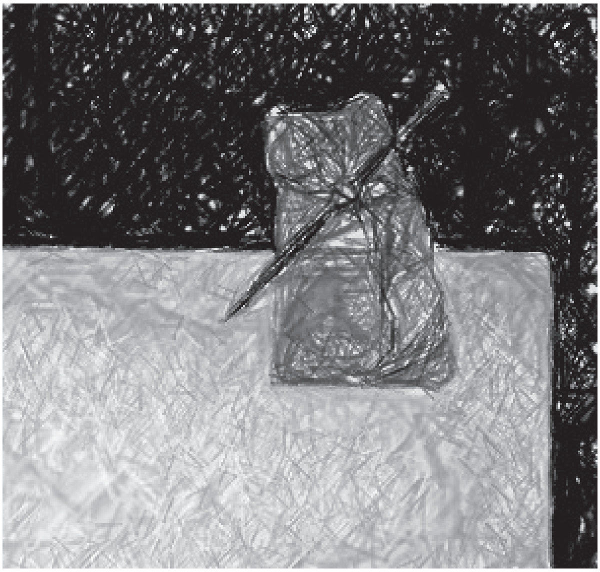

Figure 1: *The GPs' manifesto taped to the glass door of the Ministry of Health in March 2015*

1

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.

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[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'

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[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

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[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

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[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*

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[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-

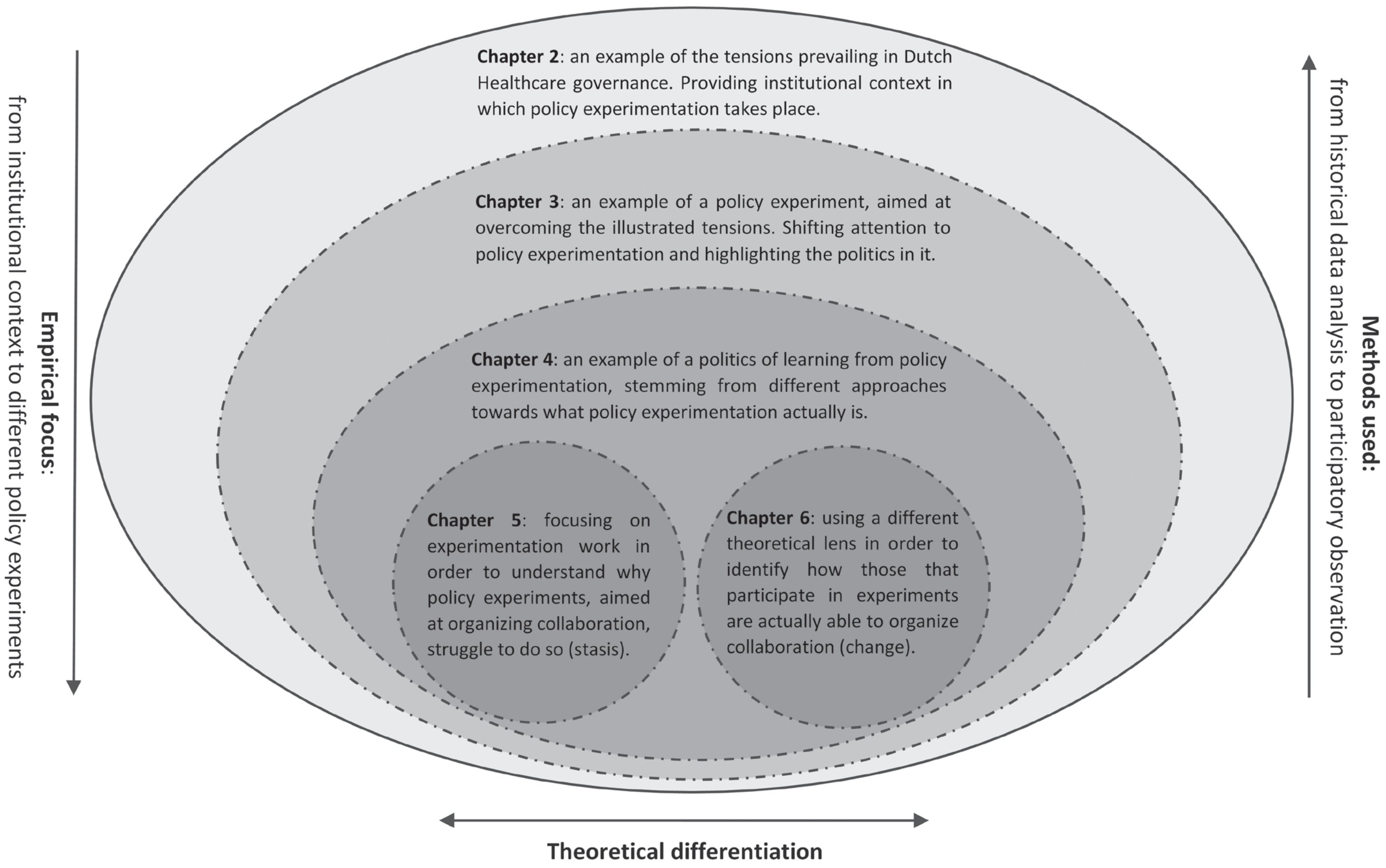

Figure 3: *Overview of the structure of the empirical chapters in this dissertation*

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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2

Who contextualizes clinical epidemiological evidence?

A political analysis of the problem of evidence-based medicine in the layered Dutch healthcare system

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Submitted for review

Abstract

We critically examine the discussion on the role of evidence-based medicine (EBM) in healthcare governance. We take the institutionally layered Dutch healthcare system as our case study. Here, different actors are involved in the regulation, provision and financing of healthcare services. Over the last decades, these actors have related to EBM to inform their actor specific roles. At the same time, EBM has increasingly been problematized. To better understand this problematization, we organized focus groups and interviews. We noticed that particularly EBM's reductionist epistemology and its uncritical use by 'professional others' are considered problematic. However, our analysis also reveals that something else seems to be at stake. In fact, all the actors involved underwrite EBM's reductionist epistemology and emphasize that evidence should be contextualized. They however do so in different ways and with different contexts in mind. Moreover, the ways in which some actors contextualize evidence has consequences for the ways in which others can do the same. We therefore emphasize that behind EBM's scientific problematization lurks a political issue. A dispute over *who* should contextualize evidence *how,* in a layered healthcare system with interdependent actors that cater to both individual patients and the public. We urge public administration scholars and policymakers to open-up the political confrontation between healthcare actors and their sometimes irreconcilable, yet evidence-informed, perspectives.

Keywords: evidence-based medicine; institutional layering; politics; healthcare decision-making; qualitative research.

Introduction

In many countries, ‘evidence-based medicine’ (EBM) has become an important principle in healthcare governance (Harbour and Miller 2001; Berwick 2016). It emerged in the field of clinical epidemiology and gained prominence amongst professionals in the 1990’s (Sackett et al. 1996). EBM aimed to reduce unexplained and therefore undesired variation in the provision of care. It advocated treatment based on the best clinical epidemiological evidence available (Berwick 2016) and criticized healthcare decision-making based on professional authority. It encouraged more standardized forms of decision-making, based on statistical evidence about the effectiveness of interventions. EBM furthered randomized controlled trials (RCT’s) as the gold standard of evidence (Timmermans and Berg 2003).

The standardizing qualities of EBM are increasingly called into question (Greenhalgh et al. 2014). In the academic literature, EBM is criticized along two lines of argumentation. In the first, authors criticize its epistemological reductionist approach and complex methodology; emphasizing that EBM draws predominantly on statistical data derived from selective populations, analyzed in ways that only methodological experts understand (Berlin and Golub 2014). In the second, authors criticize its use in – and beyond – the counselling room. Their critique is that professionals and ‘professional others’ (such as healthcare managers, policymakers, health insurers and regulators) base their treatment plans, policies or monitoring instruments on statistical data, without taking into account the situation of individual patients (Greenhalgh et al. 2014; Hargraves et al. 2016).

The questioning of EBM’s scientific principles and uncritical use have become laden affairs in hospitals, knowledge centers, insurance companies and government offices. Actors defending evidence-based healthcare decision-making are classified as orthodox positivists (Mol and Evers 2017 [responses]). Actors questioning the dominant role of statistical evidence in healthcare decision-making are accused of quackery in turn (Mol and Evers 2017). At conferences, the vices and virtues of EBM are celebrated and disqualified. Presenters are lauded or hooted (personal observations 2017). The EBM discussion has become a site of pluralism, conflict and strive (Mouffe 2005).

We argue that a political analysis of the discussion generates insights that cannot be captured by biomedical or professional approaches. Informed by Mouffe (2006) and Bacchi (2012), we conceptualize contemporary healthcare systems as highly political. On the one hand, such systems consist of different regulatory frameworks (from professional self-regulation to regulated markets; cf. Van de Bovenkamp et al. 2014; Felder et al. 2018). On the other hand, such systems harbor a plurality of actors that shape and legitimize their actors-specific roles by relating to different regulatory frameworks as well as scientific truth claims and counterclaims (Deacon 2000; Halffman 2003; Flynn 2005; Bacchi 2012).

Informed by the above, we examine a) how EBM informs the identities, roles and positions of different actors in layered healthcare systems; and b) the perceived problems that emerge from such differences when it comes to healthcare decision-making. We do so by answering the following research question:

> *How and by whom has the role of EBM in healthcare decision-making been problematized and why is that the case?*

The Netherlands has become an exemplary case to reveal the complex relations in which EBM has become constituted as a problem that needs to be solved. Here, healthcare governance, traditionally controlled by professional authority, has been supplemented with a plethora of market and state-based regulatory arrangements (Van de Bovenkamp et al. 2014). In doing so, the Dutch case resonates well with the layered healthcare systems in many western countries (Tovey et al. 2014; Berwick 2016).

Our political analysis reveals that behind the epistemologically and professionally framed discussion unfolds a dispute over who is able – and should be allowed – to interpret and contextualize clinical epidemiological evidence in decision-making that does right to individual patients and upholds the quality, safety and affordability of a collective healthcare system. The future of EBM should therefore not just be an epidemiological or professional project. Instead, we urge policymakers and scholars of public administration to take the EBM discussion seriously and to start focusing on the layered healthcare systems in which evidence is contextualized and evidence-based decisions are being made.

EBM in the layered Dutch healthcare system

As in many western countries, the dominant position of Dutch healthcare professionals has been called into question; particularly so since the 1970’s (Freidson 1973). EBM played an important role in this process as it scrutinized healthcare decision-making based on professional authority and stimulated healthcare decision-making based on the best evidence available (Sackett et al. 1996). The early advocates of EBM however still intended for evidence-based decision-making to be a professional affair; describing it as a process of critical appraisal (Greenhalgh et al. 2014). Critical appraisal here referred to the use of: (a) evidence, (b) clinical experience and (c) patients’ needs and wishes, during shared decision-making with patients in the counselling room (cf. Sackett et al. 1996).

However, Dutch healthcare governance was changing beyond the convinces of professional self-organization and regulation. As new governance principles such as 'accountability', 'efficiency' and 'affordability' became important frames of reference (Berwick 2016). So too were new regulatory arrangements introduced on top of professional self-regulation. A key example in the Netherlands is the introduction of the Health Insurance Act in 2006 (Helderman et al. 2005). This act aimed to reduce costs and raise the quality of healthcare services through the introduction of market mechanisms. It decreed that professionals should start competing with one another on the quality and price of healthcare services. At the same time, it strengthened the position of health insurers. They should start negotiating with professionals about the price, volume and quality of care provided.

Meanwhile, the Dutch healthcare system was not entirely left to the whims of the market. In addition, several semi-governmental organizations received parts to play in safeguarding access to care and minimum quality (Van de Bovenkamp et al. 2014). The Dutch Healthcare Institute was charged, amongst other things, with stimulating and overseeing the development of quality instruments and with advising the Minister of Health on which care should be included in and excluded from the 'basic healthcare agreement'. This agreement recognizes the minimum care to be covered by health insurers; thereby making such care accessible for (obligatory insured) Dutch citizens. Moreover, the Dutch Healthcare Inspectorate continued to inspect on the quality and safety of care provided.

By introducing market mechanisms beside professional self-regulation and state-based regulation, a layered healthcare system emerged (Van de Bovenkamp et al. 2014). An effect of such layering is that healthcare decision-making has become fragmented (Felder et al. 2018). It prompted a proliferation of 'professional others' involved in healthcare decision-making (Lascoumes and Le Galès 2007). Examples are health insurers, policymakers, knowledge institutes and inspectorates. Each of these actors has adopted EBM in the ways in which they shape their roles and legitimize role-specific decisions (Deacon 2000; Flynn 2005; Bacchi 2012). But, as we will also show in of our empirical section, such wide uptake of EBM has not brought coherence in the governance of care (cf. figure 4).

Methodology

Our inquiry stems from a broader discussion in the Netherlands on the vices and virtues of evidence-based decision-making. In fact, the first and third author participated as researchers in a Dutch advisory board (de Raad voor de Volksgezondheid en Samenleving [RVenS]) that sought to better understand the implications of this discussion for Dutch healthcare governance (RVenS 2017). The data gathered for the policy advice is reused in this paper.

Although the identified problems presented here generally reflect the policy advice, we have placed more emphasis on a political analysis of such problematization (Bacchi 2012).

To gain insight into the Dutch discussion, the RVenS organized two focus groups in November and December 2016. The first included a variety of experts (N=7), including medical sociologists, a medical history scholar and a medical philosopher, studying and publishing on EBM. The second included healthcare practitioners from the field (N=5), including a medical specialist, a general practitioner, a geriatric practitioner, a medical researcher and a junior medical specialist. To gain complementary insight, the RVenS organized additional interviews in the spring of 2017. Interviewees were: a psychiatrist (N=1); gynecologists (N=2); midwife (N=1); and respondents from the Dutch Healthcare Inspectorate (N=2); a knowledge institute (N=5); and a healthcare insurer (N=2).

The aim was not to work towards a representative sample of an actor group specifically (e.g. medical specialists), nor of the Dutch healthcare system more generally (e.g. professionals, health insurers and policy makers). Instead, the aim was to gain insight into the different ways in which EBM was problematized and/or defended. Respondents were thus identified through their engagement in the discussion.

Focus groups and interviews were semi-structured around three main questions. (I) How does EBM contribute to the provision of healthcare? (II) Which problems or challenges do respondents encounter? And (III) which directions for improvement or change do respondents identify? Both focus groups and all but one of the interviews were audiotaped and transcribed verbatim. Where audiotaping was not possible, fieldnotes were made and further elaborated afterwards. The individual contributions of respondents were anonymized.

For this paper, we revisited the transcripts and coded descriptions of what EBM is (and what not), what its problems are (and what not), how it should be used by who (and who not) and why that is the case (legitimations). We member-checked our analysis on two separate occasions in the spring of 2017. We first presented our preliminary interpretation on a conference on evidence-based guideline development. We furthermore presented our analysis during the public release of the policy advice (RVenS 2017). Comments and suggestions were used to fine-tune our analysis.

The problem of EBM in the Dutch governance of care

This empirical section is divided into three parts. First, we present how EBM informs the actions of different actors in Dutch healthcare governance. Thereafter, we present how and by whom EBM has become problematized. Lastly, we consider how these problematizations mirror decision-making dynamics between actors in the layered Dutch healthcare system.

Part 1: The use of EBM by different actors

Each of the actors introduced in figure 4 uses EBM in and on their own terms. In the coming four subsections, we describe how.

Evidence in the counselling room

The professionals we interviewed described themselves as interpreters who make context dependent decisions about individual treatment plans. Such treatment plans are informed by clinical epidemiological evidence, but they cannot be reduced to such evidence. In fact, the interviewed professionals stressed that, as professionals, they should be able to translate evidence to the health problem of individual patients. In the words of a professional:

> *'The whole idea is that you explore the problem of the patient in the context of the patient, then look into what the [evidence informed] guidelines say about what we do – on average – with such a problem and after that make a decision together with the patient.'* (geriatric professional, focus group 2016)

We observed that the way professionals describe their own practice strongly resembles Greenhalgh and colleagues' (2014) celebration of an original form of EBM (Sackett et al. 1996). One thing is different though. There where Sackett and colleagues' (1996) reading of EBM emphasized the critical appraisal of the best evidence available – with *the best* referring to RCT's and meta-analysis thereof – interviewed professionals mostly referred to evidence-informed professional guidelines. In the next paragraph, we explain why this is an important difference to emphasize.

Evidence in guideline development

Even though professionals frequently refer to professional guidelines when talking about evidence, such guidelines are more than a representation of clinical epidemiological evidence. In fact, not only in the counselling room, but also in the development of guidelines, such evidence is weighted next to clinical experience and patients' needs and wishes.

> *'Guidelines are supported by evidence, but they also include a translation of the international evidence to the Dutch context, the extent of the problem here, its specific organization of care, the patient perspective. Only after that do we present considerations and recommendations.'* (gynecologist, interview 2017)

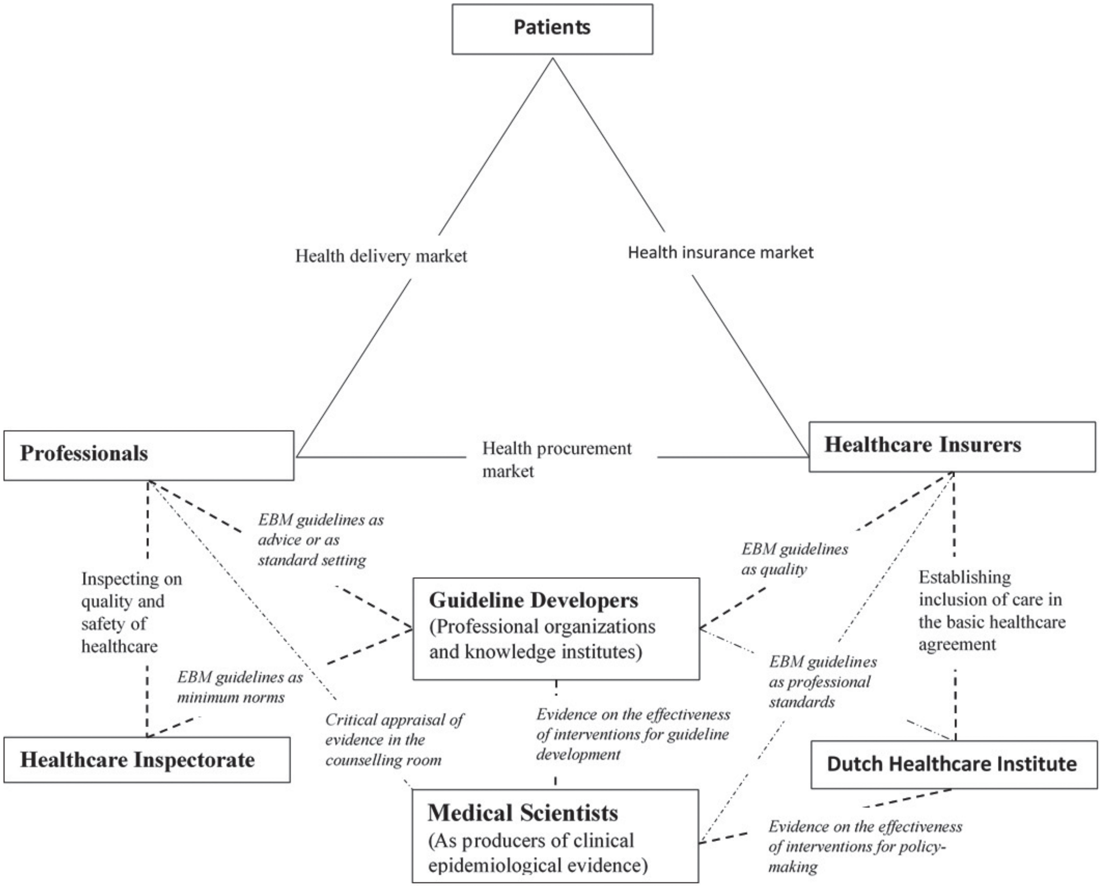

Figure 4: *A representation of the layered Dutch healthcare system and the role of clinical epidemiological evidence therein*

Although the relative weight of the patient perspective remains an important point for discussion (Van de Bovenkamp and Zuiderent-Jerak 2015), the abovementioned quote illustrates how professional guidelines claim to be more than a sum of the epidemiological evidence on a topic. In fact, what emerges is a situation in which evidence is contextualized on two levels within a professional context: in the development of guidelines and in the counselling room.

Evidence in regulating quality and safety

Next to professionals, other actors use professional guidelines to inform their actor specific actions. For instance, the Dutch Healthcare Inspectorate uses the developed guidelines to: (a) prospectively influence healthcare processes; and (b) retrospectively assess the safety and quality of care provided (Inspector, interview 2017).

In the inspectorate's line of reasoning, the content of care is still in the hands of professional organizations through their key role in guideline development. The inspectorate in turn supervises whether professionals live up to the uniform agreements that professionals set for themselves in these guidelines. In the words of an inspector (interview 2017):

> '*There is no evidence that driving on the right side of the road is safer than driving on the left side of the road. Nevertheless, there is enough evidence that supports the idea that a decision needs to be made to either drive on the left or on the right side of the road.*'

In this line of thought, the inspectorate acknowledges the weighing of evidence on the level of guideline development. At the same time and in contrast to the first subsection, the inspectorate's approach however compromises the critical appraisal of such guidelines in the counselling room. To be specific here, the inspectorate supports the professional's claim that clinical epidemiological evidence needs to be contextualized. The inspectorate however also emphasizes that such contextualization should be done uniformly and on an aggregate level; that of the professional organization.

Evidence in policymaking

Also the Dutch Healthcare Institute uses clinical epidemiological evidence and professional guidelines to inform their actions. They do so to provide policy advice to the Ministry of Health about which treatments should be (preliminary) included in the 'basic healthcare agreement'. The basic healthcare agreement dictates which care is to be considered standard insured care and needs to be covered by Dutch health insurers. The Institute's objective is to include care that is proven effective and affordable in order to protect a healthcare system that is collectively financed (Dutch Healthcare Institute 2015).

The Institute developed a systematic assessment framework to support them in identifying what can be considered care that is proven effective and affordable (Dutch Healthcare Institute 2015). Relative effectiveness is the key principle here. This means a treatment needs to be an improvement of the already existing treatments, this improvement needs to be significant, and there needs to be confidence that the improvement exerts itself in professional practice (Dutch Healthcare Institute 2015). It is here that professional and patient perspectives are taken into account, specifically there were evidence is inconsistent and/or where there is broad consensus between professionals and patient organizations about value of treatment (Dutch Healthcare Institute 2015).

In following these steps systematically, the Dutch Healthcare Institute explicitly relates their actions to the principles of EBM. In their own words:

> '*We use the principles of EBM in our assessment. Although it was developed to aid professionals to make clinical decisions for individual patients, its principles have found a much broader application. It is also used in the development of professional guidelines and policies regarding public health. In these cases, it is no longer about decision-making in relation to individual patients, but rather about advice and decisions on the level of the population.*' (Dutch Healthcare Institute 2015: 6)

The Dutch Healthcare Institute uses EBM's methodological design on how to gather and grade evidence (Timmermans and Berg 2003), but explicitly departs from Sackett and colleagues' (1996) emphasis on weighing such evidence in the context of individual patients. Instead, they weigh such evidence in the context of the Dutch population. Although professional insights and the patient perspective are taken into account as sources of information, the Dutch Healthcare Institute makes their evidence-based assessments relatively independent from the professional organizations.

Concluding remarks for part 1

All actors presented above legitimize their roles and decisions by relating to clinical epidemiological evidence. Each of these actors furthermore stresses the importance of contextualizing evidence. They do so on different levels and in line with their perceived roles. Individual professionals contextualize evidence in the counselling room in relation to individual patients; professional organizations (and the healthcare inspectorate) do so on the level of guidelines development in relation to patient groups; and the Dutch Healthcare Institute does so in policymaking in relation to the Dutch population.

Part 2: EBM's problematization

In this subsection, we present the main problems identified in the Dutch EBM discussion. We want to emphasize at the onset that it is mainly professionals who voice problems with EBM. Below, we discuss these problems in turn.

The biddable use of guidelines

The most frequently addressed problem voiced by professionals is about other professionals. It addresses the way in which evidence-based guidelines are used in the counselling room:

> '*Guidelines should provide support in the counselling room, but often they are used as key stones. You receive a patient with hypertension and check the guideline for treatment. A second question could then be 'who is actually sitting in front of me?' But often, doctors don't do that.*' (internist, focus group 2016)

These professionals stress the importance of weighing clinical epidemiological evidence next to clinical experience and patients' needs and wishes, but conclude that there is a lack of it in the counselling room. This is a longstanding problematization of EBM, frequently addressed in the literature as well (McCartney et al. 2014).

Importantly, those that address this problem relate such uncritical use of guidelines to forces external to individual professionals and their actions in the counselling room. A junior medical specialist tries to describe the cause of this problem:

> '*It is a kind of defensive medicine; because others can hardly question your actions when you followed the guidelines.*' (focus group 2016)

This professional articulates uncertainty amongst professionals. A form of uncertainty that constrains them to critically interpret – and where necessary divert from – guidelines in decision-making with and for individual patients.

Weighing evidence on the right level

We previously observed that professional organizations considered their guidelines as uniform agreements amongst professionals about how to treat patients. In order to function as such, these guidelines are informed by clinical epidemiological evidence, clinical experience and the patient perspective. Guidelines are thus much more than representations of clinical epidemiological evidence alone. Yet it is exactly this weighing of such evidence on the level of guideline development that is problematized by professionals we interviewed.

> *'When something is proven effective, then there is no problem in presenting that in guidelines [and considering that a uniform agreement]. The problem however is that many things in guidelines are based on consensus or authority. When something is based on consensus or authority, I have the feeling that it is even harder to divert from the guideline.'* (gynecologist, interview 2016)

There where advice in guidelines is based on consensus – or a weighted interpretation of evidence – professional organizations have already included the patient perspective and clinical experience on an aggregate level. In the counselling room, professionals subsequently feel that they are expected to follow the weighted advice (or rather agreement). Diverting from the guidelines then no longer means diverting from the clinical epidemiological evidence. Instead, it means diverting from the agreements that professional organizations, in collaboration with other actors, have made as a professional collective for individual professionals.

The professionals we interviewed thus feel that the interpretation of clinical epidemiological evidence next to patients' needs and wishes is important, but problematize the level on which such interpreting is done. These professionals criticize the emergent trend in which professional organizations translate evidence, clinical experience and the patient perspective into general agreements presented in guidelines (previous subsection). As these professionals argue, such guidelines can never capture the situated complexity of treating individual patients. They produce a false sense of collective professional control over healthcare decision-making and impede the role of individual professionals; which is to weigh evidence, next to clinical experience and patients' needs and wishes, with patients and in the counselling room.

The professional other

The fact that 'professional others' use such professional guidelines to inform their actor-specific actions further complicates the situation. In fact, such use is problematized by both professionals and representatives of professional organizations that engage in guideline development.

> '*What I find problematic is that many healthcare actors* [other than professionals] *see guidelines as "this is the way things need to be done and when you don't do it like that it is wrong." The inspectorate for instance talks about norms. In that phrasing already lies a very different meaning attached to guidelines.*' (representative of a knowledge institute, interview 2016)

The problem here is not that insurers and inspectorates use professional guidelines to monitor care provided by professionals per se; but rather, that in the way in which they do so, the advice presented in guidelines become norms that apply to the treatment of individual patients. Such norms can in turn be used to measure the quality of care provided to individual patients.

> '*The problem is that insurers use insights derived from averages of populations to measure the quality of care delivered to individual patients.'* (internist, focus group 2016)

In these quotes, professionals present a precarious tension between: (a) the way in which professionals translate professional guidelines to the context of individual patients; and (b) the way in which insurers and inspectorates use professional guidelines to determine whether the care that has been provided to individual patients is in line with the uniform agreements made. For most interviewed professionals, it is here that professional guidelines, useful for tinkering in the treatment for and with individual patients, consolidate into rigid norms.

Concluding remarks part 2

In the discussion on EBM, a distinction is drawn between the (ideal typical) patient-centered individual professional and the (problem typical) standardization-centered professional other. Whether this professional other is a health insurer, health inspectorate, or professional organization does not really seem to matter. What matters to those that problematize EBM is that clinical epidemiological evidence is reductionist and needs to be interpreted in the context of individual patients. At the same time, the counselling room is furthered as the site where evidence informed healthcare decision-making should take place. In the next section, we discuss why this line of reasoning is – in itself – a problem.

Part 3: Who decides based on what?

It is important to underline that other actors involved in the governance of care do not disagree with healthcare professionals that clinical epidemiological evidence needs to be interpreted and contextualized. In fact, most actors involved seem to interpret and contextualize such evidence themselves, albeit in and on their own terms (see first empirical subsection). The issue therefore seems to be not about whether clinical epidemiological evidence should be interpreted and contextualized (making the discussion about EBM's reductionist epistemology somewhat trivial), but rather about *who* should interpret and contextualize such evidence and *how*.

For most professionals that engage in the EBM discussion, the question who should interpret clinical epidemiological evidence is easily answered:

> '*Health insurers should not be able to say: "there is no evidence for this so we do not pay". We sit in the counselling room not them... Insurers shouldn't mingle in these kinds of discussions, they should not determine, only pay.'* (gynecologist, interview 2017)

In the Netherlands, after the introduction of the Health Insurance Act in 2006, health insurers are formally given the role to represent their insured (patients) in negotiations with professionals about the price and quality of care. However, neither professionals nor insurers act as independent negotiators. As presented in the previous subsections, professionals are deemed by inspectorates to live-up to the uniform agreements presented in guidelines developed by professional organizations. Insurers are obliged to insure care included in the 'basic healthcare agreement'. In this context, evidence-based healthcare decisions are no longer under control of the professions, nor insurers, patients or the state. Instead healthcare decision-making has become fragmented and dynamic, influencing – and being influenced by – actors in different spheres (Van de Bovenkamp et al. 2014).

This creates direct tensions between actors involved about how to interpret and contextualize clinical epidemiological evidence and about the consequences of such interpretations. In the words of a gynecologist:

> '*We just had a discussion with the Dutch Healthcare Institute about fertility preservation… There is this professional guideline that says it is considered good care when you discuss this and that with patients and when you decide to freeze an ovary. Putting it back, however, is considered another treatment. A process for later. So far, 70 children have been born by a replaced ovary. We thus see that it is possible. But the Dutch Healthcare Institute still considers it experimental* [in other words, the clinical epidemiological evidence for this treatment is not yet conclusive]. *Hence, it is not considered insured care. It feels so wrong that the professional guideline considers it good care, but the Dutch Healthcare Institute does not recognize it as such. It makes me mad and I think it is terrible.'* (gynecologist, interview 2016)

In abovementioned example, the Dutch Healthcare Institute relates to EBM's evidence hierarchy in order to make a binary decision that counts for all Dutch citizens; the exclusion of a treatment from the basic healthcare agreement due to limited and low graded evidence (Guyatt et al. 2011). Of key concern is that this interpretation of evidence by the Dutch Healthcare Institute differs from – yet does have consequences for – the evidence-informed actions of professionals in the counselling room. These professionals want to interpret the evidence that does exist in the context of individual patients. However, this becomes impossible because the basic healthcare agreement prescribes what insurers should consider insured care. Professionals, in turn, can hardly recommend treatments that are not covered by health insurers. In the Dutch governance of care, the evidence-based advices and decisions of some actors can thus exclude and simultaneously limit the evidence-based actions of other actors.

It is in this context that many professionals emphasize and problematize EBM's reductionist epistemology and stress the importance of contextualizing such evidence in the counselling room. However, we would like to point out that the problem is not necessarily EBM's reductionism, but rather that two interdependent actors interpret and contextualize clinical epidemiological evidence in very different ways. The professionals interpret such evidence in the context of the situation of an individual patient; the Dutch Healthcare Institute interprets such evidence in the context of policymaking on the level of the Dutch population. The problem is thus not a lack of contextualization, but rather a difference in contextualization.

Conclusion

In this paper, we formulated the following research question: *How and by whom has the role of EBM in healthcare decision-making been problematized and why is that the case?* We took the Netherlands as our case study. We observed that EBM informs the practices of a variety of actors, operating on different levels (figure 4). We furthermore observed that each of these actors underlines the importance of contextualizing clinical epidemiological evidence. They contextualize such evidence within their own organizations (from the counselling room to policy offices), according to actor specific methodologies (from critical appraisal to systematic assessments) and in relation to actor specific objectives and/or responsibilities (from crafting individual treatment plans to proposing national policies). We also observed that in layered healthcare systems, the contextualization of evidence by one actor, can limit the ways in which other actors are able to contextualize such evidence.

Based on above-mentioned observations, we challenge dominant claims made in the Dutch EBM discussion, as well as in the international medical literature. In them, emphasis is often placed on the facts that: a) clinical epidemiological evidence is reductionist (Bolt and Huisman 2015); b) that such evidence should therefore always be contextualized (Hargraves et al. 2016); and c) that this no longer happens because professional others have adopted EBM uncritically and place constrains on individual professionals to contextualize clinical epidemiological evidence in the counselling room (Greenhalgh et al. 2014).

The main problem in abovementioned line of reasoning is the step from b to c. As we revealed, clinical epidemiological evidence is interpreted and contextualized on different levels, by different actors and in the context of a great many things; ranging from patients' individual needs and wishes, to quality and safety, healthcare expenditures and the protection of a collectively financed healthcare system. In this light, classifying EBM as a reductionist approach might be epistemologically sound. It is however nowhere near adequate for resolving the current tensions that have emerged around evidence-informed decision-making. In fact, all actors agree that EBM is a reductionist approach and that clinical epidemiological evidence needs to be contextualized. Taking this argument one step further, the problem seems to be that different actors contextualize evidence in and on their own terms. The contextualization of EBM is not absent, rather, it is all over the place.

Discussion

EBM is particularly problematized in a medical and scientific register. However, we argue that the discussion is actually fueled by: I) tensions between individual and public needs; II) the layering of institutional arrangement that have been introduced to deal with such tensions; and III) the differences between actors and their idiosyncratic roles and positions presumed and legitimized by such layered arrangements as well as evidence (Van de Bovenkamp et al. 2014; Felder et al. 2018). This makes the EBM discussion not just a professional affair, but rather a question of governance. We therefore urge policymakers and public administration scholars to take the EBM discussion seriously and to start scrutinizing the layering of healthcare systems and the ways in which such layers shape the ways in which evidence informed healthcare decision-making takes place. We furthermore urge medical professionals to take the EBM discussion beyond their counselling rooms and open-up to a broader discussion about the role of clinical epidemiological evidence in layered healthcare systems (Tovey et al. 2014; Berwick 2016).

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3

Design thinking as a ritualized change strategy in the governance of healthcare:

an ethnographic case study

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Submitted for review

Abstract

We aim to understand the potential of ‘design thinking’ for healthcare organizations that try to adapt to shifting principles and actor relations in the governance of healthcare. We asked the following research question: *how does design thinking contribute to the generation of alternative organizational strategies for the contemporary problems of healthcare organizations in the Netherlands?* To answer this question, we took a particular ‘design-thinking experiment’ as our case study and collected data through participatory observation and semi-structured interviews. Drawing on anthropological theory on ritualization, we argue that design thinking was important for the participating healthcare organizations in an unexpected way. Instead of generating new ideas, the design-thinking experiment functioned as a *catalyst* and *legitimator*. Our insights have consequences for how we conceptualize the productive potential of design-thinking experiments in the governance of healthcare and beyond.

Keywords: design thinking, ritualization, ethnography, alternative organizational strategies, the Dutch Healthcare Inspectorate.

Introduction

> *21 August 2017* – In the center of The Hague (the Netherlands), tucked away in a hallway corner on the 20th floor of the Ministry of Health, a head of department of the Dutch Healthcare Inspectorate meets with one of her inspectors, two designers, an artist, a professor of healthcare sociology, one of her PhD students and one of her bachelor students. They are gathered in the prelude to a 'design-thinking experiment' in which three healthcare organizations, amongst which the Inspectorate, are supported by creative designers in rethinking their role and position in the governance of healthcare. At stake today is an initial exploration of the Inspectorate's organizational problem. '*If only we could do away with those inspection reports',* the head of department says half jokingly….
>
> *21 October 2017* – After a day and a half of intensive design thinking sessions, the design group moves from the exploration phase into the design phase. They need to produce a creative, implementable solution to the Inspectorate's organizational problem. However, the problem has been hard to define. Consequently, the design-thinker's motto to change problems into opportunities is left wanting. '*But what if you cease providing inspection reports?',* the creative designer suggests in a probing manner. The different members of the Inspectorate look at each other and nod convinced. That is an excellent idea. Not long after, they turn into implementation mode; discussing where, when and how the omission of an inspection report might be arranged. (reconstructed from fieldnotes 2017)

Based on abovementioned observations, we could draw the cynical conclusion that design thinking does not offer anything *creative* or *new* to healthcare organizations aiming to rethink their roles and services in light of shifting principles and actor relations in the governance of healthcare. For us, however, these observations prompted two questions that warranted further exploration. How was an already brewing – but not yet accepted – idea turned into an alternative organizational strategy? Moreover, what exactly was the role of design thinking in that process?

Design thinking has been described in different ways, yet most authors agree that it tends to follow a particular script; starting with the end users in mind and moving from idea generation, to prototyping, to testing and implementation (Brown 2008; Martin 2009). With its emphasis on ideation, design thinking entails a human-centered, instead of analytical or technological, approach towards organizational change (Kimbell 2011). It moreover values collaboration between practitioners, designers, clients and researchers, emphasizes situated and creative thinking, stresses the importance of (re)conceptualizing wicked societal problems into organizational opportunities, and promises the generation of innovative solutions (Buchanan 1992; Brown 2009).

Design thinking is widely covered in the literature on business management and strategic innovation (see for examples Martin 2009; Brown and Wyatt 2010; Mootee 2013). This body of literature describes how organizations can use design thinking to develop new products, services and strategies that cater to the needs of customers. In doing so, the literature attributes much potential to design thinking as a change strategy (Brown 2009).

This paper intends to contribute to the design thinking literature in two ways. Firstly, even though much potential is attributed to design thinking, empirical analysis on how design thinking contributes to organizational change remains scarce (Kimbell 2012). We therefore set out to analyze a design thinking experiment empirically whilst borrowing insights from the anthropological literature on strategy workshops (Johnson et al. 2010). Secondly, even though design thinking is extensively discussed in the business management literature, it has not yet been picked up by scholars studying innovation and change in healthcare governance (see for exceptions Roberts et al. 2016; Eines and Vatne 2018). Healthcare is an interesting setting to study design thinking initiatives because healthcare organizations are increasingly investing in it as a change strategy. Moreover, the healthcare sector is typically characterized by a multitude of interdependent actors that together shape the services provided to end users (in this case, patients). This means that healthcare organizations do not only need to relate to end users, but also to other actors involved in healthcare provision.

In the Netherlands, many conventional healthcare organizations (ranging from home care organizations to health insurers and healthcare inspectorates) are currently aiming to reconfigure their roles and services. Here, supply-driven, professionally-controlled, and medically-centered healthcare provision is steadily making way for more integrated and patient-centered approaches (Berwick 2016). This means that healthcare is increasingly approached as coproduced by a plurality of professional others; including insurers and inspectorates, as well as patients, their families, and the communities in which they are embedded (Doherty and Mendenhall 2006; Epstein and Street 2011). However, such collaboration and coproduction requires a blurring of organizational roles, boundaries and responsibilities that conventional healthcare organizations struggle to accomplish (Epstein and Street 2011). Some of these healthcare organizations have therefore started to adopt design thinking as their change strategy.

In this paper, we aim to better understand the potential of design-thinking strategies for healthcare organizations that try to reconfigure their roles and services in light of shifting principles and actor relations in the governance of healthcare. In order to do so, we tried to capture our two initial questions (presented at the onset of this introduction) into the following research question: *How does design thinking contribute to the generation of alternative organizational strategies for the contemporary problems of healthcare organizations in the Netherlands?*

We take a particular design-thinking experiment as our case study. In this experiment, representatives of three Dutch healthcare organizations (a healthcare inspectorate, an insurer, and a home care organization) were supported by six designers, four scientists, three students, and a plethora of practitioners (such as medical doctors and nurses). At stake was how these organizations tried to reconfigure their roles and services in relation to a specific group of 'hard-to-reach' or 'vulnerable' end users (as framed in design-thinking terminology). We (the authors) acted as 'observing participants' by collecting detailed fieldnotes and photographic materials as the experiment unfolded. We furthermore conducted interviews with all organizational representatives involved during and after the experiment took place.

Drawing on the anthropological theory on ritualization – which we will further introduce in the next section – we argue that the design-thinking experiment was relevant for these healthcare organizations in an unexpected way. Instead of using design-thinking strategies to develop new ideas, concepts, and solutions in order to keep up with and adapt to changing actor relations and principles in the governance of healthcare, the experiment showcased an empathetic rehearsal of already-existing, yet not formally adopted ideas and solutions brewing amongst organizational representatives. Design thinking was thus not a site where alternative organizational roles and services were created, but rather a site were alternative roles and services were perpetuated. In that sense, the design-thinking experiment's contribution was twofold. On the one hand, it functioned as a *catalyst*: an affective and protective time-space where alternative organizational configurations could be articulated, rehearsed, and adapted. On the other hand, it functioned as a *legitimator*: the fact that these alternative configurations were cultivated in an experimental setup helped to legitimize their organizational existence.

These insights have consequences for how we conceptualize the emergent potential of design-thinking experiments in the sense that ideas are not created in them but catalyzed and legitimized by them. Before further discussing our case and presenting our conclusions, we introduce the theoretical lens through which we examined the design-thinking experiment.

Design thinking and ritualization

Design thinking is a concept that has been widely adopted in management literature since the turn of the century (Kimbell 2011). Here, it is described as a future-oriented, exploratory, and human-centered approach towards problem solving (Brown 2008; Kimbell 2011). Design thinking typically starts with end users in mind and moves from idea generation, to prototyping, to testing and implementation (Brown 2008; Martin 2009). Meanwhile, it highlights a depoliticized, fragmented and episodic way of working that has a clear beginning and end and is detached from everyday organizational routines. Although design thinking highlights multidisciplinary collaboration and values different levels of expertise, it also places strong emphasis on the creative and mediating role of the participating designers (Julier 2008). They have a key role as the cultural intermediaries in multidisciplinary teams and as the interpreters of what end users need. With their '*creative ways of solving problems, designers can turn their hands on anything'* (Kimbell 2011: 287).

Abovementioned literature generally discusses design thinking in two complementary ways. Firstly, it describes design thinking ideal typically, paying attention to the specific characteristics that make design thinking a strategy for organizational change. Secondly, it attributes much potential to these characteristics described; with the promise of a solved problem for those that stick to the script and are willing to engage with a creative designer.

Johnson and colleagues (2010) have studied strategy workshops empirically in order to better understand whether and how such workshops are able to produce organizational change. In resonance with the literature on design thinking (Kimbell 2011), Johnson and colleagues (2010) highlight the episodic, scripted nature of strategy workshops and propose that such workshops could very well be approached as more or less *ritualized*. Johnson and colleagues (2010) subsequently stress that this approach allows for the use of analytical categories from the anthropological literature. Such categories, in turn, makes it possible to structurally observe, analyze, describe, and compare such workshops and how alternative organizational strategies emerge through the practices of those involved (Bourque and Johnson 2008; Vaara and Whittington 2012). Due to the similarities between Johnson and colleagues' (2010) description of strategy workshops and the characteristics attributed to design thinking in the literature, we adopt the same categories in our empirical analysis of the design-thinking experiment.

Johnson and colleagues (2010) propose the use of five analytical categories in their empirical analysis of strategy workshops. The first three of these categories are aimed at describing the strategy workshop itself. These are: removal, liturgy and ritual specialist. *Removal* is the extent to which the strategy workshop is detached from everyday organizational routines. Removal can be achieved spatially, but also by doing something different, or levelling or inverting social status. Furthermore, removal has clear beginnings and endings contributing to the episodic nature of the strategy workshops. *Liturgy*, in turn, refers to the script that participants follow in this alternative time-space. This script can be more or less formal yet needs to underwrite the alternative rules of conduct. The *ritual specialist*, lastly, is there to impart the liturgy to participants and to make sure participants stick to the script.

Through the characteristics mentioned above, Johnson and colleagues (2010) argue that strategy workshops have the potential to create a social limbo that encourages behavior different from the everyday (Johnson et al. 2006). In order to capture such behavioral changes, the last two analytical categories are concerned with describing the group that partakes in a strategy workshop. Johnson and colleagues (2010) refer to these categories as communitas and antistructure. *Communitas* refers to the group's potentiality; such as their emotional energy, confidence, enthusiasm and willingness to embrace the situation and take action. *Antistructure,* in turn, refers to the actual suspension of participants' normal social status. Even though such suspension might be part of the liturgy, the extent to which social hierarchies dissolve or inverse differs between participant groups.

Johnson and colleagues (2010) use these five categories to analyze under which conditions strategy workshops can create the communitas and antistructure amongst participants that is necessary to embrace alternative strategies. However, in their discussion, they also underwrite that the extraordinary circumstances under which such alternative strategies are developed – in workshops that are far removed from everyday organizational routines – actually make it hard to implement such strategies under normal organizational circumstances; that is, translate them into everyday organizational procedures and routines (Schmidt 2008; 2010). As such, their analysis is mainly concerned with the extent to which participants experience the strategy workshops as valuable and legitimate. The alternative strategies that emerge in such workshops and through the practices of those involved, are not scrutinized (Kimbell 2012; Vaara and Whittington 2012).

However, we are interested in how alternative organizational strategies emerge in design-thinking experiments. To better understand this process, we use Johnson and colleagues (2010) characteristics to analyze a design-thinking experiment, whilst simultaneously shifting attention from the legitimation of the design-thinking experiment itself to the development and legitimization of the alternative organizational strategies emerging in the design-thinking experiment through the practices of participating designers, researchers, students, and organizational representatives (Kimbell 2012; Vaara and Whittington 2012). To do the latter, we will also attend to the articulation of problems and solutions, the deliberation on such problems and solutions, and the work involved to embed designed solutions into organizational routines (Schmidt 2008; 2010; Vaara and Whittington 2012).

In order to understand how the design-thinking experiment contributes to the generation of alternative organizational strategies, above-mentioned theoretical reflections have thus sensitized us towards: a) mapping how the design-thinking experiment was organized; b) tracing how participants reconfigured organizational problems into alternative organizational strategies over the course of the experiment's unfolding; and c) gathering participants' reflections on how the experimental set up contributed to the generation of these alternative strategies. In the next section, we discuss how we gathered such data.

Methodology

Our empirical analysis builds on a combination of participatory observations and semi-structured interviews. Below we discuss how we conducted and combined both methods.

Participatory observation is an important research methodology in anthropology and sociology (Clark et al. 2009). It means that researchers actively participate in the environment under study. They do so to gain an intimate familiarity with, in this case, the design-thinking experiment and its participants. Participatory observation enables researchers to focus on concrete actions of the participants, whilst simultaneously capturing the content of conversations and use of language (Mortelmans 2013).

In our case, we introduced ourselves as researchers and we informed the key participants about our research project. Thereafter, the first three authors (MF; TKV; MS) each joined one of the participating healthcare organizations and rotated halfway through. During the sessions, we actively supported the participating organizations in the design-thinking process; thinking with them about how to frame problems and find fitting solutions, or facilitating deliberation through notetaking and summarizing. At the same time, we made detailed fieldnotes about the experimental setup and the content and form of the discussions. Important here was to capture who said what in response to who or to which element in the design-thinking experiments' setup. Because the articulation of ideas occurred primarily via keywords on post-its and posters, these fieldnotes were complemented with photos of the produced texts. Each author used their fieldnotes and photos to write out detailed observation reports. The last author (AB) observed the overall process and supported the two designers that organized and facilitated the workshop, sometimes joining discussions within the smaller groups.

In addition to participatory observation, semi-structured interviews were conducted with key participants of the experiment (N=14); two participants did not respond to our request for an interview. The topic lists were structured around three themes: (a) the organization's reasons for participating; (b) the design-thinking experiment and how it was experienced (setup and process); (c) changes in the organization after the experiment (articulation and implementation of the organizational problem/solution); d) reflections on how the experimental setup contributed to such changes. The interviews were transcribed verbatim.

During the analysis, all the authors revisited the observation reports (consisting of photographs and fieldnotes) and transcribed interviews. We iteratively went back-and-forth between analytical themes and our theoretical framework (Timmermans and Tavory 2012). Our analysis focused on: a) mapping how the experiment was organized; b) tracing how alternative organizational strategies emerged; and c) reflecting on how the experimental setup contributed to such changes (see also table 1). Preliminary findings of the field reports were first discussed amongst the first three authors and after that discussed with the last author.

Table 1: *Overview of the study design*

Analytical steps	Methods used	Data gathered
Mapping the design-thinking experiment	Field observations	- Researcher diaries (n=3) - Researcher maps (n=3) - Photo's (n=55)
Tracing the generation of alternative organizational strategies	Field observations	- Researcher diaries (n=3) - Researcher maps (n=3) - Photo's (n=55)
	Interviews	- Facilitators (N=2) - Designers (N=4) - Organizational participants (N=7) - Student (N=1)
Participant reflections on how the experimental set-up contributed to such changes	Interviews	- Organizational participants (N=7 – the same as above)

We ensured the quality of the study by taking the following steps. Firstly, we decided to combine different sources of data (observation reports and interviews) to enhance the internal validity of the study. Here, the interviews helped us to validate and enrich insights from the observation reports. Secondly, we worked with a team of four researchers that rotated between organizations halfway during the design-thinking experiment, together reflecting on the research steps and analyzing each other's material. Lastly, we member-checked the final version of this paper before submission. It was during this member check that we heard that the participating inspectorate had been nominated for an innovation prize for an experiment with mystery guests. In this experiment, an idea that had been discussed during the design-thinking sessions had been embedded (see further results section).

Below, we have structured our results section into three parts. We first focus on the experiment's preparation phase. Thereafter, we describe the design-thinking experiment. Lastly, we pay attention to the aftermath. In our analysis, we revisit the analytical categories proposed by Johnsons and colleagues (2010), whilst simultaneously highlighting how alternative strategies emerged (Schmidt 2010). In order to understand this process in detail, we have chosen to zoom in on one of the participating organizations specifically: the Dutch Healthcare Inspectorate (henceforth the Inspectorate). It is here that an alternative organizational strategy emerged and became embedded into broader organizational processes. This makes the Inspectorate an empirical example of how design thinking may contribute to the generation of alternative organizational strategies in the governance of healthcare.

Design thinking as an instrument for organizational change

Our case study did not have an official title. Most called it '*the experiment*', although some referred to it as '*the design-thinking sessions*' and again others referred to it as a '*summer school'* (fieldnotes 2017). Funded by the European Union and financially supported by EIT health, the program was aimed at stimulating innovation amongst '*healthcare students from all walks of life*'; from bachelor students to healthcare professionals, managers and policymakers (EIT Health 2018).

Preparation phase

The first time representatives of the Inspectorate met with the designers, researchers, and students was during a meeting in preparation of the design-thinking sessions on the 21st of August 2017 (see epigraph). The goal was to formulate a problem that the group could focus on during the design-thinking experiment itself.

The representatives of the Inspectorate wanted to focus on the role that their inspection reports play in improving the quality of healthcare. They explained that their mission, as an inspectorate, is to assert that vulnerable citizens receive healthcare and support that is suitable, effective, and integrated (fieldnotes 2017). In order to do so, the Inspectorate operates closely with other inspectorates in the domain of healthcare and welfare (cf. Rutz et al. 2013). To gain insight into the healthcare and support provided to vulnerable groups, the Inspectorate furthermore focusses on thematic inspections on a municipal level. An example is the care and support provided to citizens with a minor mental disability. The Inspectorate is innovating in the methods through which they gain insights into the care and support provided to such vulnerable groups. Experiments with mystery guests are organized, focus groups are arranged and close collaboration with professionals and policymakers is sought (inspector, interview 2018). The Inspectorate however still uses traditional, summative inspection reports in order to articulate (potential) problems in the provision of integrated care and place issues on the agenda of professionals and policymakers. They produce these reports because: a) '*it is just the way they do things*' (inspector, interview 2018); and b) the other inspectorates operating in fields of healthcare and welfare expect them to do so. These summative inspection reports however present the Inspectorate with a complex problem.

One of the Inspectorate's inspectors had studied the impact of the Inspectorate in her PhD thesis. Ironically, she noticed that by delivering summative inspection reports, the Inspectorate distanced itself from the very networks it had built up in order to gain insight into the care and support provided on a municipal level. Moreover, professionals and policymakers did not gain ownership over the problems identified by the inspectorate. Because of that, the recommendations presented in the inspection reports seemed to have little lasting effect on the practices of professionals and policymakers (Rutz et al. 2013; 2017). In response, the Inspectorate was looking into alternative strategies to create continuity in improving the quality and integration of healthcare and welfare services on a municipal level. As one inspector therefore asked during the explorative meeting with designers and researchers: '*how can we write reports that are not a collection of plusses and minuses, but instead, motivate local healthcare actors to act?*' (paraphrase from fieldnotes 2017) As presented in the epigraph, the Inspectorate's head of department took this one step further and advocated the idea to leave out an inspection report and have an impact in a different way (reconstructed from fieldnotes 2017).

The design-thinking experiment

The two-day experiment itself was staged on the top floor of 'Spring House', a building painted bright red and situated close to the central train station in Amsterdam's bustling city center. Spring House contains a restaurant, flexible workspaces, and presents itself as '*the home for radical innovators*' and as '*a network, workspace and lab (…) functioning as a catalyst for positive change.*' (Spring House 2019) The heart of the experiment was a central meeting area. Around it were several 'satellite' rooms, separated from the 'center' by movable glass doors (see for a map appendix 1). This set-up facilitated participants to disband and work in smaller teams, as well as to come together and share ideas collectively. The area was furnished with tables and chairs, twisting stairs, many plants, sofas, and a balcony overlooking a busy Amsterdam waterway (fieldnotes 2017). Bare walls were plastered with banners carrying texts like: '*don't forget about the needs and desires of* *people.'* (fieldnotes 2017) The scene breathed creativity as well as purpose (a calling even): the need for organizations to better meet the needs of people. Moreover, the time-space in which the design-thinking sessions were organized was far *removed* from the everyday organizational routines of the participating organizations.

In coming up with an alternative organizational strategy, three representatives of the Inspectorate joined two other healthcare organizations (an insurer and an elderly home care organization). The three healthcare organizations were also supported by six designers, four scientists, three students, and a plethora of field experts and practitioners. Together, over the course of two days (29-30 September 2017), they followed the carefully planned and scripted design-thinking experiment.

Established hierarchies between the participants were immediately dismantled. At least, that was the idea. This meant that students and scientists, organizational participants and field experts were stimulated to feel the same opportunities to contribute to the experimental process. Such *antistructure* was stimulated in two ways. First of all, it was emphasized by the facilitators at the beginning of the experiment and thereafter repetitively articulated. As such, it was noted as an important 'shared' rule in the experimental time-space (resonating with the idea of *removal*) (fieldnotes 2017). Secondly, emphasis was placed on the fact that all participants, somehow knew one another personally. It was an experiment for *intimae* and supposed to be a safe, yet challenging environment.

The hierarchies between participants were as such 'articulately' dissolved. Meanwhile, the participating designers acted as *liturgy specialists* and as such controlled the experimental process and content. Two of the designers introduced themselves as the experiment's facilitators. Three other designers, each navigated one of the teams through the different stages of the design-thinking process. Each of these designers had a portfolio that testified to their ability to: a) think creatively; b) reason from the perspective of end users; and c) make linkages between organizational problems, societal developments, and different forms of knowledge and people's needs and desires (interview with the experiment's facilitators 2018).

Besides emphasizing the importance of antistructure and introducing the designers that would join the teams, the facilitators firmly nested the experiment itself into a design-thinker's ethos. Firstly, the facilitators used a potent mixture of everyday yet powerful and promising words, such as *radical change* and *revolution;* as well as design technical jargon, such as *divergence* and *convergence* (fieldnotes 2017). Secondly, the facilitators gave two tasks to the participants: a) to turn wicked problems into creative solutions; and b) to think from the perspective of end users. Thirdly, the experiment itself was divided into four different stages, resonating with the double diamond model (British Design Council 2005, see figure 5). There was a research phase in which the organizational problem was to be further explored 'divergent thinking' and defined 'convergent thinking'. Thereafter, there was a design phase in which different solutions were to be proposed and developed 'divergent thinking', whereafter one of these solutions would be chosen and implemented 'convergent thinking'. Each of these stages was complemented with events that would stimulate participants in their divergent/convergent thinking.

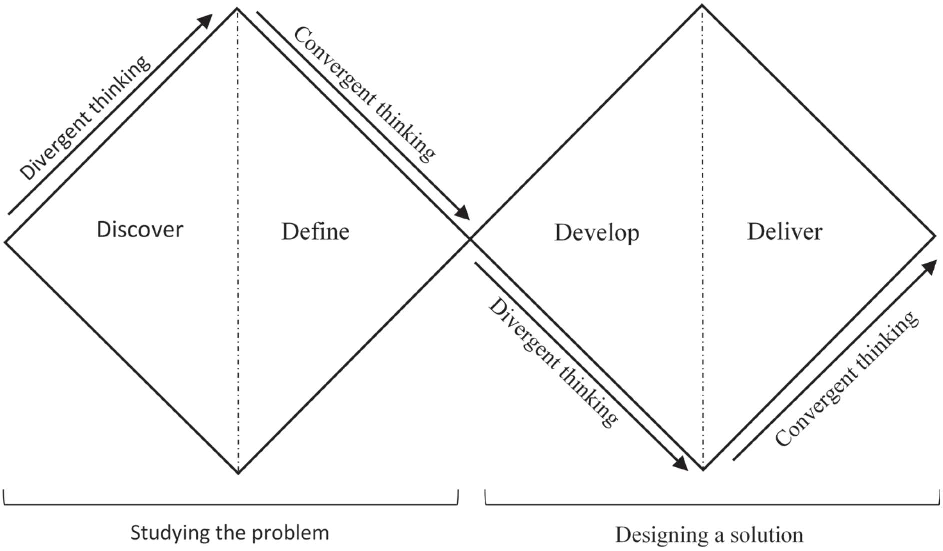

Figure 5: *Double diamond and its stages (British Design Council 2005)*

During the design-thinking experiment, representatives of the Inspectorate were off to a rough start. They needed to deal with two initial problems. Firstly, as outlined above, the designers placed strong emphasis on reasoning from the perspective of end users (read patients). The Inspectorate was however not directly providing services to such end users, even though they used care receivers as informants to gain insight into the care and support provided to them. Instead, with their audits and inspection reports, the Inspectorate targeted professionals and policymakers (fieldnotes 2017). Secondly, representatives of the Inspectorate needed to convince other participants (especially the other healthcare organizations) that they were different from the inspectorates that these others had in mind. Instead of judges of the quality and safety of healthcare, they wanted to facilitate the improvements and integration of these healthcare services (fieldnotes 2017). Interestingly, both problems strengthened the participating inspectors' convictions that they needed to present themselves differently. Their main challenge was framed as follows: '*How do we make sure that professionals use our findings to improve the quality and safety of care?'* (fieldnotes 2017)

As part of the schedule of the day, the liturgy contained several distinct elements. For example, a researcher presented a collection of colourful and inspiring trends and innovations. Experts were invited to join the design-thinking groups from a certain moment onwards, and a market was organized in order for organizational representatives to present their preliminary solutions to invited guests (amongst which several healthcare professionals, policymakers, researchers, and marketing experts).

One such element stood out according to the organizational representatives of the Inspectorate (interview 2018). Early on, during the exploration phase of the organizational problems, a professional tango dancer asked a representative of each organization about their organization and the problem they were facing (see figure 6). After that, he started dancing, being led by, as he explained himself: '*whatever he sensed was the right move to make.'* (paraphrase from fieldnotes 2017) The dance was interrupted several times to reflect on how the dance represented the problems of the organization. The dance was supposed to give participants a mirror image of their own organizations through a medium other than words (fieldnotes 2017). As such, the dance helped either in narrowing down or opening up how participants thought about their organizational problems. The dancer danced the Inspectorate as a group that wanted to collaborate but was avoided by others. In this light, the dance could be interpreted as an embodied translation of the problem that the organizations had already articulated.

Figure 6: *The dance (photo: Stuart Acker Holt)*

Nevertheless, something important happened during the dance. In the words of an inspector: '*The most important lesson we learned is that we actually did not realize that we are so threatening to others… that nobody really wants to work with us…'* (interview 2018) The dancer thus confronted these organizational representatives with an image of their organization that they did not feel comfortable with. Strangely enough, this interpretation reinforced the Inspectorate representatives' convictions that their organization was on the right track (they thought of their organization as being different from the one performed in the dance as they believed they were not threatening at all, but helpful). The dance urged organizational representatives to explicate to others what their 'true' organizational nature was: '*the dance is not who we are actually.'* (interview 2018)

Following the dance, the facilitators allowed organizational representatives to articulate a desired future and ideas about how to get there. It created a time-space for organizational representatives to contemplate. In the words of an inspector: '*Now we had the chance to really share ideas with one another… Normally and under pressure of time, we do not really develop our ideas further.'* (interview 2018) In the sessions that followed, the Inspectorate explored different solutions to their challenge. Solutions that resonated within the design-thinking group were: '*let local parties chose the themes of inspection*'; '*let municipalities inspect one another*'; and '*let professionals write the recommendations.'* (documented materials during the sessions 2017) A solution supported by most representatives of the Inspectorate was: '*never again produce an inspection report.'* (documented materials during the sessions, 2017) In an effort to combine the latter with some of the other solutions presented, the inspectors framed the following solution as the outcome of their design-thinking challenge: '*To not produce an inspection report and let professionals themselves write recommendations.'* (documented materials during the sessions 2017) They had thus stayed very close to the suggestions already articulated in the preparatory meeting (see epigraph).

In the time-space outside the confines of their organizational routines, pieces were falling in place for the organizational representatives. In case of the Inspectorate: a) leaving out a report would make the Inspectorate seem less scary (in response to the dance); and b) letting professionals formulate their own points for improvement would create ownership amongst professionals for the problems that needed to be solved (in response to their challenge to create more impact and continuity). Moreover, c) one of the inspectors was involved in an experiment using mystery guests with a minor mental disability in order to better understand how they received and perceived social services. That experimental setting was considered to be a great opportunity to test the leaving out of an inspection report (fieldnotes 2017).

Aftermath

The first Monday after the design-thinking sessions ended, one of the participating inspectors contacted the council of collaborating inspectorates.

> '*I told them that we wanted to mobilize professionals and policymakers to make changes and that the delivery of a report was in our way… That we wanted to leave out the delivery of an inspection report… They told me this was possible under the condition that its results would be evaluated…'* (interview 2018)

This response of the council allowed the inspectors to embed the omission of an inspection report in the experiment with mystery guests that was already being implemented. Concretely, it would mean that alternatives to the inspection report were going to be sought in that experiment with mystery guests.

> '*We organized a meeting with professionals and managers and instead of writing a report ourselves, they now needed to tell us what they thought was of importance... What went well and what should be improved… We asked them what they need in order to change things.'* (inspector, interview 2018)

Even though the results of the experiment still need to be evaluated, it is already interesting to observe here that it took a design-thinking session to change ideas about alternative courses of action already-existing amongst the Inspectorate's representatives (omitting the inspection report) into an alternative organizational strategy that gained enough legitimacy to be implemented on an experimental basis (being embedded in another experiment).

In November 2018, the experiment with mystery guests received the Dutch innovation price. In the words of the jury: '*it takes courage to use this target group as a mystery guest and to appeal to the intrinsic motivation of municipalities instead of the raised finger as a supervisor.*' (Ministry of Social Affairs 2018), the latter hinting at the omission of a summative inspection report.

Design thinking as a change strategy

Based on our reconstruction, we draw the preliminary conclusion that, at least ideas wise, not much *revolutionary* (to use a word from the design-thinking ethos) happened during the design-thinking experiment. The Inspectorate had used the experiment to solidify insights that had been floating amongst its representatives and had been previously articulated in a PhD thesis. In a similar vein, the home care organization saw it as another step in revising – and making more concrete – its organizational strategy (director of the home care organization, interview 2018). The insurer used it to convince more regional offices to embrace its revived community-based strategy (head of department, interview 2018).

How can we explain that every organizational representative that had participated in the design-thinking experiment had framed it as '*a source of change*' (director of the home care organization, interview 2018)? Moreover, how could it be possible that recommendations at the end of an inspector's six-year PhD thesis only took two design-thinking sessions in order to turn from theoretical suggestions into an implementable solution? To better understand the impact of the design-thinking sessions, we discussed the results of our assessment with the organizational representatives that had participated. In the next paragraphs, we present some of their responses and identify two ways in which the experiment contributed to the emergence and materialization of solutions.

Design thinking as a catalyst

In Spring House, far away from their daily tasks and routines, participants had a chance to really talk to one another: '*we could collect, connect, and substantiate ideas that had never been properly tended to.*' (inspector, interview 2018) Such productivity ascribed to the experiment is by Johnson and colleagues (2010) typically related to the idea of *removal*.

The experiment fostered such removal spatially by being staged far away from the participants' organizations. However, the design-thinking sessions were more than a gathering of organizational representatives outside the confines of their organization. Participants were exposed to a plethora of events in this faraway space, such as the dance. Moreover, they were exposed to a liturgy that was new to them; a blend of revolutionary language and design methodologies. Indeed, as another inspector reflects on these different events: '*it was one surprise after another, truly I still do not fully comprehend what we have experienced.*' (interview 2018) Some of these experiences were dissonant, frustrating, and incomprehensible for the participating inspectors: '*That continuous emphasis on end users, I did not fully understand it and it did not seem to fit our cause.*' (interview 2018) Others were more compatible: '*we invited some local general practitioners, we immediately understood one another and said: "let's do this."*' (director of the home care organization, interview 2018)

Abovementioned *removal* and *liturgy* boosted the *communitas* amongst the experiment's participants. For the participating inspectors, such communitas developed in three iterative ways. Firstly, they experienced that 'organizational others' had talked about and danced their inspectorate incorrectly. This triggered the participating inspectors to actively (re) present their organization and explain to others who they (the Inspectorate) really were and what their contemporary organizational problem actually was (fieldnotes 2017).

Secondly, in response to the experienced dissonance, participating inspectors teamed up. They formed a bond, sticking together even when the experimental setup asked them to disband; invoking small rebellious acts during the experiment's unfolding (fieldnotes 2017; cf. Wallenburg et al. 2019). They needed one another to make sense of – and control – what was happening around them and the problem(s) and solutions they had been articulating (inspector, interview 2018). Thirdly, the sheer magnitude of experiences that participating inspectors were exposed to force them to differentiate between what was and what was not helpful to solve *their* contemporary organizational problem. At some point during the first day, the inspectors, for instance, rebelled against one of the designers that wanted to push them to focus on end users (people with an intellectual disability) in their solution to be designed. As inspectorate, they instead wanted to focus on the professionals and municipalities that were providing services to people with an minor mental disability (fieldnotes 2017).

These observations resonate with the argument that interaction is an important medium through which new organizational frames emerge and substantiate (Schmidt 2010). Indeed, the facilitators of the design-thinking experiment heavily invested in the fostering of interactions both amongst organizational representatives and amongst organizational representatives and organizational others. But we also noticed that the participating inspectors responded to this interactive experimental setup by: a) staying together and increasing ownership over the problem to be articulated and solution to be designed; b) differentiating between what fitted and did not fit *their* problem; and c) drawing on their own knowledge and experience in order to find a solution to the problem defined. In our case, this meant connecting the project of one of the inspectors (the experiment with mystery guests) to the research findings of another inspector (in which the effects of summative inspection reports were problematized).

Removal, *liturgy,* and *communitas* thus indeed provided opportunity and necessity for organizational representatives to rearticulate and substantiate ideas they had previously been playing with within their organizations (Johnson et al. 2010). At the same time, during the experiment's unfolding, organizational representatives also carefully excluded dissonant perspectives and information from their organizational problem to be articulated and alternative organizational strategy to be designed. The experiment and its design-thinking methodology thus typically functioned as a catalyst. Instead of building upon the designer's creativity as a source of inspiration and change (cf. Julier 2008; Kimbell 2011), the experiment boosted what had been already been brewing amongst organizational representatives and allowed for the participating inspectors to craft their ideas into an implementable solution (Vaara and Whittington 2012).

Design thinking as legitimator

Another way in which the design-thinking experiment had impact has not been described in so many words by organizational representatives. Nevertheless, we could observe it almost continuously, yet in different forms. During the design-thinking sessions, there was this air of complexity and incomprehensibility floating about. Liturgy and liturgy specialists played a key role here (fieldnotes 2017); below we explain how.

As previously described, design thinking was introduced as a specific methodology, referring to various authors and models, giving it an analytical, even absolute, appearance. This design-thinking methodology was furthermore presented and implemented by several designers. The facilitators took great care in introducing themselves and the other designers and their portfolios (field observations 2018). In addition, university representatives were participating and the experiment itself was funded by the European Union (fieldnotes 2017). Ample time and space was taken in making all these things explicit.

Not only did this add up to a somewhat exclusive, fun, and bustling environment to be part of (derived from our own experiences noted down in our fieldnotes 2017), it also affected the ideas of the participating organizational representatives. On the one hand, in the words of the director of the home care organization: '*The sessions strengthened our conviction that we were on the right track.*' (interview 2017) On the other hand, it could also be used by organizational representatives to convince their organizational peers upon their return that they brought back something valuable. *'Because the university had been present, suddenly that and that person became impressed with what we were doing.'* (insurer, interview 2018)

Running their ideas through the design-thinking experiment helped organizational representatives to legitimate their ideas in the eyes of organizational peers. Participants went home with an alternative organizational strategy that was substantiated in an experiment that was funded by the European Union and facilitated by renowned designers in collaboration with a well-known university. In case of the Inspectorate, the solution that the participating inspectors had been piecing together had gained enough status to become embedded into an already-initiated experiment with mystery guests in monitoring the care and services provided to people with a minor mental disability.

Conclusion

We aimed to better understand the potential of design-thinking experiments for healthcare organizations trying to reconfigure their roles and services in response to shifting principles and actor relations in the governance of care. We formulated the following research question: *How does design thinking contribute to the generation of alternative organizational strategies for the contemporary problems of healthcare organizations in the Netherlands?*

To answer our research question, we examined how, over the course of a design-thinking experiment's unfolding, participants worked towards alternative organizational strategies. In doing so, we took Johnson and colleagues' (2010) line of analysis one step further. They used the anthropological literature on *ritualization* in order to study which characteristics make a strategy workshop – in our case the design-thinking experiment – a legitimate activity as experienced by participants. Instead, we studied how within the design-thinking experiment, as a more or less ritualized episode, alternative organizational strategies emerged through the practices of those involved (Vaara and Whittington 2012).

We observed that *removal* provided a time-space for participants to rearticulate and substantiate ideas they had already been playing with within their organizations. Meanwhile, their exposure to an extra-ordinary *liturgy* forced these participants to stick together and to take ownership over the problem to be articulated and solution to be designed and implemented. In this light, participants carefully excluded dissonant perspectives and perpetuated ideas that had already been brewing amongst themselves and within their organizations. On the one hand, the experiment successfully provoked participants to do so. On the other hand, dissonant contributions of organizational others never became part of the solutions to be implemented. As such, the design-thinking experiment typically contributed to the generation of alternative organizational strategies by functioning as a *catalyst*.

However, being a catalyst was not all there was to the experiment. Running their ideas through the design-thinking experiment also helped participants to legitimate their ideas in the eyes of organizational peers upon their return. In fact, after the EU-funded and university-supported design-thinking experiment, the previously precluded idea of omitting an inspection report had suddenly gained enough status within the Inspectorate to become provisionally embedded into an already-initiated, high-profile experiment with mystery guests. As such, the design-thinking experiment also contributed by functioning as a *legitimator.*

In the design-thinking literature, design thinking is described as a depoliticized way of working that is detached from everyday organizational routines (Kimbell 2011). We however argue that design-thinking experiments are very political processes. We observed a politics of including and excluding insights from organizational others during the experiments unfolding. In this process, the way in which organizational representatives perceived their own organization’s role served as a main frame of reference and was – to a large extend – reproduced (e.g. Felder et al. 2018a). Moreover, we observed a politics of repositioning. Organizations wanted to demonstrate to organizational others who they really were and what they could and could not do for organizational others (e.g. Felder et al. 2018b).

Such observed politics is however not necessarily unproductive (Zuiderent-Jerak 2015). The ritualized design-thinking experiment catalyzed the imaginaries of participating organizational representatives into legitimate alternative organizational strategies. It indorsed the participating organizational representatives to craft ideas together and embed them into broader organizational developments (Vaara and Whittington 2012). In our case, the precluded idea of omitting an inspection report materialized as part of the inspectorate’s high-profile and award-winning experiment with mystery guests in monitoring care and support provided to people with a minor mental disability.

In this article, we have specifically foregrounded the Inspectorate. In doing so, we backgrounded the ways in which the design-thinking experiment contributed to the development of alternative organizational strategies for the participating home care organization and insurer. Even though representatives of these organizations also described the experiment as a source of change, we also noticed that both organizations had a history in organizing design thinking sessions. Somehow, design thinking had become embedded in their organizational routines. But in doing so, it also lost some of its episodic and removed characteristics. Instead, it seemed to have become a parallel, but mainstream time-space in which organizations discussed – but also parked – organizational challenges and solutions. This observation implies that design thinking can have very different significance for the organizations that try to harness it to reconfigure their roles and services. More research is necessary in order to better understand whether and how such routinized experimental time-spaces resonate with and contribute to everyday organizational changes.

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Appendix

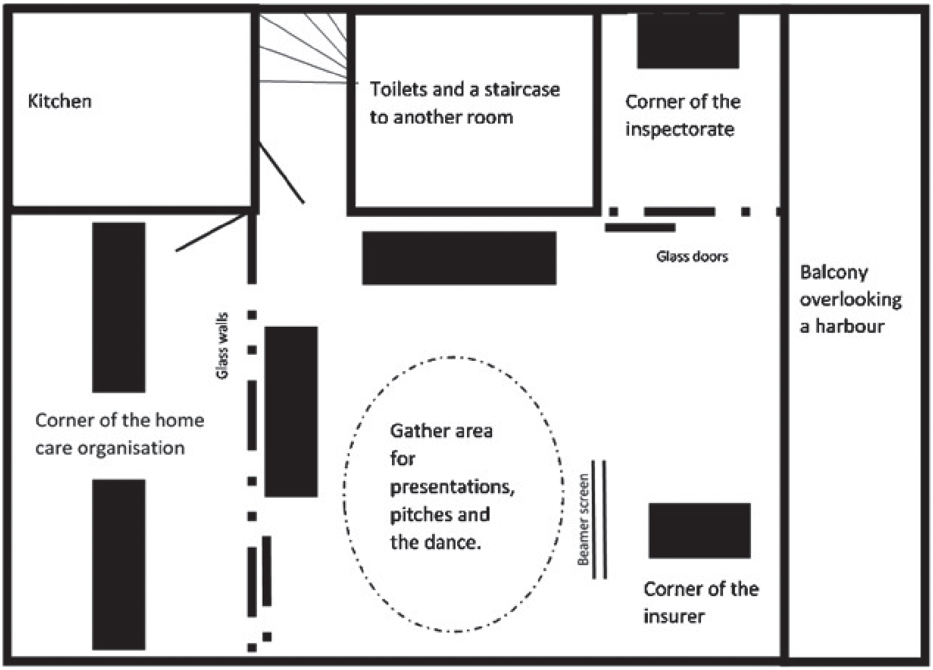

Figure 7: *Map of the design-thinking experimental set-up (derived from fieldnotes 2017)*

4

Politics of policy learning:
evaluating an experiment on free pricing
arrangements in Dutch dental care

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Published as:
Felder, M., Van de Bovenkamp, H. M., and de Bont, A. A. (2018). Politics of policy learning:
Evaluating an experiment on free pricing arrangements in Dutch dental care.
Evaluation, 24(1), 6-25.

Abstract

In Dutch healthcare, new market mechanisms have been introduced on an experimental basis in an attempt to contain costs and improve quality. Informed by a constructivist approach, we demonstrate that such experiments are not neutral testing grounds. Drawing from semi-structured interviews and policy texts, we reconstruct an experiment on free pricing in dental care that turned into a critical example of market failure, influencing developments in other sectors. Our analysis, however, shows that (1) different market logics and (2) different experimental logics were reproduced simultaneously during the course of the experiment. We furthermore reveal how (3) evaluation and political life influenced which logics were reproduced and became taken as *the* lessons learned. We use these insights to discuss the role of evaluation in learning from policy experimentation and close with four questions that evaluators could ask to better understand *what* is learned from policy experiments, *how*, and *why*.

Keywords: dental care, evaluation, healthcare markets, policy experiments, politics.

Introduction

In many healthcare systems, market mechanisms are introduced on an experimental basis to try to contain costs and improve the quality of services (Harrison and Calltorp 2000; Selker and Wasser 2014; Grit and Zuiderent-Jerak 2015). In line with this development, scholars have begun paying attention to how policy learning takes place through experimentation (Picciotto 2012) and the role evaluation should play in the process (Martin and Sanderson 1999; Arkesteijn et al. 2015). We contribute to this nascent field by studying a policy experiment 'in practice'.

In the literature, two distinct epistemic approaches can be identified that focus on learning in relation to policy experiments (Picciotto 2012). In the first, policy experiments are considered tests, designed to examine solutions to relatively concrete problems with well-established rigorous methods (Ludwig et al. 2011). In the second, policy experiments are seen as protective spaces for reflexive learning (Sabel and Zeitlin 2012). These approaches have conceptualized the role of evaluation differently. Emphasis is placed either on the summative *ex post* measurement of outcomes, or on the formative *ex durante* monitoring of changes and the fostering of dialogue between stakeholders (Arkesteijn et al. 2015).

Although these approaches to experimentation, learning and evaluation seem conceptually and operationally irreconcilable, they can – in practice – be entrenched in a single experiment (Regeer et al. 2016). An excellent example is the experimental introduction of price liberalization in Dutch dental care.

On 1 July 2011, Healthcare Minister Schippers decided to introduce this experiment to encourage entrepreneurship, improve service quality, stimulate product innovation and contain costs (Schippers 2011c; 2011d). The experiment should continue for three years, with regular evaluation and adjustments made, when and where necessary. Depending on the results, structural changes in the financing system for Dutch dental care could be implemented (Schippers 2011a; 2011b; 2011c). At first sight, the experiment appeared to be an opportunity for reflexive learning.

But instead of lasting three years, the experiment was cancelled after six months, mainly because of an observed price rise. As opposed to reflexive learning, a tester-oriented logic had become dominant. According to this view, the experimental dental care market had been put to the test, but rising prices demonstrated that the market had failed (Kuiken 2012). Although generally agreed to be a failure, it did produce learning. According to healthcare economists, politicians and consumer organizations, the failure proved that transparency on quality – a criterion considered lacking in dental care – should be deemed a prerequisite for any healthcare market to function properly (Varkevisser 2012).

Nowadays, the importance of quality transparency has become mainstream in Dutch policy discourse. Nevertheless, at the time of the experiment, its cancellation, the lessons learned and the role of evaluation were highly contested. In line with this observation, we take a constructivist approach and argue that policy experiments with market mechanisms are not neutral testing grounds (Muniesa and Callon 2007). To better understand *how* we learn *what* from policy experiments, it is important to make explicit the processes that produce the lessons learned (Van Assche et al. 2014) and the role that evaluation has in these processes (Martin and Sanderson 1999).

Following Van Assche et al. (2014), we argue that special attention should be paid to the different logics – unique sense-making models based on particular distinctions, observational procedures, conceptual mappings and causal inferences – that are reproduced in the policy experiment and its evaluation. To understand how and why some logics get reproduced and inform lessons learned, whereas others get ignored, even forgotten, special attention should be paid to how different logics and practices imply and reinforce one another (Van Assche et al. 2014; cf. Muniesa and Callon 2007; Butler 2010). To reveal that process in the Dutch dental care experiment, we pose the following research questions:

> *What experimental and market logics were present in the experiment? Which of these formed the basis for the lessons learned and why was this the case*?

Guided by these questions, we reconstruct the experiment in Dutch dental care. This reconstruction contributes to the literature on evaluation and policy experimentation. A shift is occurring in this literature, from conceptualizing the role of evaluation as *ex post* reporting of outcomes, to making explicit the processes through which policy experiments produce their outcomes (Pawson and Tilley 1997; Martin and Sanderson 1999; Dixon-Woods et al. 2011). Now, the experiment, its context and its outcomes have become objects of scrutiny and learning. In this article, we take this development a step further, aiming to understand an experiment's observed outcomes – and lessons learned – by revealing different logics reproduced during the experiment by different actors involved. In line with this approach, we close our paper with a methodological note directed to scholars of evaluation and evaluators who are particularly dedicated to making explicit – or to intervene in – the processes through which lessons are learned (Regeer et al. 2009; 2016; Dixon-Woods et al. 2011; Arkesteijn et al. 2015). But before presenting our findings, we first develop the theoretical lens through which we scrutinize our case: the policy experiment in dental care.

Experiments and politics of policy learning

Two distinct epistemological approaches can be identified in which learning by experimentation is discussed (Picciotto 2012; Vaessen and Raimondo 2012).

The first approach conceptualizes learning by experimentation as a testing ground. In this line of reasoning, the experiment functions as a time-space in which to test a predefined policy intervention under controlled circumstances (Ludwig et al. 2011). The policy intervention is introduced into a small, controlled setting that includes a limited number of variables (Duflo and Kremer 2005; Oakley 2007). Ideally, the effects of the intervention are measured and compared to a control setting which has not had the intervention introduced (Campbell 1998). Often, though, control settings are absent or difficult to arrange, and the post-intervention situation is compared to the pre-intervention situation (Duflo and Kremer 2005; Oakley 2007). The results from these tests are evaluated *ex post* and used to inform *ex ante* predictions on the effects of scaling up a policy intervention (Greenberg and Morris 2005; Wolpin 2007). In this approach, the role of evaluation is distant and summative, geared towards measuring impact with predetermined indicators and placing a value on whatever is measured by relating it to predetermined program objectives (Martin and Sanderson 1999).

The second approach conceptualizes learning through experimentation as a process of reflection and improvisation in a multi-stakeholder context (Friedman 2001; Patton 2008). Here, experimentation is about creating opportunities to obtain new ideas and insights and not testing predetermined policy formats or program theories (Sabel and Zeitlin 2012). To do so, the experiment is conceived as a protective time–space that is informed by – but detached from – the stabilizing forces that impede change. Examples are formal rules and routines, existing infrastructures and dominant material investments (Arkesteijn et al. 2015). These experiments allow stakeholders to interact, bring different knowledge and practices together and reflect on the results of the interaction. Reflection can lead to proposing further steps, implementing these and a new round of reflection. In this line of experimentation, objectives are intangible to some extent and redefined over the course of the experiment (De Wildt-Liesveld et al. 2013). Here the role of evaluation is engaged, reflexive and formative (Martin and Sanderson 1999). Some scholars describe evaluators as change agents who critically engage in formulating problems, implementing preliminary interventions, inductively mapping the impact and formulating new steps to be taken, informed by the primary lessons learned (Regeer et al. 2009; Arkesteijn et al. 2015).

Both approaches to experimentation and evaluation can be considered ideal types that further their own ideas about the role and design of experiments and how to interpret and evaluate their results. In practice, however, policy experiments are often conducted *in vivo* (Muniesa and Callon 2007), meaning that interventions are introduced into real-scale, real-life settings, involving an undefined number of stakeholders and participants with their own ideas of what the experiment is for and how it should be designed. If we want to understand how and what we learn through policy experiments, it is essential to gain insight into the ways in which experiments actually unfold in practice. Here, lessons from constructivist literature are of great value.

This literature specifically focuses on experimental practices (Latour 1987; Muniesa and Callon 2007) and the social construction of markets (Callon 1998; Mackenzie et al. 2007; Mitchell 2008). It uses the concept of performativity to address the process of experimentally introducing economic propositions, drawn from economic theories, into socio-material arrangements and through selective observation and demonstration, stabilizing them into the social-material setting. Here, the key mechanism is that the observed outcomes of an introduced economic proposition are starting points for further action and thus inform policy learning in a certain direction (Mackenzie et al. 2007). Meanwhile, the original proposition is reproduced through newly proposed and implemented action (Van Assche et al. 2014). In revealing this process, constructivist scholars have been able to trace how a particular market turned out the way it did and the role of an economic proposition in that process.

The experimental introduction of an economic proposition derived from a particular economic theory is rarely an exclusionary event, reserved for the reproduction and stabilization of that single economic proposition (Butler 2010). Policy experiments usually involve an undefined number of stakeholders and participants who bring into – or project onto the experiment – their own languages, conceptual mappings and causal inferences (Muniesa and Callon 2007; cf. Garrety and Badham 2004). Besides market logics, other logics are also introduced to – or are part of – the socio-material setting into which an economic proposition is introduced. Examples are the different logics for what an experiment is and how it should be evaluated.

If we shift our attention from what is actually learned from the policy experiment to the experimentation process, then it becomes apparent that diverse propositions, logics and practices not only imply policy learning, they are also implied in reproducing one another in the course of the unfolding experiment (Butler 2010; Van Assche et al. 2014). In other words, certain ways of approaching experiments fit better with certain ways of approaching markets, certain ways of approaching healthcare, and certain acts of 'capital P politics'; the latter referring to the formal or informal organization and enactment of government (Marres 2013). For example, different conceptualizations of the market can become part of a ‘capital P political’ debate and certain acts of leadership, framing and parliamentary presentation can influence which conceptualization becomes dominant during evaluation.

Different logics can thus create conditions for one another to be reproduced, stabilized and taken as starting points for further action (Butler 2010; Van Assche et al. 2014). Different logics can also create conditions that halt another’s reproduction. Logics might thus also be implicated in each other’s undoing (Butler 2010). What is learned from the experimental introduction of market mechanisms depends on how different concerted logics are reproduced, in concurrence, at the cost of other logics. Inspired by Butler (2010, on performative politics), we refer to this process as the *politics of policy learning*.

In this paper, we pay close attention to how the different market and experimental logics implicated one another during the unfolding experiment. Additionally, we demonstrate how some concerted and implicated logics constituted what was learned from the experiment, at the cost of other logics. Evaluation and ‘capital P politics’ played an important role in this process. Reconstructing a *politics of policy learning*, we argue, is therefore key to a critical and fuller understanding of the epistemological and political dimensions behind the experimental creation of healthcare markets. Only when we understand the different logics and evaluative and ‘capital P political’ practices implicated in policy experiments can we better understand the experiment’s outcomes and consider whether and how these should inform the governance of future healthcare markets (cf. Butler 2010).

Methodology

Below we present our reconstruction of the policy experiment on free pricing arrangements in Dutch dental care. This experiment provides an excellent opportunity to reveal a *politics of policy learning* that is inherently part of policy experiments, especially because of the participating stakeholders’ strikingly different approaches to the market and the experiment.

Please note, we [the authors] did not participate in this policy experiment as researchers or evaluators. Our findings are based on a historical reconstruction. Reconstructing past events through a combination of archival data and interviews – the latter pointing to the inclusion of contemporary interpretations of past events – faces the problem of dealing with retrospectively constructed meaning in a new and different actuality (Dirksmeier and Helbrecht 2008). Considering this caveat, we argue that our findings must be read as a contemporary picture of past events. Our findings are, however, important beyond their historical value because they reveal a *politics of policy learning* that has methodological implications for evaluators' *ex post* evaluation – or *ex durante* participation in – policy experimentation. We come back to this point in our discussion.

Our study is based on document analysis and semi-structured interviews. Data gathering and analysis was a cyclical, iterative process in which document selection and analysis complemented the conducting and analysis of interviews (Marshall 1996). In this process, letters and policy documents helped us to identify the specific logics through which the experiment was observed and described and to place events and interviewees' interpretations in the context of time (Aminzade 1992). In total, we analyzed four policy documents, five organization websites, 14 letters to and from the House of Representatives and 31 newspaper articles. Policy documents and letters were obtained from the digital archives of the Netherlands Healthcare Authority (NZa) and the Ministry of Healthcare, Welfare and Sports (VWS). News items were selected on the keywords: 'experiment' [experiment], 'dental care' [mondzorg], 'free prices' [vrije prijzen], 'rising prices' [prijs stijging(en)], 'price liberalization' [prijs liberalisering], 'dentists' [tandartsen].

To obtain multifaceted insight into how the policy experiment unfolded, we conducted interviews in addition to our document analysis. We used purposive sampling (Marshall 1996). Here, we used documents and news items to identify actors involved in the experiment. Striving for inclusive actor representation, we furthermore followed a strategy resembling stakeholder analysis. We identified actors who had an interest in the experiment, were affected by it, or who influenced the decision-making process. Additionally, we asked respondents to point out relevant others (Varvasovszky and Brugha 2000).

The interviews (n = 13) were conducted between March and September 2015. We approached politicians (N = 2), representatives of professional organizations (N = 4), dentists (N = 4), consumer organizations (N = 2) and a member of the NZa (the Dutch healthcare inspectorate responsible for the development of healthcare markets) (N = 1). We chose to conduct semi-structured interviews. We asked interviewees to reflect on their objectives for the experiment, their observations on its design, what they aimed to achieve and how they interpreted the outcome. All interviews were audiotaped, transcribed verbatim and coded. We member-checked our interpretation of the interviews by sending our reconstruction of the experiment, highlighting quotes and insights from each interview, to our respondents. Below, the official public texts by the actors are reported with actual names. However, interviewees' responses are anonymized. All quotes are translated to English.

During our analysis, we focused on the use of concepts (e.g. creating or guarding), the drawing of distinctions (e.g. is or is not an experiment) and the proposition of causal inferences (e.g. if this, then that). A helpful starting point was our attempt to identify what kind of experiment it actually was, according to those involved. From there, we identified how descriptions of the experiment resonated with descriptions of the market (the object of experimentation). Lastly, we traced how these descriptions were reproduced in (a) the market scans, (b) decision-making in the Dutch House of Representatives and (c) in the lessons drawn from the experiment.

Empirical reconstruction

In the following sections, we reconstruct how the experiment in Dutch dental care unfolded. We follow a chronological structure, but identify different logics along the way. In the first three subsections, we focus on the object of experimentation: price liberalization in dental care. Here we identify two market logics. In two subsequent subsections, we focus on the experimental logics reproduced during the experiment's unfolding. Thereafter, we pay attention to how evaluation and political life were implicated and informed the lessons learned.

Prelude to the experiment

The roots of this experiment trace back three decades. A key point in time is the release of the Dekker report in 1987 (Helderman et al. 2005). The Dekker committee advised the Dutch government to introduce a system of regulated competition in the healthcare sector, in which healthcare insurers would negotiate with healthcare professionals on price, quality and volume. Although several similar recommendations and initiatives followed, it took until 2006 to institutionalize market mechanisms through the 'Law for Ordering Markets in Healthcare' (Wet Marktordening Gezondheidszorg [WMG] 2006). The goal was to provide rules and guidelines in the:

> '*Development, ordering and surveillance of healthcare markets to stimulate an effective and efficient healthcare system and contain the development of costs.*' (WMG 2006)

Dental care was one of several subsectors to explore the possibilities of price liberalization. Professional organizations in this sector were important proponents of this. For years, they had been searching for ways to gain the freedom to implement innovative, sometimes more expensive but qualitatively better, techniques and services. According to them, the sector had a growing variety of products and services. Even so, it was still financed through an average-based system. For each of 400 identified standardized diagnosis-treatment combinations, the state calculated a standard maximum remuneration. This had huge implications:

> '*I would like to use an operation microscope in my practice. It's a beautiful instrument, but expensive. So, we don't use it. That's a pity because it would improve quality and save time.*' (representative of a professional organization, interview 2015)

Because of the hitherto state-controlled financing structure, dentists claimed they were unable to use new techniques. After all, how could they use occasionally more expensive technology if the state forced them to charge fixed prices? Even when private patients were willing to pay more, dentists were unable to charge extra costs. Due to the financing structure, the sector had '*slipped into a one-size-fits-all rationality*.' (representative of a professional organization, interview 2015) Price liberalization, these professional organizations felt, would provide a way out this conundrum.

For the professional organizations, the WMG law introduced in 2006 offered new prospects. It coined the possibility of price liberalization (NZa 2006), concurring with the development of healthcare markets (WMG 2006).

Recommendation for a market experiment in dental care

A semi-governmental inspectorate, the NZa, was established in 2006 to coordinate the healthcare market development process, describing their role as '*the creator and guardian of healthcare markets.*' (NZa employee, interview 2015)

The NZa quickly published a program theory, in which they defined the market as an 'instrument' capable of doing something (NZa 2006: 7). It could improve quality, stimulate diversity, solve regional scarcities and lower costs. But the market also needed to be contained. After all, its workings were associated not only with desirable effects such as lower costs, but also with undesirable effects such as supplier-induced demands (NZa 2006). The NZa therefore set out to '*proactively establish conditions for the market to work*.' (NZa 2006: 1) These conditions included '*rules of the game*' (NZa 2006: 8) and the presence of:

- *transparency on a product's content, quality and price;*
- *accessibility & capacity/distribution (no scarcity or entrance barrier);*
- *equal bargaining power between market players.* (NZa 2006: 17–29)

The first year after the WMG law was introduced, much emphasis was placed on identifying these conditions in various healthcare subsectors, including dental care. The NZa advised the Health Minister not to liberate pricing in dental care due to (a) an identified scarcity of dentists, (b) the existence of an entrance barrier and (c) a lack of transparency in the price, content and quality of the services provided (NZa 2006). In other words, the dental market did not meet the necessary conditions for price liberalization to work well.

However, the NZa's mission was not only to *guard* markets, but also to *create* markets. In this role, the NZa argued that not all conditions had to be present at the start of price liberalization (NZa 2006: 19):

> '*We don't want to suggest that if a market isn't transparent yet, that is automatically a reason to advise the Minister against liberating price setting.*'

This line of reasoning became more prominent in the *re*assessment of the dental care sector in 2009. Now, the NZa distinguished between the prerequisites for price liberalization and conditions that could be established after liberalization was initiated. They referred to the latter as 'in-growth' conditions (see Table 1).

In 2009, the NZa still identified regional scarcities in the provision of dental care and still observed a lack of transparency in quality, content and price (NZa 2009: 12-13). But reasoning from a creator logic, now the lack of transparency and the presence of scarcity became the focal points for change. In a move that turned their 2006 argument on its head, the NZa argued that '*some identified issues might be resolved by the market itself once free pricing arrangements are introduced.'* (NZa 2009: 11)

Table 2*: Selection of conditions clustered by the NZa (2009: 11)*

Condition	prerequisite / in-growth
Transparency	
Content	in-growth
Quality	in-growth
Price	in-growth
Market access	
Scarcity (lack of)	prerequisite
Entrance barrier (lack of)	prerequisite
Easiness to choose and shop between providers	in-growth
Market behavior actors involved	
Incentive for insurers to critically bargain	prerequisite
Incentive for the consumer to critically bargain	prerequisite
Equal bargaining power between market players (providers/insurers/patients)	in-growth
Equal bargaining power among providers	in-growth

Caught between creator and guardian logics, the NZa concluded that price liberalization in dental care was wrapped in uncertainty. Therefore, the NZa suggested introducing an experiment. As they said (NZa 2009: 15):

> '*An experiment will give the opportunity to see how prices, quality and accessibility develop in a free market environment.*'

In comparing the NZa assessments of 2006 and 2009, we observe that the NZa identified itself as a *guardian* and a *creator* of healthcare markets. In their guardian role, they emphasized the importance of identifying and installing (pre)conditions to contain healthcare markets. In their creator role, they emphasized that it needed much observation, interpretation and improvisation to learn how to develop healthcare markets. An experiment would give the NZa the opportunity to combine both its roles. It would give space for developing a dental care market (the market needs to be created), but if things got out of hand, price liberalization could always be turned back (the market needs to be guarded). However, as we reveal later on, these two ways of approaching 'the market' fitted better with other conceptions of what 'an experiment' is and how to evaluate it.

Getting the experiment through the House of Representatives

Following the NZa's recommendation, Health Minister Schippers sent the following letter to the Dutch House of Representatives:

> '*I have decided to pursue the introduction of an experiment with free pricing arrangements in Dutch dental care in 2012, provided that the necessary prerequisites of transparency are met.*' (Schippers 2011a)

Although the NZa had defined quality transparency as an in-growth condition (see Table 1), Schippers maintained in her letter that transparency was a prerequisite for the experimental introduction of free prices. Following her proposal, much of the debate in the House of Representatives centered on whether transparency in content, price and quality was present and whether free prices could thus be introduced (Schippers 2011c).

Schippers acknowledged that Dutch dental care had not yet established proper quality transparency. However, instead of calling off the experiment because of that, she now followed more closely the line of reasoning that the NZa had forwarded in 2009. To the House of Representatives she explained:

> '*It is exactly the prospect of free pricing arrangements that has triggered the substantial development of quality indicators.*' (Schippers 2011c)

To further ease the concerns raised, the Minister stressed that although progress was being made in developing quality indicators, she agreed that it was a top priority in making the dental care market function properly. To demonstrate her seriousness on this point, she proposed pursuing the experiment for three years – instead of the five suggested previously by the NZa. This time reduction, she argued, would put extra pressure on the professional organizations to finish establishing quality indicators (Schippers 2011b). Moreover, the NZa would monitor the experimental dental care market every three months and the results of these quarterly market scans would be evaluated in the House of Representatives.

> '*If accessibility, affordability and quality of care were harmed, the experiment could always be turned back.*' (Schippers 2011c)

According to Schippers (2011c), one should take a possible price rise into account when talking about liberating prices. But any price rise should be linked to a rise in quality as well. Schippers did not convince all members of the House of Representatives. After all, how can you measure a rise in quality if the quality indicators had not been established? (member, House of Representatives, interview 2015). As one representative observed:

> '*This happens more often with experiments. Something is introduced experimentally but it almost never gets turned back, even when it has a negative effect. They do this to push things through.*' (interview 2015)

When it came to voting for the experiment, Schippers counted on the support of coalition parties in the House of Representatives. Although the opposition introduced a resolution, in the end, the majority supported the experiment; 93 voted for and 57 voted against (Kuiken and Voortman 2011) and the free pricing experiment was introduced on 1 January 2012 (Schippers 2011d).

We want to stress here that Minister Schippers skillfully navigated the experiment through the House of Representatives by drawing from both creator and guardian logics. On the one hand, she emphasized development and adaption (e.g. creating quality indicators on the go). On the other hand she emphasized conditions (the same quality indicators) and limitations (e.g. conditions under which prices were and were not allowed to rise). Most opposition representatives – many were left wing – saw the experiment as an attempt by the liberal Minister to liberate the dental care market without too much trouble (*they do this to push things through*). Suspicious opposition representatives therefore continued emphasizing the need to guard such markets (*what to do when negative effects occur*). Nevertheless, due to the support of the coalition parties, the introduction of the experiment was approved.

But what kind of experiment was actually introduced? Moreover, how were its effects going to be uncovered and evaluated? As we reveal in the coming sections, different actors involved in the policy experiment answered these questions differently.

The experiment as an opportunity to learn how to have free prices

Following the positive vote in the House of Representatives, in autumn 2011 the NZa started preparing for the experimental introduction of free prices. These preparations entailed more than just the 'legal' liberalization of prices. The NZa also worked on setting some of the conditions deemed necessary for the market to function properly.

To secure transparency in the content of services provided, the NZa reworked the old, technically challenging remuneration system. In that state-controlled system, 400 indicators prescribed what a dentist was maximally allowed to charge for specific treatment. In the new system, patients would have to understand the price of each treatment. Therefore, the 400 indicators were condensed into 150 understandable treatment options (NZa employee, interview 2015). To secure transparency in treatment prices, dentists were obliged to rework the 150 treatment options into their own price lists which, in turn, needed to be presented in their waiting rooms and on their websites by 1 January 2012; the official starting date of price liberalization.

To develop transparency in quality, the Minister asked dental care organizations to continue working on developing quality indicators. Likewise, the chairs of the professional organizations argued that parliament's decision to introduce an experiment '*innately stimulate[d] the industry to work on quality indicators, clinical working guidelines and other initiatives.*' (interview 2015)

However, neither the NZa nor the professional organizations thought that the experiment could proceed without further intervention. One NZa employee said:

> '*It takes time for a market to settle. Providers set prices. Patients come, see that the prices are too high and go somewhere else. That is, if the market works properly. But you'll see that only after a few months. I mean, most patients don't go to their dentist more than twice a year.*' (interview 2015)

Possible interventions in response to unwanted effects could only be decided in the direct context in which these effects were observed. A certain kind of improvisation was needed:

> '*If parties harm the stakes of consumers, for instance by conducting unwanted behavior that upsets competition, the NZa should be able to intervene. A monitor should provide the basis for judging which instruments should then be deployed.*' (NZa 2009: 105)

This learning-by-doing approach is even more sharply defined by a former representative of one of the professional organizations (interview 2015):

> '*The experiment would be an opportunity to observe how this all goes, how things develop under close scrutiny, of course, and we'd be able to adjust things if unwanted effects occur. In essence, the implication of such an experiment is that things need adapting and developing. Many things could happen. We'd see how transparency in content, price quality could develop, how quality indicators could develop and compare all that to* [what's happening in] *other countries.*'

The professional organizations clearly saw the experiment as a protective space for reflexive learning about free pricing. This fitted well with the idea that markets need to be created and that required lots of preparation, observation and improvisation. In resonance with this reflexive experimental logic, the NZa would conduct quarterly market scans to be discussed in the House of Representatives and provide the basis for new steps to be taken.

The experiment as a test

There was, however, another approach to the experiment, namely, as a test to see if the market, once liberated, could be contained and work properly. This approach draws heavily on the pre-conditionality of transparency in price, content and quality, initially stressed by the NZa and Health Minister. Opposition representatives, as well as patient and consumer associations took this line of reasoning further. These organizations maintained that the experiment could only be initiated when the preconditions had been met. They raised the question of how customers could critically bargain on price and quality if they had insufficient information about quality. Looking back, a representative of 'Patiëntenfederatie Nederland' (Dutch Patient Federation) recalls (interview 2015):

> '*We were aware of the upcoming experiment and were involved in some of its developments. But we thought that it was introduced too soon.*'

Reasoning from a tester's perspective, the Dutch Patient Federation questioned the lack of quality transparency in the experimental set-up. They formulated a hypothesis that this lack would inevitably lead to a rise in prices:

> '*According to the Dutch Patient Federation, it isn't true that prices will fall because of market competition. Prices will only rise because it's too hard to compare dentists and the quality of their services.*' (Powned 2011)

The Dutch Patient Federation and opposition representatives felt that the experiment was not yet ready to be initiated and nor was the dental care sector ready to have free prices (interview 2015).

To sum up, two conceptualizations of the experiment held sway. In the first, the experiment was interpreted as a time-space for learning how to have free prices in dental care. In this formative approach, *ex durante* monitoring and improvisation were key. In the second, the experiment was a test to see if free pricing in the dental care sector could be contained. In this summative approach, the installation (or lack) of preconditions, the formulation of a (negative) hypothesis and the *ex post* revealing of (undesirable) effects stood central. As we discuss in the next subsection, these approaches produced different insights into the experimental dental care market.

Monitoring the experiment: contested observations

In January 2012, dental care prices were liberated. At that time, the hypothesis that prices were going to rise – as put forward by the Dutch Patient Federation in the prelude to the experiment – had received much media attention (NOS 2011; Powned 2011). Consequently, various media investigated developments as soon as pricing was liberated. They compared price lists and reported huge differences between dentists (NOS 2012a). These media reports put pressure on Minister Schippers and she asked the NZa to conduct two quick scans in January and February 2012 to 'officially' monitor initial price developments (NZa 2012a).

The NZa analyzed 183 price lists published on dentists' websites and compared them to what treatment would have cost in the old system. This was difficult because most of the 400 price indicators of the old system had been conflated into 150 new indictors (in working towards content transparency). In the process, some old indicators were lost, while others were merged, or newly introduced. Consequently, the 150 new indicators could hardly be considered the sum of the old (NZa 2012a). Nevertheless, the NZa focused on the 36 most comparable products and concluded that dental care had become more expensive by 4 per cent (NZa 2012a: 13). The NZa pointed to the space for errors in comparing 2011 to 2012 based on two different systems and a limited range of products (NZa 2012a) and advised waiting for the first quarterly market scan, which would also consider developments in transparency, consumer satisfaction and stakeholders' roles (NZa 2012b).

In the first quarterly market scan (NZa 2012b), the NZa reported positively on the development of quality indicators; these were almost ready for implementation. They also reported positively on transparency developments in price and content. Most clinics had a website and presented the price list in their waiting rooms. However, the NZa also concluded that prices had gone up by 9.6 per cent. Again, the NZa stressed the space for errors due to the conflation of price indicators. In the accompanying policy letter, the NZa therefore emphasized that its findings needed to be interpreted with caution (NZa 2012b).

The NZa's market scans became a subject of debate. The professional organizations contested the price rise. The NZa was 'comparing apples to oranges' due to the conflation of the indicator system (chair of a professional organization, interview 2015). The professional organizations did notice that:

> '*For the first time, patients were informed of price and content in waiting rooms and on websites. The experiment furthermore created lots of dynamics. Dentists started giving five-year warranties, something that could never have happened in the regulated system.*' (chair of a professional organization, interview 2015)

The NZa, professional organizations and media were not the only ones monitoring the effects of the experiment. It was also under the scrutiny of other actors. On 1 June 2012, the Dutch Consumer Organization released a report of a test they had conducted at various dental clinics on the possibility for consumers to undergo just one treatment – placing a crown. Calling on 500 dentists, they discovered that 75 per cent of these dentists were unwilling to accept a new patient for only one treatment. In 44 per cent of the cases, providers were willing, but only if the newcomer became a regular patient (Dutch Consumer Organization 2012a). Drawing from an economic theory that prices are controlled by the mechanisms of supply and demand, they concluded that 'the market can only be successful when enough providers want to compete and when consumers are looking for better or cheaper care' (Dutch Consumer Organization 2012a). Because the first were unwilling and the latter were unable to do so, they concluded that the market experiment *failed* (Dutch Consumer Organization 2012b).

The professional organizations responded by stressing that shopping around for the cheapest provider would highly endanger the quality of care in dentistry.

> '*A mouth has 28 teeth and all of them are related to one another. If you want to make a good long-term plan for them, you need one director.*' (chair of a professional organization, interview 2015)

We stress that, even though the NZa was formally assigned to monitor the experiment, monitoring and particularly also the valuing of the revealed effects was done by multiple actors, most notably professional organizations, consumer organizations and the media. Notwithstanding this plurality of observers, we identified two ways in which the preliminary effects of the experiment were revealed and valued. The first placed great emphasis on the rise in prices and lack of opportunity for consumers to swap dentists in search of better or cheaper care. Actors following this line concluded that introducing free pricing had failed. The second placed the emphasis on the positive effects of price liberalization, such as transparency in price and content, as well as the introduction of five-year warranties on services provided. Actors following this line concluded that free prices triggered several interesting developments worthy of further exploration. What to do with such contested observations, interpretations and judgements?

The formal periodic evaluation of the experiment in the House of Representatives

In the spring of 2012, the Dutch political landscape changed dramatically. The three coalition parties – Liberal Party (VVD), Christian Democrats (CDA) and Dutch Freedom Party (PVV) – failed to agree on an austerity program to meet the 2013 maximum government deficit of 3 per cent as ruled by the European Union. The coalition fell apart on 23 April 2012 and Schippers became the outgoing Health Minister (NOS 2012b). This had consequences for the support of the experiment in the House of Representatives, which became evident in the prelude to the first formal periodic evaluation of the experiment. A PVV representative said:

> '*It's a very simple sum: not enough suppliers and a great demand, so prices go up. In times of crisis that shouldn't be the case.*' (Agema 2012)

The (former) opposition representatives realized that almost a year after they had introduced their previous resolution, a new vote in the House of Representatives could stop the experiment. One representative reflects:

> '*Because the coalition lost the PVV, they no longer had a majority supporting the experiment. That gave us the chance to kill it*.' (interview 2015)

Drawing the same conclusion as the Dutch Consumer Organization – that the market had *failed* because of quality transparency and the rise in prices – on 5 July 2012, opposition representatives framed a resolution against the experiment:

> '*The experiment with free pricing in dental care has failed. Prices have risen tremendously for patients, there is no freedom of choice and still no transparency in quality.*' (Kuiken 2012)

In 'capital P politics', specifically in doing opposition work, using the word *failure* was very successful. The word was already embedded in the hypothesis formulated by the Dutch Patient Federation in October 2011, made explicit by the Dutch Consumer Organization in June 2012 and repeated by opposition representatives in July 2012. Failure – and the logic of containment and guardianship that it stemmed from – resonated strongly in the House of Representatives. It was used for one purpose, to find support for cancelling the outgoing Minister's introduction of free pricing arrangements in dental care.

Although Schippers questioned the premature establishment of failure, emphasized learning and called for patience and careful decision-making (Schippers 2012), the resolution was supported by a close but clear majority: 78 against 72 votes (Kuiken 2012). As a result, Schippers was politically forced to cancel the experiment after only six months, 2½ years before its planned ending. An opposition representative (personal communication, 17 June 2015) reflected:

> '*It would've been neater if we'd given the experiment more time to unfold. But that's not how things always go in politics. We weren't there for good governance. Rather, we were there for politics*.'

Although this citation underlines the impact that capital P political life can have on the evaluation of experimentation processes, we want to stress that this political act during the first formal periodic evaluation of the experiment in the House of Representatives had an effect only because it drew on specific conceptualizations of the experiment and market.

How and what did we learn from this policy experiment?

We described different logics about markets and the experiments, through which the effects of the experiment were revealed and valued in different ways. We also showed how these logics, together with capital P politics, informed the evaluation process. Notwithstanding the politics and contestations, a lesson was learned from the experiment that has since become 'taken for granted'. Below, we recapitulate how that lesson emerged.

In the course of the experiment, two lines of thinking reinforced one another and were reproduced and stabilized concurrently: (I) the market was approached as a system to be guarded and (II) the experiment was a test to reveal whether or not the market could be contained. These lines fit well with the first approach towards policy experimentation and evaluation described in our theoretical section. Here, the experiment is considered a time-space in which a predefined policy intervention is tested under controlled circumstances and in which the role of evaluation is geared towards *ex post* measuring of impact and valuing such measured impact by relating it to predetermined program objectives (Greenberg and Morris 2005; Wolpin 2007; Ludwig et al. 2011).

In the case of the dental care experiment, actors following these tester and guardian logics (a) stressed the lack of preconditions, (b) put forward a skeptical hypothesis that price rises were inevitable, (c) placed much emphasis on measuring price developments in the initial stage of the experiment and (d) deemed such rising prices undesirable. Together, these guardian (I) and tester (II) logics prompted ad hoc measurement of pricing at the start of the experiment and framed how its results should be interpreted *ex post*; as proof that the dental care market could not be contained (cf. Muniesa and Callon 2007).

The reproduction of the tester and guardian logics were advanced by the dramatic change in the political climate during the experiment. Opposition representatives who had interpreted the liberal Minister's introduction of experimental free pricing as 'just another way to push things through', now saw an opportunity to halt that process. Drawing from guardian and tester logics, they stressed measured price rises, connected them to absent preconditions, and called for capital P political intervention. On the way, they managed to convince a majority in the House of Representatives to cancel the experiment.

Meanwhile the lack of transparency in quality – as a control mechanism – was put forward as the main reason for the rise in prices and the failing dental care market. Consequently, quality transparency, treated in 2009 as an in-growth condition by the NZa, became a vital precondition for market liberalization. The failed experimental dental care market became a critical example of that lesson learned (Varkevisser 2012). Three years later, Minister Schippers pronounced 2015 as 'the year of transparency' and developing quality transparency turned into a key objective for the healthcare sector (Schippers 2015).

As the importance of quality transparency grew from the main lesson learned, the idea that markets need to be created and that experiments should be considered as time-spaces to learn how to do this – in line with the second approach to policy experimentation and evaluation discussed in our theoretical section (cf. Martin and Sanderson 1999; Regeer et al. 2009; Arkesteijn et al. 2015) – became overshadowed. The positive effects revealed by the professional organizations – for example, that for the first time patients were being informed about the price and content of dental treatments and that new products and services were being released on the dental care market – were ignored (Schippers 2012). In addition, the ideas that observed effects were part of an *ex durante* evaluation process and that undesirable effects could be corrected, were also ignored. The professional organizations therefore concluded that their experiment had been nothing more than a political ball game and their trust in policy development and politics was severely damaged (representative of a professional organization, interview 2015).

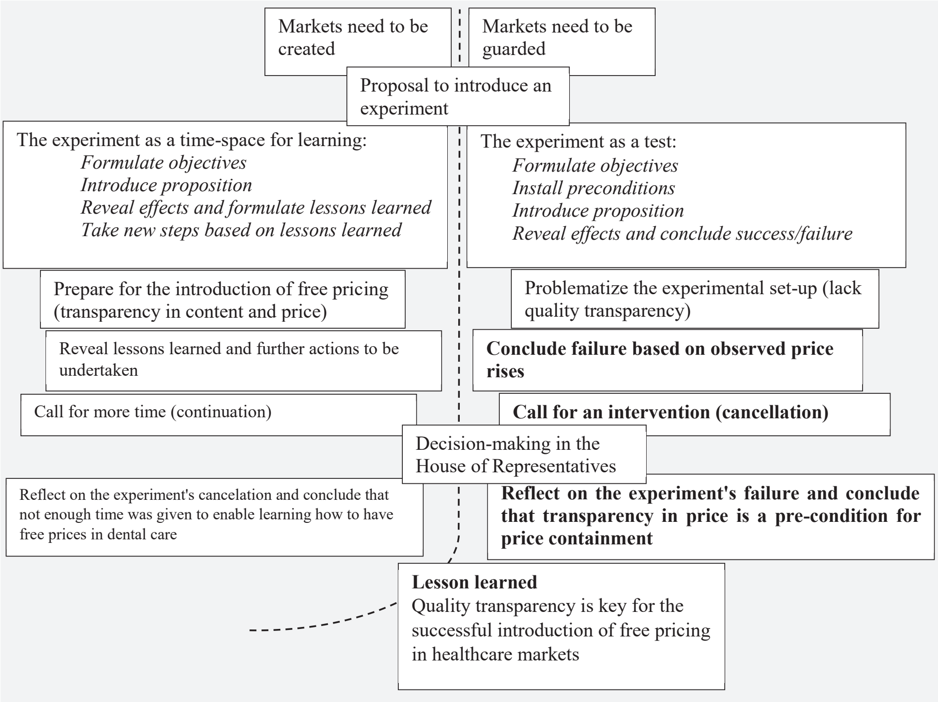

Figure 8: *A politics of policy learning*

Figure 8 captures the *politics of policy learning* and how the two logics concerned created the conditions for one another to be reproduced and stabilized. The dotted line represents the schism between the two lines of thinking about experiments and markets that developed during the progress of the experiment.

Discussion

In this paper, we fleshed out various market and experimental logics entrenched in a single policy experiment. Based on these insights, we would like to close with an epistemological and a methodological point for further discussion about the role of evaluation in policy experimentation. We discuss them in turn.

Reconstructing the experiment in Dutch dental care enabled us to reveal how the different market and experimental logics were, in concurrence with evaluation and capital P politics, implicated in (a) each other's reproduction and (b) which insights were taken as starting points for further action. In the process, some concurrent logics informed the lessons learned, while others were forgotten. Other authors have also observed various ways in which the effects of an experiment are valued and have pointed at the relevance of adopting constructivist approaches in the organization and evaluation of policy experiments (Martin and Sanderson 1999; Arkesteijn et al. 2015). In policy experimentation and its evaluation, multiplicity has become an accepted concept (Martin and Sanderson 1999; Sabel and Zeitlin 2012). However, even in these constructivist approaches, the experiment itself is often still considered a singular, productive entity; a time-space that can (a) bring stakeholders with different views together and (b) reveal effects to which different meanings can be ascribed (Regeer et al. 2009, 2016; Sabel and Zeitlin 2012; De Wildt-Liesveld et al. 2013; Arkesteijn et al. 2015).

Reconstructing the policy experiment in dental care, we actually observed two experiments unfolding at the same time, in two distinct epistemological spheres. In the first, an experiment was used to test if the dental care market could be contained. In the second, an experiment was used to create a protective time-space where stakeholders could reflexively learn how to have free prices. We therefore underline that policy experiments can be just as multiple as the worlds they are supposed to bring together; the latter in line with the experimentalist governance and reflexive evaluation literature (Martin and Sanderson 1999; Sabel and Zeitlin 2012). Instead of situated between different worlds and accommodating multiple logics, policy experiments can become fragmented and contested; reproducing and being reproduced by the multiple logics and practices they are supposed to accommodate (Luhmann 1996; Fuchs 2001; Van Assche et al. 2014).

For a while in the dental care experiment, two approaches were reproduced simultaneously, but not concurrently. In one approach (market creator), the experiment was a formative timespace for reflexive learning on how to introduce and stabilize certain propositions. In the other approach (market guardian), the experiment was a summative test to see if the introduced proposition functioned properly. Yet after the results of the first round of monitoring were evaluated in and beyond the House of Representatives, one approach could no longer exist beside the other. After all, in the summative testing logic, the monitors had proven that the dental care market could not be contained and the experiment was finished. Those who saw the quarterly monitor as a first formative stage in a continuous trajectory of *ex durante* evaluation and reflection were unable to counter this *ex post* and summative judgement.

As we demonstrated, both approaches informed policy learning in distinct ways (see figure 8). We cannot predict what would have happened if the experiment had continued for the planned three years. Maybe the diversification of products in dental care would have continued, instead of lapsing back to the previous situation. Maybe the development of quality indicators would have been finished. Both developments might have triggered the further stabilization of free prices, feared by left-wing opposition representatives and theorized about in the performativity literature (Mackenzie et al. 2007). Most likely, the professional organizations in dental care would have been less alienated from policy development and politics than is now the case.

Taking into account the different directions of learning that different policy experimental approaches produce, evaluating policy experiments should therefore include reflection on the *politics of policy learning*. This means being sensitive to the logics and practices through which the experiment is conceptualized, operationalized, implemented, observed and evaluated by the various actors involved; and the exclusionary starting points for further action that these different logics and practices generate. We are therefore sympathetic to scholars who call for a more engaged role of evaluation in policy experiments (Martin and Sanderson 1999; Regeer et al. 2009; Van Mierlo et al. 2010; Arkesteijn et al. 2015). However, we warn against (a) *a priori* readings of policy experiments as a protective space for reflexive learning, and point out (b) the various directions of learning that summative and formative approaches may nurture (see figure 8).

In addition to the principles and insights developed in the reflexive evaluation literature (Regeer et al. 2009; 2016; Van Mierlo et al. 2010; Arkesteijn et al. 2015; cf. section two of this paper), we propose that evaluators should address four basic questions, in dialogue with the involved actors, including policy makers and politicians, at repetitive stages during the unfolding experiment. These are: (1) what kind of experiment is it? (2) what is the object of experimentation? (3) what role does evaluation have in the experimentation process? and (4) what are we learning and how does that relate to the first three questions? While answering these questions, particular attention should be paid to the logics with which the actors observe, describe and value the experiment, its objective and (preliminary) results. In order to do so, evaluators should be sensitive to the distinctions, observational procedures, conceptual mappings and causal inferences furthered by the participating actors, including themselves.

It is through such reflections on the *politics of policy learning* – not only on the object of experimentation, but also the logics of experimentation and how these imply one another – that insight can be gained into the *how* and *why* of *what* we learn from policy experiments. We are convinced that answering these questions not only provides insights into paths of learning, but also functions as an important strategy to align the ways in which an experiment is observed and valued by the various actors involved (cf. Geels and Schot 2007; Van Mierlo et al. 2010). It provides possibilities for stakeholders to reflect on their own and be aware of others' approaches to the experiment. Only through such reflection can we better understand, not only what we learn from a policy experiment, but also give words to and come to terms with, what is lost in the process (Butler 2010; cf. Regeer et al. 2009; Arkesteijn et al. 2015).

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5

Together alone: organizing integrated, patient-centered primary care in the layered institutional context of Dutch healthcare governance

Published as: Felder, M., Van de Bovenkamp, H. M., Maaijen, M. M. H., and de Bont, A. A. (2018). Together alone: organizing integrated, patient-centered primary care in the layered institutional context of Dutch healthcare governance.

Journal of Professions and Organization, 5(2), 88-105.

Abstract

We aim to better understand the dynamic between professionals and institutions by scrutinizing how professionals conduct institutional work in a layered institutional context. To date, institutional scholars have either studied professionals or institutions as objects of maintenance or change. Here, we suggest an alternative 'relational' and 'evolutionary' interpretation of the relation between institutions and professionals. We do so by introducing a two-dimensional analytical framework. We illustrate the relevance of this framework by analyzing a policy implementation program called 'Primary Focus'. This program sought to improve the provision of integrated and patient-centered primary care by organizing multidisciplinary collaboration. Progressing through various forms of institutional work, we describe how professionals internalized the principles of 'patient-centeredness' and 'multidisciplinary collaboration' and set out to reach program objectives. We reveal that, while professional identities, roles, and positions were changing in the program, professional boundaries were reproduced. In the process, patient-centeredness turned from a shared objective into a contested professional quality. Consequently, the program did not lead to the new organizational formats that policymakers had been aiming for. Our two-dimensional approach allows us to explain how this happened and why professionals had literally been working together alone.

Keywords: healthcare professionals; multidisciplinary collaboration; institutional work; institutional layering

Introduction

Classically, institutional theorists scrutinized how institutions, as relatively stable sets of practices and rules, steer particular patterns of behavior (March and Olsen 1998; Lowndes 2010; Scott 2014). This static, linear and top-down reasoning has largely been abandoned and in its place, two alternative lines of inquiry have gained prominence. In the first, scholars problematize institutional stability and set out to understand how institutions change over time. These scholars pay particular attention to the process in which new institutional arrangements are introduced on top of preceding arrangements. This process creates a 'layered' or 'complex' institutional environment (Mahoney and Thelen 2010; Smets and Jarzabkowski 2013; Van de Bovenkamp et al. 2014; 2017). In the second line of inquiry, scholars question the deterministic nature of institutions. These scholars seek to understand how actors—institutional agents—purposively and intentionally create, maintain or destroy institutional arrangements in order to create or maintain privileged institutional positions and roles. They conceptualize such activities as 'institutional work' (Lawrence and Suddaby 2006; Lawrence et al. 2009; Currie et al. 2012; Muzio et al. 2013; Wallenburg et al. 2016a).

Although both concepts of 'institutional layering' and 'institutional work' have received extensive scholarly attention over the past decade, far less attention has been paid to the connections between the two (Jarzabkowski et al. 2009; Smets and Jarzabkowski 2013). In fact, only recently has attention shifted towards understanding how institutional agents work with (in) layered, complex institutional environments (see e.g. Smets and Jarzabkowski 2013; Van de Bovenkamp et al. 2014; 2017). We aim to contribute to this nascent field by focusing on the institutional work conducted by professionals in the layered institutional context of healthcare governance.

We argue that a better understanding of how healthcare professionals relate to their layered institutional contexts through institutional work is important for three reasons. Firstly, many national healthcare systems have layered new institutional arrangements on top of existing ones. One example is introducing market mechanisms beside continued professional self-regulation (Van de Bovenkamp et al. 2017). Secondly, 'institutional layering' has significant consequences for the identity, role and position of healthcare professionals (Freidson 1973; Dwarswaard 2011; Wallenburg 2012; Berwick 2016;). For instance, professionals are institutionally encouraged to compete with one another, while still needing to comply with professional standards. Thirdly, institutional layers enable—or force–professionals to relate to different institutional arrangements at different times and for different reasons (Smets and Jarzabkowski 2013; Van de Bovenkamp et al. 2014; 2017; Bévort and Suddaby 2016). Capturing how professionals relate to and work with different institutional arrangements therefore complements our understanding of the complex dynamic between institutions and professionals. Moreover, it offers insight into the often unanticipated social realities shaped through these interactions (Lawrence et al. 2013; Smets and Jarzabkowski 2013; Van de Bovenkamp et al. 2014).

To reveal the dynamic between professionals and their layered institutional contexts, we focus on primary care in the Netherlands. Here, between 2009 and 2015, the Dutch implemented a national policy program called 'Primary Focus'. The program stimulated professionals to develop new organizational formats for the provision of integrated, patient-centered care (ZonMw 2009; 2015). The program was introduced on top of—or next to—the market-based healthcare system introduced in 2006. In turn, the market-based system was introduced on top of the traditional regulatory formats of professional self-regulation and top-down regulation by the state (Helderman et al. 2005; 2012; Van de Bovenkamp et al. 2017). Informed by the literature on institutional work and layering, we answer the following research question:

> *How did participating professionals work on new organizational formats for the provision of integrated, patient-centered care in the layered institutional context of Dutch healthcare governance?*

In the next section, we further develop the concepts of 'institutional work' and 'institutional layering' and define a two-dimensional analytical framework for studying their interrelations (cf. Wells et al. 2002). This framework supports a more relational and evolutionary approach towards interpreting institutional work with (in) layered institutional contexts (Smets and Jarzabkowski 2013; Zundel et al. 2013; Van de Bovenkamp 2014). Thereafter, we present our empirical reconstruction of the Primary Focus program. We describe how different professionals collaborated in the development of new organizational formats for the provision of integrated, patient-centered care; particularly so by constructing digital referral systems. We furthermore highlight how, at the same time, patient-centeredness turned into a contested quality, claimed by participating professionals who wanted to position themselves between patients and other providers in these referral systems under construction.

Theoretical framework: a two-dimensional approach to capturing institutional work with (in) a layered institutional context

Institutional theory has long aimed to understand the role of formal, explicit structures in constraining and enabling the rational behavior of institutional subjects (Scott 1987; 2014;

Lowndes 2010). In this line of enquiry, 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: 190) This reading of institutions stimulated research into the processes through which institutions (re)produce meaning and govern practices (March and Olsen 1995; Scott 2014). Here, institutions were – and continue to be – considered to help understand, structure and steer the world around us.

In response to defining institutions as 'stable' collections of rules, some scholars have started scrutinizing how institutions change over time (Mahoney and Thelen 2010; Van de Bovenkamp et al. 2014; 2017). They have observed that institutional arrangements rarely stay stable, neither are they abruptly and entirely replaced by others (cf. Gersick 1991; True et al. 2006). Instead, new institutional arrangements are often introduced on top of – or next to – preceding institutional arrangements. Mahoney and Thelen (2010) have conceptualized this process as 'institutional layering'. In a similar vein, Greenwood et al. (2010; 2011) and Smets and Jarzabkowski (2013) have coined the presence of multiple, sometimes contradictory institutional logics as 'institutional complexity'. Examples are the different combinations of regulatory arrangements in the governance of care. Here, in many countries, professional self-regulation has been complemented with market mechanisms, consultation and state-based regulation (Smets and Jarzabkowski 2013; Van de Bovenkamp et al. 2014; 2017).

Scholars interested in the consequences of institutional layering have observed that the effects of institutional layering depend on the way in which institutional actors, such as professionals, interpret and reproduce different arrangements in different situations and for different reasons. This observation has driven these scholars to connect the concept of 'institutional layering' to the literature on 'institutional work' (Smets and Jarzabkowski 2013; Bévort and Suddaby 2016; Van de Bovenkamp et al. 2017).

The 'institutional work' literature stems from a practice-oriented reading of institutions and institutional change (Cetina et al. 2005). It problematizes the notion that institutions 'steer' the behavior of institutional subjects (DiMaggio 1988). It stresses that the way in which institutional arrangements structure the world around us, depends on the way in which they are introduced, interpreted, applied and (re)worked by institutional actors (Battilana 2006; 2011; Lawrence and Suddaby 2006; Suddaby and Viale 2011; Muzio et al. 2013; Wallenburg et al. 2016a). Many of these studies focus on work conducted by healthcare professionals (e.g. Suddaby and Viale 2011; Currie et al. 2012; Wallenburg et al. 2016a). In these studies, professionals are not only the targets of institutional change, but also the key agents in bringing about change (Cetina et al. 2005).

To underline the agency of institutional actors, Lawrence and Suddaby (2006) have described 'institutional work' as '*the purposive actions of individuals and organizations, aimed at creating, maintaining or destroying institutions*' (Lawrence and Suddaby 2006: 215). Institutional work scholars therefore typically approach professionals as reflexive, goal oriented and capable (Lawrence et al. 2013); as '*foresighted actors who envisage desirable institutional arrangements and pursue them through planned change*' (Smets and Jarzabkowski 2013: 1282). Desirable institutional arrangements, in this line of inquiry, are institutional arrangements that support or improve the institutional position of the actor doing the institutional work (cf. North 1990; Fligstein 2001).

To capture the activities of actors purposively creating or maintaining institutions, Lawrence and Suddaby (2006) developed a framework which identifies and illustrates various forms of creation and maintenance work (see table 4; for a more detailed description of the different kinds of institutional work, Lawrence and Suddaby 2006: 221–230). Examples of institutional 'creation work' are the construction of new networks, network identities, the (re)defining of boundaries, the formulation of criteria for membership, as well as changing norms and belief systems. Such work is typically and purposively performed by the institutionally underprivileged. After all, building new networks and network identities as well as institutionalizing new norms and belief systems provides the potential to adopt new roles and improve one's professional position. Examples of institutional 'maintenance work' include ensuring compliance through policing, embedding activities, and making them routine. Valorizing traditional institutional outcomes and demonizing new institutions and their outcomes are also categories of maintenance work. All categories of maintenance work focus on the reproduction of traditional institutionalized norms and belief systems. Maintenance work is therefore typically performed by institutional elites who want to protect their privileged positions (cf. Lawrence et al. 2009; Currie et al. 2012).

When we aim to connect the literature on institutional work and institutional layering, we need to address three related analytical problems (see specifically, Lawrence et al. 2013; Smets and Jarzabkowski 2013; Zundel et al. 2013). Firstly, most institutional work scholars focus on identifying some form of intended, planned action related to the improvement or maintenance of a particular institutionalized position. This focus has resulted in an ever-increasing list of institutional work categories that represent rather singular and linear actor-institution dynamics (Lawrence et al. 2013). However, these studies do not capture how professionals simultaneously respond to and work with different institutional arrangements (Currie et al. 2012; Smets and Jarzabkowski 2013). Secondly, most studies are based on retrospective data, for instance, interviews in which actors look back on and give meaning to past actions and their outcomes (Lawrence et al. 2013). This tends to reproduce narratives of strategy, choice, and projective agency. The problem is that improvisation in the moment and coping with a changing institutional environment remain out of sight (Smets and Jarzabkowski 2013; Bévort and Suddaby 2016). Thirdly, because most institutional work studies focus on revealing and classifying the purposive actions of institutional agents, institutions are usually taken as the object of change or maintenance, thus ignoring or overlooking changes on the level of the institutional agents themselves (Hwang and Colyvas 2011; Lawrence et al. 2013; Zundel et al. 2013).

On the basis of these analytical problems, Smets and Jarzabkowski (2013) conclude that '*we lack differentiated, dynamic and empirically grounded understanding of how different modes of agency unfold as actors develop and realize their interests in particular institutional settings.*' (Smets and Jarzabkowski 2013: 1282) Therefore, they call to reconnect '*the macro world of institutions with the micro world of actors that populate them.*' (Smets and Jarzabkowski 2013: 1280) In a similar vein, Zundel et al. (2013: 103) call for '*relational [and dynamic] analyses of agents in context.'*

Informed by both these calls, we use a two-dimensional analytical framework to capture institutional work with (in) a layered institutional context. The first dimension is the layered institutional context into which the Primary Focus program (our case study) was introduced. Here attention is paid to the different institutional arrangements and governance principles in place, as well as those introduced by the Primary Focus program. The second dimension is how professionals related to and worked on the governance principles and program objectives stressed in Primary Focus and its broader institutional context, while simultaneously taking into account their own professional positions. In this second dimension, special attention is paid to planned action, improvisation, coping and responsiveness (Smets and Jarzabkowski 2013). In the following section, we describe the methods used to study these dimensions and the relations between them.

Methodology

This section introduces our case study, the Primary Focus program and describes the methods used. The section closes with a detailed description of the two-dimensional analytical framework used to study institutional work in a layered institutional context.

Case study

The restructuring of the Dutch healthcare system is an interesting setting to study professionals in a layered institutional context because several major policy changes affected them over the last two decades. In 2006, the government introduced market mechanisms on top of professional self-regulation and state regulation (cf. Helderman et al. 2005). In this market-based system, health insurers would represent their insured clients in negotiations with professionals on the price, content and quality of the provided care (ZvW 2006). An important aim of the reform was to create more competitive, demand-driven care attuned to the wishes of patients (or health care consumers in terms of the market). Consequently, professionals lost a certain amount of regulatory control over the provision of care. Now they had to negotiate with insurers on the volume, price, and quality of care provided. At the same time, they were encouraged to compete with one another and adapt their services to meet the critical demand of patients (ZvW 2006; cf. Helderman et al. 2005). Yet, even though market mechanisms were introduced, professional organizations continued to exercise control over the content of care and the state continued to monitor quality and safety. What emerged was a layered institutional context in which professional self-regulation, state regulation, and market regulation complemented one another (cf. Van de Bovenkamp et al. 2014).

The Primary Focus program was introduced three years after the market-based system was introduced. It resulted from a vision document written by the Dutch Minister of Health, in which he signaled the fragmentation of healthcare services in the primary care sector (Klink 2008). To counter this fragmentation, the program specifically sought to stimulate the development of new organizational formats for the provision of integrated primary care. The program coordinator, ZonMw, received a budget of €18,650,000 from the Ministry of Health to support 67 pilot projects. In these projects, diverse primary and secondary care professionals sought to develop new organizational formats for the provision of integrated primary care on a regional scale. The program was implemented between 2009 and 2015 (ZonMw 2009, 2015).

Data collection

The third and fourth authors of this paper were involved in the Primary Focus program as researchers. They were part of an interdisciplinary research group, commissioned by ZonMw with the task of evaluating how and to what extent participating professionals had successfully managed to attain the objectives of the program. They did extensive fieldwork on eight of the 67 funded projects (SMOEL 2015). To examine closely how professionals worked towards the new organizational formats for providing integrated primary care, we elected to focus on two of these projects for two reasons. Firstly, the digital records of these projects include transcripts of interviews with a variety of participating professionals (N=17), detailed fieldnotes on project meetings and workshops (20 hours), project proposals (N=2) and progress reports (N=8) (Table 1). Such variety in data was not available for all the projects. Secondly, in both projects, a relatively diverse but comparable group of professionals was working on reorganizing the regional provision of care. Both projects included professionals from primary care (such as general practitioners, midwives and physiotherapists) and secondary care (specialists and hospital managers).

The first project, called MuON (Multidisciplinary Oncology Network), sought collaboration between primary and secondary care providers in the treatment of cancer (MuON mission statement 2009). Actors considered part of the core group of this project were the oncology department of a regional hospital, an oncological patient counseling organization and several physiotherapists, general practitioners as well as a patient representative. The second project, PCS (Pregnancy Center Stage), also sought collaboration between primary and secondary care providers, but this time in the provision of pregnancy care. Actors considered part of the PCS core group were six regional midwiferies, the regional hospital and its clinical midwifery department.

Secondary analysis

Notwithstanding the third and fourth authors' closeness to the projects, we argue that our two-dimensional inquiry into the Primary Focus program and the two projects it funded, can best be read as a secondary analysis of the data. Secondary analysis is distinct from document analysis in that it includes non-naturalistic data such as interviews and field observations, in contrast to naturalistic data such as autobiographies, personal diaries, or photographs (Heaton 2008). There is an ongoing debate on how to interpret results of a secondary analysis. It is considered useful when new research questions are based on previously collected qualitative data (Boslaugh 2007; Heaton 2008; Hinds et al. 1997). In our case, we re-used qualitative data—gathered during the unfolding of the program in order to evaluate program results—to better understand institutional work with (in) a layered institutional context. Like most qualitative analysis, analyzing and interpreting pre-existing data meant constantly moving between the theory, our analytical framework, the database and the data collection context (Wells et al. 2002; Irwin and Winterton 2012). To do the last, the first and second authors involved frequently discussed the preliminary results with the third and fourth authors. To further validate our findings, we member- checked our reconstruction by sending it to the project leaders of the projects examined (Mortelmans 2007). The project leaders responded positively and had no additional suggestions or comments.

A two-dimensional analytical framework

To gain insight into how professionals participating in these two projects worked on new organizational formats in their layered institutional context, we further operationalized the dimensions presented at the end of the theoretical framework. For Wells et al. (2002), multidimensional analytical frameworks are useful in order to track the dynamics of policy reforms in complex institutional contexts. In our case, this meant (I) mapping the layered institutional context and objectives of the Primary Focus program and (II) gaining insight into how professionals related to the program objectives and worked towards meeting them. In the following passages, we describe how we analyzed these two dimensions (for a schematic summary, see table 3).

Table 3: *Operationalization of our multidimensional analytical framework*

Dimensions of analysis	Object of analysis	Data analyzed
Dimension 1: Institutional layering	Regulatory arrangements and governance principles emphasized in the Primary Focus program	Primary Focus program text (N=1)
	Regulatory arrangements and governance principles to which the Primary Focus program related	Additional policy documents (N=5)
	Regulatory arrangements beyond the Primary Focus program, but part of the institutional context of participating professionals	Interviews with professionals (N=17)
Dimension 2: Institutional work	The operationalization of the Primary Focus program into regional projects	Project proposals (N=2) Progress reports (N=8) Interviews with professionals (N=17)
	Work done related to professional interests (roles and positioning)	Interviews with professionals (N=17) Field observations (20 hours)
	Outcomes of the work observed	Interviews with professionals (N=17) Progress reports (N=8) Formal program evaluations (N=2)

Dimension 1: To map the layered institutional environment into which the Primary Focus program was introduced, we began with document analysis. We were particularly interested in identifying the regulatory arrangements addressed and furthered by the program. We took the Primary Focus program text (ZonMw 2009) as a starting point and identified: (a) the related regulatory arrangements previously introduced; (b) the policy problem to which it responded; and (c) the regulatory arrangement underlying the proposed solution. In the process of identifying (a), (b), and (c), we identified five additional key texts that the program was building on. These included a vision document produced by the Dutch Minister of Health and several advice documents from a patient organization, the Dutch Healthcare Inspectorate and policy research institutes. For our analysis of these additional texts, we again used (a), (b), and (c) as codes. To map institutional arrangements beyond the program and its texts, but relevant to the participating professionals working with (in) the program, we relied on interview transcripts. We identified and coded: (a) additional regulatory arrangements mentioned; and (b) how the professionals related them to the work done in the Primary Focus program.

Dimension 2: To gain insight into how actors reacted to program objectives and worked towards reaching them, we revisited and analyzed project proposals and progress reports as well as semi-structured interviews and fieldnotes. We were particularly interested in three aspects of institutional work. First, how did professionals interpret and translate the program into project objectives. Here, the two project proposals and progress reports were of particular importance. We coded these texts, identifying (a) problem formulations; (b) mission and vision statements; (c) preliminary outcomes; and (d) new steps to be taken. Secondly, informed by the literature on institutional work, we were also interested in how the participating professionals worked on their profession-specific stakes while working on the collective program objectives. At this stage of our analysis, we relied on interview transcripts and field observations. Here, professionals sometimes directly voiced how they interpreted the projects and how they worried about—and worked on—their own roles and positions. To recognize the less outspoken forms of positioning work, we used Lawrence and Suddaby's (2006) institutional work framework as a sensitizing scheme (for a schematic representation, see table 4). Informed by this scheme, we analyzed the transcripts and fieldnotes on descriptions of activities that potentially flagged the conduct of institutional work.

Table 4*: Schematic representation of different forms of institutional creation and maintenance work (Lawrence and Suddaby 2006)*

Institutional work objective	Strategy	Specific actions
Creating institutions	Political work	- Vesting influence - Defining access - Gain advocacy
	Reconfiguration of believe systems	- Constructing identities - Changing norms - Constructing networks
	Altering the boundaries	- Mimicry - Theorizing - Educating
Maintaining institutions	Coercion	- Enabling - Policing - Deterring
	Normative	- Valorizing - Demonizing - Mythologizing - Embedding and making routine

Results: working with (in) the layered institutional context of primary care

This empirical section is structured according to our two-dimensional analytical framework. We first describe the layered institutional context of the Primary Focus program. Then we describe how the participating professionals related to the program and worked on new organizational formats and their positions in them. We have summarized our findings in figure 10.

Dimension 1: the Primary Focus program and its layered institutional context

To gain insight into the layered institutional context of Primary Focus, we describe the problem the program sought to solve, the new institutional arrangements through which it proposed to do so and the regulatory arrangements already in place on top of which the program was introduced.

A vision document on primary care by the Ministry of Health set the agenda for redesigning the sector. The Minister started his line of reasoning by celebrating the introduction of market mechanisms (Klink 2008). He observed that professionals had begun diversifying their services to gain competitive edge and that patients consequently had more opportunities to follow tailored care trajectories (Klink 2008). He also observed that professionals were becoming more specialized and differentiated. Classically, primary care was associated with services provided by the general practitioner. Now, the Minister stressed, nurse practitioners, specialist nurses, physiotherapists, midwives and neighborhood nurses had entered the domain of primary care by providing services outside the hospital [conceptualized as secondary care in the Netherlands (and elsewhere)].

Although this diverse group of care providers fitted the market model of competing healthcare providers, the Minister also observed a reverse side to this development: '*Primary care providers are working in organizational contexts in which they, detached from one another, focus on only part of the problem of a patient.*' (Klink 2008: 3) In instances where different providers are involved in care provision for a single patient – as in cases of multimorbidity – this inward-looking orientation led to various professionals treating only one aspect of a patient's problem (cf. IGZ 2007; RIVM and NIVEL 2005).

Although, the Minister gave no explicit reasons for the inward-looking orientation, he hinted at several causes throughout the vision document. Important examples are: (a) the financial stakes that influence the way in which specific professions hold on to patient and financial flows (Klink 2008: 3); and (b) a lack of emphasis placed on the development of interdisciplinary guidelines, in contrast to the ongoing development monodisciplinary guidelines (Klink 2008: 20). Some authors have pointed out the directive nature of these monodisciplinary guidelines for the provision of care (Van de Bovenkamp et al. 2014). They observe that individual professionals appear reluctant to divert from monodisciplinary guidelines, especially where inspectorates inspect the quality and safety of care, using norms and schemes informed by such guidelines (for a specific example in our case, see box 1). In an institutional environment in which inspectorates hold professionals accountable for the care provided, professionals thus tend to provide care in line with intra-professional standards instead of the patient's needs and/or wishes (Siu et al. 2015).

In his vision document, the Minister emphasized that fragmentation was frustrating the effective, affordable and patient-centered care that he was aiming for. Therefore, he reasoned, special attention should be paid to organizing cohesion between the primary care services (Klink 2008). To achieve integration, the Minister emphasized two governance principles. Firstly, he called on professionals to abandon their intra-professional orientation, to look beyond their competitive stakes and start collaborating with professionals from other disciplines on the provision of integrated care. He underlined this desired change with the principle of 'multidisciplinary collaboration' (Klink 2008). Secondly, the Minister stressed that in the market-based system, patients are expected to start acting as critical consumers. Yet, the Minister observed, they could not do this on their own. The primary care sector needed to help patients coordinate their personalized care trajectories. (Klink 2008). The sector should act as a compass for patient, by being sensitive to patients' needs and wishes and support patients' decision-making on what care to receive from which providers where and when (cf. NPCF 2009). The Minister underlined this with the principle of 'patient-centeredness'.

Following the Minister's vision document, the Dutch Ministry of Health asked ZonMw to develop and run a policy implementation program that sought to further substantiate the Minister's vision for the primary care sector. ZonMw translated the principles underlined by the Minister into the following program objective: 'To better meet the needs of care-users by strengthening multidisciplinary collaboration and coordination' (ZonMw 2009: 11). To achieve this collaboration, they funded 67 pilot projects. By monitoring these projects,

BOX 1 VOLUME NORMS IN PREGNANCY CARE.

The provision of Dutch pregnancy care had received much critique due to lagging quality and safety in comparison to neighboring countries in the year before the start of the PCS initiative (Stuurgroep Zwangerschap en Geboorte 2010). In response to this critique, new national health standards were being developed (Muijsers 2010). Standards that could not only be used for inspections (fitting state based and top down regulatory arrangements), but also as quality indicators to be used by critical consumers (more in line with market regulation). One of the standards discussed was the number of pregnancies that a hospital minimally needed to facilitate in order to be allowed to offer clinical pregnancy care. Several regional hospitals that facilitated pregnancies on a relatively low frequency, including the regional hospital featuring in our case study, were anxious that they would not meet such volume norms (Muijsers 2010). This, in turn, would not only affect the hospital but also the primary care midwiferies in the region. After all, these would no longer have a hospital in the proximity to turn to when the delivery turned problematic (Midwife, personal communication 2012). Both primary care midwives, hospital managers, and gynecologists therefore needed to rethink the role of the hospital and the midwiferies in the regional organization of pregnancy care.

ZonMw aimed to identify best practices in developing new organizational formats for the provision of integrated, patient-centered primary care (ZonMw 2009).

We can conclude from the above that the Primary Focus program was a product of a layered institutional context. It was introduced in response to the combined effects of different institutional arrangements. On the one hand, the primary sector was diversifying (an effect of the market). On the other hand, professionals continued to look inwards at the content of the to be provided care (effects of professional self-regulation and state-based regulation [inspectorates]). To counter the fragmentation stemming from the layered regulatory arrangements, the Minister introduced the governance principles ‘multidisciplinary collaboration’ and ‘patient-centeredness’ for the primary care sector (see also figure 10).

Dimension 2: working towards the organization of multidisciplinary, patient-centered care

Here, we focus on how the participating professionals interpreted the program and translated its objectives and underlying principles into collaborative pilot projects. We also show how they worked on their own positions, while working on the project objectives.

In the proposals submitted to ZonMw, the participants of the two projects stayed close to the principles ‘multidisciplinary collaboration’ and ‘patient-centeredness’, described by the Minister and emphasized in the Primary Focus program. The PCS initiative, for instance, framed their mission statement as:

> ‘[To organize] *multidisciplinary collaboration in the provision of pregnancy care in which the (pregnant) woman and her (unborn) child and possibly her partner, take center stage. Together the different professionals provide customized care. The pregnancy care professionals (midwives in primary care and gynecologists in hospital care) will act as case managers in this process. This is how the best possible care can be provided at home when possible and in the hospital when necessary.’* (project proposal 2011: 5)

The MuON initiative had similar objectives. Here, however, extra attention was placed on the self-management abilities of patients (MuON mission statement 2009). PCS and MuON followed two strategies to achieve multidisciplinary collaboration and ensure that patients were put center stage (figure 10).

Strategy 1: multidisciplinary referral systems

To capture multidisciplinary collaboration, participants of both projects proposed to develop a new referral system that professionals and patients could use to coordinate the integrated care trajectories. While discussing the form and content of these referral systems, participants in both MuON and PCS initiatives were particularly concerned with two related issues: (a) establishing an identity for the referral system under development; and (b) defining the system's inclusion and exclusion criteria.

In the MuON initiative, for instance, participants sought a collective identity that separated their multidisciplinary referral system from the messy reality of contemporary oncology care. Therefore, they proposed to develop an online environment that would include all the relevant care providers (MuON mission statement 2009). It would be a digital system that patients and professionals could use to gain an overview of the various kinds of oncological care available in the region. As one participating physiotherapist said:

> '*We* [the project members] *are concerned with questions like: 'if a particular kind of profession is necessary, why is it necessary? What accreditation do we need to establish whether somebody has the right to participate?' You see, if anyone could join, then we would end up with the same mess as before. And then, again, patients wouldn't know where they will end up. I think that physiotherapists are important contributors to the network; nursing and neighborhood care too. And in fact, the general practitioners and hospitals should be part of the network as well.'* (interview transcript 2013)

Professionals taking part in the MuON project agreed that there should be limits to the reach of multidisciplinary collaboration. They needed to formulate clear criteria, indicating who should be included or excluded from the referral system. However, while professionals were formulating such criteria, two things happened related to (re)confirming professional positions. First, most obviously, participating professionals placed their own contribution to the referral system beyond the question of doubt. For instance, the physiotherapist cited above emphasized that physiotherapists were important contributors and from thereon listed the relevant others. Secondly and more subtly, while formulating the inclusion criteria for relevant others, professionals reasoned from the perspective of how such a system could contribute to their own professional practice. A hospital manager in the MuON project, for instance, called the multidisciplinary referral system under development a comprehensive list that hospital workers could use to guide their patients to good supplementary care in the primary care sector. However, to ensure the quality of such care, the primary care professionals included in the list had to comply with hospital standards.

> '*In the case of homecare organizations we could ask, for instance, if they have oncology nurses on their teams, how many patients they would see, and what about their education levels, extra schooling and so forth? That also applies to the physiotherapists. We couldn't commit to letting any physiotherapist in, just because they say "I want to be in your network". Instead, we would look at their qualifications [e.g., BIG*

> *registered, special training]. And if these were good enough, they could join.'* (hospital representative, interview transcript 2013)

But while the hospital manager was stressing the hospital's perspective on inclusion and exclusion criteria, one patient representative (interview transcript 2013) was wondering:

> '*As soon as you choose to include only the providers registered on BIG [a registration that allows practitioners to use a legally protected title, belonging to their profession, in order to carry out certain reserved procedures], you let go of demand-driven care provision. This excludes the skin therapist, the creative arts therapist and the movement therapists. But some patients like to do painting after they've had an operation*.'

Working on developing a multidisciplinary referral system for patient-centered care, participants in the MuON project were clearly reasoning from the perspective of their own professions and were tinkering which other professionals could help them provide integrated, patient-centered care. We observed similar work in the PCS project. Here, professionals wanted to realize a protocolled, themed pregnancy care trajectory which included different professionals at different times for different services. In this initiative, primary care midwives identified which care problems manifested themselves in the region and assessed which 'other' providers in their locality could be considered relevant others at different stages of the pregnancy (Project document, news bulletin 2011). In so doing, primary care midwives established themselves as the first link in—or at the center of—the pregnancy care chain (figure 9).

Strategy 2: introducing patient-centered care providers

Besides organizing multidisciplinary collaboration, participating professionals also intended to operationalize the principle of patient-centeredness. Most participants in the MuON project, for instance, agreed that if patients were going to use the digital referral system to coordinate their own care trajectories, they would need guidance. In the words of a representative of the patient counseling organization (interview transcript 2013):

> *'Placing the patient central means that patients need to start managing their care trajectories themselves. That they should take control of that. The question is who should support them in that*?'

This stance closely mirrors the Minister's call for the primary care sector to act as a compass for patients (Klink 2008). It is, however, important to notice that by asking who should support patients in coordinating their own care trajectories, acting as a compass for patients

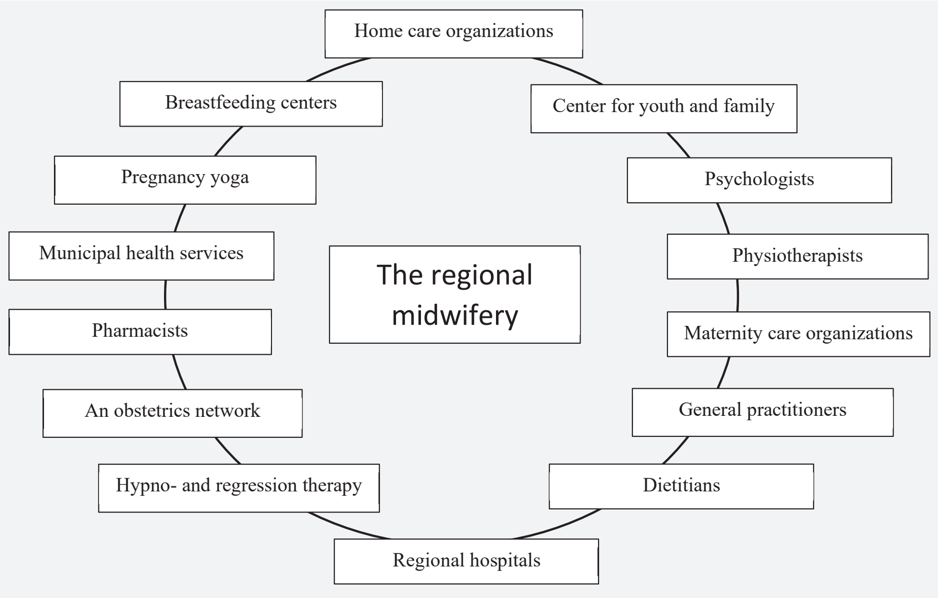

Figure 9: *Visual representation of the multidisciplinary pregnancy care network (http://dezwangerecentraal.nl)*

changed from a role ascribed to the primary care sector in general, into the specific role of a primary care provider. The Minister also addressed this issue in his vision document.

> '*At every moment it needs to be clear for the patient and the relevant healthcare providers who is responsible for the patient's care trajectory, to make sure that at least someone is responsible. Therefore, one professional in the healthcare chain needs to have an overview of the healthcare process of a patient*.' (Klink 2008: 11)

The Minister did not specify who this primary care provider should be. Yet for some participants, the question was easily answered. As a general practitioner, participating in the MuON initiative emphasized:

> '*As a general practitioner I get to know my patients well over the years. I know their history, how they react to things, you really get to know patients. . . Traditionally, the general practitioner gets lots of information from all sides. And traditionally, there is a moment of contact between the practitioner and the patient. Almost all referrals to secondary care are approved, or initiated, by the general practitioner. Every other line of care gets produced artificially after that*.' (general practitioner, interview transcript 2013)

Emphasizing his closeness to patients and his connection with other care providers, this general practitioner argued that his coordinating task was being threatened by recent developments in the primary care sector.

> '*That coordinating role is very important to me. These days, you see case managers pop-up everywhere. Some of them are positioned entirely outside of primary care. At least, outside the general practitioner's practice, like a home care organization that says "I can deliver case managers". Well I think it is fragmenting care. Case managers, fine, but why outside the general practitioner's practice? I am almost starting to see the home care organizations as competitors. Of course that's not accurate, I mean, they have their own qualities and identity, but they are getting in my way*.' (general practitioner, interview transcript 2013)

The general practitioner clearly questioned the capabilities of home care organizations to deliver case managers and emphasized that such work should be left to general practitioners. However, it is important to note that he did not necessarily resist the introduction of new institutional arrangements such as market mechanisms and state-initiated (re)organization programs. Instead, and as the next quote reveals even more clearly, the general practitioner aimed to maintain a central position in the provision of care in a changing institutional and organizational context.

> '*In my opinion it is a very good plan, a good vision, to organize multidisciplinary care groups. But then with the general practitioner at its core*.' (general practitioner, interview transcript 2013)

In the PCS initiative as well, professional positions were defended and called into question. In another example of emphasizing patient-centered selves, primary care midwives argued that helping patients to manage their own care trajectories fitted best with the qualities of primary care midwives, compared to those of general practitioners or gynecologists. After all, primary care midwives were more experienced in conducting anamneses and in coordinating pregnancy care trajectories (project meeting, 15 March 2012; see also figure 10).

> '*We could choose a model in which primary care midwives conduct all the case management. So midwives would see pregnant women who can and want to be treated at home by a primary care provider and those who want or need to go to the hospital (. . .) This way we can make sure that no pregnant woman unnecessarily ends up in secondary care*.' (project meeting, 15 March 2012)

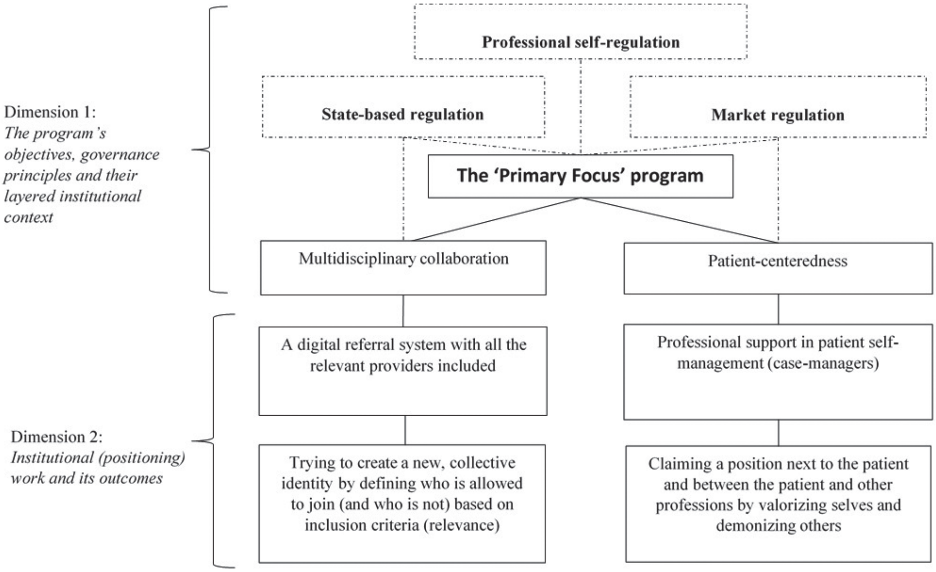

Figure 10*: Institutional work in the 'Primary Focus' program and its layered institutional context*

However, in response to discussions on the introduction of volume norms for hospital based pregnancy care (box 1), gynecologists and the regional hospital were also reconsidering their roles and positions. In an alternative organizational form proposed by the gynecologists, primary care midwives would become employees of the hospital and more deliveries would be carried out in the hospital (UVC 2016). One of the midwives was worried:

> '*They* [the gynecologists] *want to move into certain direction with pregnancy care. They want all first pregnancies to be delivered in hospital*.' (midwife, interview transcript 2012)

Another midwife interpreted this development like this:

> '*We don't want to be involved in the whole care trajectory and then arrange for the delivery to happen somewhere else [in the hospital]. That's not why I left the hospital and started working as a midwife in the primary care sector in the first place. I want to be there for the client throughout the whole process*.' (midwife, interview transcript 2012)

In the Primary Focus program, various professionals were defending, or claiming, a position beside the patient and between the patient and the other professions. They did so by emphasizing their own patient-centered qualities and problematizing those of others. And where multidisciplinary collaboration was organized through constructing a digital referral system (together), patient-centeredness itself became a quality claimed by the professionals who wanted to position themselves between the patient and the other providers in the referral systems under construction (alone). In this process, the principle of patient-centeredness turned from being a shared objective that could be achieved by organizing multidisciplinary collaboration (in line with ZonMw's program objective), into a contested professional quality. Participating in the organization of multidisciplinary collaboration for the provision of patient-centered care turned out to be also a (re)confirmation project of professional positions.

Discussion

In this article, we aim to better understand how healthcare professionals relate to their layered institutional contexts through institutional work. Reviewing the literature, we encountered three analytical problems. Firstly, many institutional work studies do not capture the layering of institutional arrangements. Secondly, most of these studies are based on retrospective data and fail to address improvisation and coping. Thirdly, institutional work studies focus on institutional maintenance or change, but changes on the level of institutional actors are overlooked (cf. Lawrence et al. 2013; Smets and Jarzabkowski 2013; Zundel et al. 2013; Van de Bovenkamp et al. 2014). To address these problems and reconnect the macro world of institutions to the micro world of professionals, we provided an analysis of agents in context. We used the Dutch Primary Focus program as our case study.

To identify the different institutional layers and different forms of institutional work, we deployed a two-dimensional analytical model. Analyzing our case, we identified multiple, sometimes contradictory institutional logics that participating professionals were dealing with (dimension 1). For instance, they needed to comply with professional standards (professional self-regulation), adhere to norms enforced by inspectorates (state-based regulation) and deal with the introduction of market mechanisms (market regulation) (Van de Bovenkamp et al. 2014). In this already layered institutional context, the Primary Focus program introduced two additional principles in the governance of care. These were 'multidisciplinary collaboration' and 'patient-centeredness'. Furthermore, we observed the participants performing different forms of institutional work (dimension 2). They performed institutional creation work by constructing new multidisciplinary referral systems and defining criteria for inclusion in and exclusion from these systems. At the same time, they performed institutional maintenance work, for instance, by defending and valorizing their own patient-centered qualities and demonizing others that appeared to do the same (Lawrence and Suddaby 2006).

However, when we aim to understand institutional work with (in) a layered institutional context, then insights from the two dimensions need to be interpreted in the context of one another as well. In fact, we argue that doing so allows us to reveal additional, complex actor-institutional dynamics that challenge current conventions put forward in the institutional work literature. We discuss two of these insights in turn.

Firstly, the way in which professionals interpreted some institutional arrangements, such as market mechanisms or volume norms, influenced the way in which they worked on other arrangements, such as the governance principles emphasized in the Primary Focus program. This is illustrated by the general practitioner and gynecologists who pondered over including home care organizations or primary care midwiferies as competitors, collaborators or even future employees in the provision of integrated and patient-centered care. In this light, professionals do not merely create or maintain institutions. Rather, professionals give meaning to new institutional arrangements and governance principles in the context of their interpretation of other institutional arrangements already in place.

Secondly, the maintenance work observed was not actually directed at upholding traditional institutional arrangements (e.g. valorizing traditional institutional arrangements and demonizing the new institutional arrangements that threaten them). In fact, the observed acts of valorizing and demonizing were more subtle and primarily directed at maintaining a central position in care provision in a changing institutional and organizational context (e.g. general practitioners, hospital managers and midwives defending their central and independent position whilst organizing multidisciplinary collaboration). To maintain a central position, these professionals embraced and participated in the bringing about of institutional change. In a complex, layered institutional context, creation or maintenance work can therefore not be reduced to the creation or maintenance of institutions. To maintain a professional position, one might need to move with and adapt to new institutional arrangements instead. This means working on the translation of new institutional arrangements, as well as working on one’s own role and identity in line with a changing institutional environment. In our case, professionals performed this balancing act by (a) developing multidisciplinary referral systems, whilst (b) adopting, internalizing, and defending the governance principle of patient-centeredness as their professional quality.

Our analysis of institutional work in a layered institutional context illustrates that being concerned with and working on one’s professional role and position can be affected by the introduction of new institutional arrangements. In turn, professional concerns about one’s professional role and position can be the sources of idiosyncratic translations and internalizations of institutional arrangements introduced (Zundel et al. 2013; Smets and Jarzabkowski 2013; Bévort and Suddaby 2016; Wallenburg et al. 2016b). Here, we want to stress that professionals participating in the Primary Focus program, interpreted and worked on the (new) governance principles introduced in the program in self-referential ways; thus in line with the conceptual and normative frames and interests already in place for each profession. Paradoxically, professional identities, roles and positions were changing, but professional boundaries were reproduced. Consequently, patient-centeredness, one of the central principles of Primary Focus, indeed easily turned from being a shared objective into a contested professional quality.

La Cour and Højlund (2013) have described such dynamics as structurally open and operationally closed (cf. Van Assche et al. 2014). With structurally open, they refer to the 'structural couplings' between professionals and their institutional environments. These couplings allow (new) principles, such as multidisciplinary collaboration and patient-centeredness to flow from policy programs to professional practice. With 'operational closure', La Cour and Højlund (2013) refer to how professionals observe and deal with such principles in their own profession' specific ways.

The structural couplings and operational closures in our case study underline a responsive interpretation of institutional work with (in) layered institutional contexts (cf. Zundel et al. 2013). As straightforward as this might seem, precisely this point is frequently overlooked in the institutional work literature. Especially where professionals are defined as '*foresighted actors who envisage desirable institutional arrangements and pursue them through planned change.*' (Smets and Jarzabkowski 2013: 1282) Or where institutional work is defined as '*the purposive actions of individuals and organizations aimed at creating, maintaining or disrupting institutions.*' (Lawrence and Suddaby 2006: 215) We therefore support institutional (work) scholarship that moves away from defining institutions or professionals as essential entities, engaged in linear interactions in which either professionals or institutions are the objects of change (cf. Hwang and Colyvas 2011). Instead, we argue for an alternative, relational and evolutionary interpretation of the dynamic between institutions and professionals. This is directed towards revealing changes on the level of institutions as well as professionals (see for similar projects: Smets and Jarzabkowski 2013; Zundel et al. 2013; Van de Bovenkamp et al. 2014; Bévort and Suddaby 2016). With our two-dimensional analytical approach, we intended to take another step in this direction.

Our two-dimensional approach allowed us to observe that the governance principles: 'multi-disciplinary collaboration' and 'patient-centeredness', were internalized by professionals that participated in the Primary Focus program. These observations resonate well with observations made by other scholars in this journal, namely that organizational principles have become part of everyday professional work (cf. Noordegraaf 2015; Postma et al. 2015). Yet, such observations also raise the question what the organizational consequence are of such internalizations. In our case study, through structural coupling, the principles of 'multidisciplinary collaboration' and 'patient-centeredness' indeed flowed between and across professional boundaries. However, through operational closures, the professionals' internalization of these principles led to adapted articulations of professional selves; their identities, roles and positions (cf. La Cour and Højlund 2013). In this light, the program did not lead to the dissolution of professional disciplinary boundaries. Neither did it lead to new organizational formats for the provision of integrated, patient-centered care, as policymakers had hoped. Instead, participating professionals had worked towards new formats for the provision of integrated, patient-centered care, by (re)organizing their own professional practice.

Conclusion

In this article, we posed the following research question: How did participating professionals work on new organizational formats for the provision of integrated, patient-centered care in the layered institutional context of Dutch healthcare governance? In order to answer this question, we took the 'Primary Focus' policy program as our case study. We used a two-dimensional framework for its analysis. This framework enabled us to study the complex, relational and evolutionary dynamic between professionals and the layered institutional contexts with (in) which they work. It sensitized us to revealing changes on the level of institutions as well as professionals. Using this framework, we noticed that the program mobilized professionals around the principles 'multidisciplinary collaboration' and 'patient-centeredness'. At stake was the development of new organizational formats for the provision of integrated, patient-centered primary care. We furthermore noticed that participating professionals embraced these principles and started working on the development of new organizational formats. However, while professionals were doing so, they interpreted program objectives and the governance principles in a self-referential way. In the process, 'patient-centeredness' changed from a shared objective, realized through the development of multidisciplinary referral systems, into a contested professional quality. In the end, the Primary Focus program did not produce the integrated, patient-centered organizational formats that policymakers had been aiming for. Instead, the program produced adapted articulations of professional selves. Professionals had literally been working together alone.

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6

Mapmaking and the (re)organization of professional practice:
a case study of Dutch primary care

Published as: Maaijen, M. M. H., Felder, M., de Bont, A. A., and Bal, R. (2018). Mapmaking and the (re) organization of professional practice: a case study of Dutch primary care.

Journal of Professions and Organization, 5(3), 230-247.

Abstract

Combining insights from sociology and geography, we examine how professionals organize professional relations, beyond the boundaries of their professional groups and through the process of mapmaking. We take the Netherlands as our case study. Here, between 2009 and 2015, the Ministry of Health initiated a program that stimulated professionals to develop alternative organizational formats for the provision of integrated primary care. Two of the funded projects used mapping techniques in order to give direction to such integrated organizational formats. Based on the literature, we develop and deploy an analytical framework that aims to capture: (1) how professionals shaped interprofessional relations through mapmaking; and (2) what the organizational consequences were of the maps developed. We reveal how professionals differentiated between elements during the mapmaking process. We furthermore demonstrate how such differentiations shaped the developed maps in particular ways. This, in turn, influenced whether and how these maps gave direction to new organizational formats. We close this article with three points that scholars need to take into account when studying mapmaking in order to gain processual and dynamic insight into the organization of professional practice.

Keywords: maps and mapmaking; organized professionalism; multidisciplinary collaboration; integrated primary care

Introduction

Classically, in the heydays of professional autonomy, sociologists that studied the formation of professional groups and their domains, focused on the ways in which these groups defined, delineated and defended distinct professional roles, responsibilities and fields of knowledge (Freidson 1973). In this line of theorizing, professional groups controlled the content and boundaries of their professional domains – and how these developed over the years – by continuously differentiating between who and what should be included into and excluded from their particular professions (Freidson 1973; Abbott 1988).

Since the 1990s, however, a more collaborative and accountability-based governance model has replaced professional autonomy in many Western countries (Light 2010; Lawrence et al. 2013; Berwick 2016). With this shift in governance, new actors have entered the healthcare arena and started to exert influence on the content and boundaries of healthcare services. In line with this development, sociologists are increasingly realizing that the content, boundaries, and organization of professional practice is not just shaped by professional groups, but also in response to broader societal developments and in interaction with professional others (Evetts 2003; Waring and Currie 2009; Noordegraaf et al. 2014).

In this context, identifying professional heartlands, boundaries, and turf wars, no longer suffices as an analytical strategy to understand organizational dynamics in healthcare governance – if ever it did (Abbott 1995). Such readings produce images of stasis, conflict, and misplaced professional autonomy in the history and future of organized professional practice. They overlook the fact that individual professionals, professional groups, and 'professional others' continuously split, join, merge, or dissolve on different levels, in different time-spaces and in relation to different developments in the governance of care (Adler et al. 2008). A sociology of organized professionalism should therefore dedicate itself to providing more detailed, dynamic, and processual insights into how interprofessional relations are crafted and recrafted and how such continuous crafting affects the content and organization of professional work (Abbott 1995).

Although allegories such as heartlands and peripheries, boundaries and turf wars, no longer suffice to describe the history and future of professionalism (Abbott 1995), some organizational scholars have started to take the spatial dimensions of (organized) professionalism and professional practice seriously (Postma 2015; Ivanova et al. 2016). Of particular concern in this article is the concept of 'mapping' interprofessional relations. Informed by geography, we point out that professional maps – and the processes of making them – are particularly interesting cases to study the crafting and recrafting of interprofessional relations (Pinder et al. 2005; Jones 2009). Such maps organize and represent interprofessional relations in a particular, discursive way (Harley 1988). Moreover, by producing a particular representation of such relations in the present, these maps give direction to possible futures (Turnbull 2007). Professional maps can therefore be described as a constitutive force in how we think about, represent, and engage with the organization of professional practice (Postma 2015).

We focus on Dutch primary care in order to examine the crafting of interprofessional relations – and the perpetuation of these in new organizational formats – through the process of mapmaking. In the Netherlands, similar to many Western countries, healthcare is provided, influenced, and regulated by an increasing variety of actors, including professionals, policymakers, inspectorates, health insurers, and patient organizations (Van de Bovenkamp et al. 2014). Some of these actors have stimulated individual professionals to organize themselves beyond the confines of their traditional professional groups and domains (Adler et al. 2008; Thomas and Hewitt 2011). A striking example is a policy program titled 'Primary Focus'. It was introduced by the Dutch Ministry of Health in 2009. It sought to stimulate the development of new organizational formats for the provision of integrated, patient-centered primary care on a regional scale (ZonMw 2015).

In this article, we study two projects that were funded in the context of the Primary Focus program. These two projects explicitly used mapping techniques in order to give direction and meaning to the (re)organization of interprofessional relations in the provision of integrated primary care. Combining a sociology of professions with insights from geography (Abbott 1995; Jones 2009), we argue that these maps – and the process of making them – provide valuable insights into whether and how professionals shaped interprofessional relations beyond the traditional boundaries of their professions and in interaction with other professionals and 'professional others'. Our research questions are:

> *How did professionals shape interprofessional relations through the process of map making and what were the consequences thereof for the organization of integrated primary care?*

In the next section, we develop the theoretical framework through which we studied the mapping of interprofessional relations. This framework supports a more processual and dynamic reading of (organized) professionalism, dedicated to revealing the intricacies of shaping professional organizational formats beyond the boundaries of traditional professional groups. Thereafter, we introduce the two projects and provide methodological insight into how we studied them. Our theoretical framework and methodology are followed by a detailed presentation of our findings and a discussion of their implications for understanding (organized) professionalism in contemporary healthcare governance.

Theory

In this section, we introduce a processual and dynamic approach toward studying professional groups in formation. Thereafter, we describe why the practice of mapmaking is an interesting case to study professional groups in formation.

Two approaches toward studying group formation

One of the fundamental characteristics of a group is that it has an inside and an outside; people, objects, and concepts that are considered part of the group and not part of it. Such insight has stimulated sociologists to study how professional groups differentiate between what is included into and excluded from their professional domains. This reading of professionalism has been used to explain how professional group compositions remain coherent over time (e.g. by controlling for membership) (Freidson 1973; Abbott 1988). Moreover, it has been used to describe how professional groups are able to adapt the content of their professions to a changing environment (e.g. including new technologies, principles, and insights as part of a professional domain; Felder et al. 2018). Because these readings take professional groups themselves as analytical starting points, they struggle to explain how professional groups dissolve, or how new professional groups are formed. At best, such dynamics are explained as hostile take-overs, or new territories to be occupied (Abbott 1995; Gieryn 1995; Hudson 2002).

In response to the above, Abbott (1995) challenges an assumption underlying the sociology of professions. He argues that sociologists should no longer start with groups and study how they remain coherent over time through continuously and intentionally differentiating between who and what is included into – and excluded from – their professional domains (e.g. Currie et al. 2012; Lawrence et al. 2013). Instead, sociologists should start identifying events of differentiation and study what such differentiations lead to, in terms of groups in formation. In other words, the group should no longer be presumed a priori, or taken as a starting point of analysis. Instead, groups should be interpreted as the temporary and accidental outcomes of an accumulation, or assemblage, of differentiations of all kinds (cf. Gieryn 1995).

Abbott (1995: 4-6) illustrates his point by presenting a historical analysis of the emergence of a group called 'social workers'. He traces how over the course of the 19th and 20th centuries – in many localities and through series of unplanned events – activities previously done by charities, churches, hospitals, psychiatrists, and settlement houses, were differentiated as distinct and connected to one another to form a systematic set of tasks, done by one role in particular: ‘social workers’.

To explain how groups are formed through the sum of differentiations, Abbott (1995) introduces the concept of yoking. He starts by defining boundaries as sites of differentiation (e.g. [primary care/secondary care]; [oncological care/non-oncological care]; [registered healthcare providers/not registered healthcare providers]). Thereafter, he describes how some of these sites of differentiation can be connected to one another. With each connection made, one side of each differentiation becomes defined as the inside of a group (e.g. oncological primary care). In doing so, connections between two or more sites of differentiation together circumscribe a certain thing in the middle; a group that is distinct from its surroundings (e.g. oncological primary care provided by registered professionals) (figure 11).

In this line of theorizing, sites of differentiation can function in two ways. Either they function as the boundaries between groups, for example, when two groups share a site of differentiation (e.g. [registered oncological secondary care providers]/[registered oncological primary care providers]). Alternatively, sites of differentiation can become junctures in the formation of new groups (e.g. professionals that break down the primary/secondary care boundary and start working across these domains). According to Abbott (1995), the constitution of groups—and the boundaries between them—indeed change through the breaking open of old connections between sites of differentiation, or by the drawing of connections with new sites of differentiation (cf. Quick and Feldman 2014).

We live in a word full of events and sites of differentiation can take on many forms (Mead 1932 in Abbott 1995: 4). Differentiations can, for instance, be made between professional groups; patient flows; problems to be solved; bodies of knowledge and practices. In this light, the governance of care is no exception (Van de Bovenkamp et al. 2014). New actors enter the healthcare arena, new concepts and principles are introduced. New practices become possible with the introduction of new technologies and legislation. Existing practices, technologies, and bodies of knowledge are called into question, or broken into distinct parts. Hence, new sites of differentiation are constantly emerging and opportunities for the breaking open of old and drawing of new connections between these sites of differentiation abound (cf. Gieryn 1995). In this light, professional groups can be considered as in a constant state of formation.

In this world of events, professional groups can therefore only endure as a coherent group, when the differentiations that circumscribe them, continue to be repeated. According to Abbott (1995), such repetition can be induced by forces that act upon groups from the outside (e.g. government legislation, recognized expertise), or by forces that regulate groups from the inside (e.g. a clear identity, membership criteria, tasks allocation, and an organized body or structure). Often it is a combination of both. After all, a group cannot reproduce itself without an internal structure and logics of reproduction. Neither can it endure when it is not recognized by the outside as the site were different 'insides of differentiation' are tied together to form a distinct whole (Wallenburg et al. 2012).

In order to understand the emergence, continuation, transformation, or dissolution of professional groups, Abbott (1995) emphasizes to start with the identification of sites of differentiation and the ways in which these are tied to other sites of differentiation. In doing so, he introduces a processual and dynamic approach to studying professional groups in formation. We use this approach to examine the crafting of interprofessional relations – and the emergence of new organizational formats for the provision of integrated primary care – beyond the boundaries of traditional professions in Dutch primary care. This is important, we argue, in order to bring into focus alternative organizational formats and sidestep traditional and rather stratified conceptions of organized professionalism (Adler et al. 2008; Noordegraaf et al. 2014). As we further develop in the next section, mapmaking is a particularly interesting case to study such alternative organizational formats 'in formation'.

Mapmaking as cases to study groups in formation

Organizational scholars have often used spatial metaphors to describe how organizations emergence, continue, transform, or dissolve. Examples are Abbott's (1988) previously discussed heartlands, boundaries, and territories. Some scholars have taken this analogy further and have started to actually study the spatial dimensions of healthcare organizations (e.g. Ivanova et al. 2016; Oldenhof et al. 2016). These scholars have turned to the discipline of geography to inform their studies. Examples are the relations between scale and organizational rationales (Postma 2015); or place as a product and producer of healthcare practices (Ivanova et al. 2016). Below, we would like to draw yet another analytical connection between geography an organization studies: the ties between organized professionalism and mapmaking (cf. Pinder et al. 2005).

Geography has traditionally concerned itself with the categorization of phenomena and with the placing of these phenomena in relation to one another across time and space (Harley 1988). Here, the map is the archetype product of geographers' efforts to represent the order and relations between people(s) and thing(s) (Harley 1988). Different maps can be drawn, with different categories and emphasizing different relations between categories (Pinder et al. 2005; Armstrong and Densham 2008). Maps can furthermore vary in size, detail, and scale. Maps can thus represent relations in infinitely different ways. What appears on maps is therefore the product of how mapmakers give meaning to such relations at particular points in time and in the context of particular (political) agendas; issues, objects, roles, and identities to be (re)presented (Harley 1988). Maps thus tell stories of inclusion and exclusion, of similarities and differences, of ties and loose ends (Sauer 1956). As representations of particular present(s), maps furthermore give direction to possible futures (Turnbull 2007; Crampton 2009). Through maps, mapmakers give meaning to the world and direction to their own place and purpose in it.

Some geographers have therefore – and one might argue rather reflexively – stressed the importance of studying mapmaking processes in their own right (Crampton 2009; Jones 2009). Instead of analyzing the spatial relations between people and things (the traditional project of geography), these geographers aim to identify: (1) processes of differentiation through which categories emerge as distinct entities to be mapped (Jones 2009); and (2) to study how these constructed entities are subsequently connected to one another on maps in order to tell a particular story (Sauer 1956; Harley 1988). Much in line with Abbott (1995), these geographers are thus no longer concerned with how a particular story should be mapped (or how an organization should be spatially represented). Instead, they focus on identifying differentiations and the ways in which these are tied together on maps, in order to understand how a particular story emerges (or how differentiations and their spatial representation come to shape organizations).

In this light, mapmaking in the Dutch organization of integrated primary care is an interesting empirical case to study Abbott's (1995) sites of differentiation and professional groups in formation. In fact, analyzing such maps and the processes of making them, helps to gain insight into how professionals (as mapmakers) differentiate and give meaning to interprofessional relations and direction to the organization of integrated primary care, on a regional scale and – importantly – beyond traditional professional boundaries. In the next section, we further discuss how we have operationalized this approach.

Methodology

In this section, we first further introduce the Primary Focus program and the two projects that used mapping techniques to give meaning and direction to interprofessional relations in the organization of integrated primary care. Thereafter, we describe how we analyzed these projects.

The Primary Focus program and the two mapping projects

The organization of Dutch primary care is complex. First, the concept of 'primary care' is used to describe a variety of healthcare services, provided outside the hospital by a variety of professionals. Examples are general practitioners, physiotherapists, midwives, dentists, and neighborhood nurses (Van Wijngaarden et al. 2006). Second, these primary care providers have organized themselves in many different ways. Some professionals are self-employed, while simultaneously being members of professional groups (like the classic image of general practitioners); others are employees of healthcare organizations (like the classic image of neighborhood nurses). Some self-employed practitioners (e.g. general practitioners) are co-located with other types of practitioners (e.g. physiotherapists). Alternatively, professionals from different disciplines can be employees in the same healthcare organization (e.g. the general practitioner-nurse-pharmacist triad; cf. Saint-Pierre et al. 2017). Third, Dutch primary care is approached as a regulated market (Helderman et al. 2005). This means that healthcare professionals and/or the organizations in which they operate, compete with other professionals and/or organizations on the price, quality, and content of care provided (Postma and Roos 2015).

The Dutch Minister of Health observed in 2008 that the introduction of market mechanisms in 2006 had indeed stimulated primary care professionals to start competing with one another (Klink 2008). He furthermore observed that the sector was diversifying. Unfortunately, the minister observed, many primary care professionals continued to have an inward orientation toward the provision of primary care services. In other words, they were primarily oriented toward the norms, standards, and practices of their own professional groups. These professionals were therefore primarily focusing on parts of a patient's problems, without taking into account how their specific services fitted the bigger picture of a patient's care trajectory. This was especially problematic, the minister argued, in the context of rising numbers of patients with chronic diseases and multi-morbidity (Klink 2008). Even though different and multidisciplinary organizational formats were thus existing in Dutch primary care, the sector continued to be rather fragmented (Klink 2008).

The Primary Focus program was introduced in 2009 in order to counter such fragmentation and work toward the organization of integrated primary care services (ZonMw 2015). It specifically stimulated primary care professionals to collaborate in taking care of joint patients (Valentijn et al. 2015). The program objective was framed as follows: '*To better meet the needs of care-users, by strengthening multidisciplinary collaboration and coordination.*' (ZonMw 2009: 11) The program funded 67 projects that centered around specific care themes and were implemented on a regional scale (ZonMw 2009). The projects were proposed and carried out by groups of primary care professionals with different disciplinary backgrounds. The program is an interesting opportunity to study professional groups in formation because it specifically aimed to stimulate professionals to look beyond their own professional groups and to develop new organizational formats for the provision of integrated care.

The two projects we examine in this article developed maps in order to give meaning to interprofessional collaboration and direction to new organizational formats for the provision of integrated care. The first project was titled 'Multidisciplinary Oncology Network' (MuON). In this project, the oncology department of a regional hospital and several oncological primary care professionals sought to strengthen the provision of integrated oncological care in the region. They observed that oncological care was increasingly taking place outside the regional hospital and closer to the homes of patients (Burghout 2011). However, the division of roles, responsibilities, and relations between the different secondary and primary care providers was unclear. For instance, it was unclear what the role of general practitioners was during the time that patients were supported by the oncological consultants of the hospital. Some general practitioners continued to support patients (mainly psychologically), whereas others did not. Moreover, the variety and number of professionals delivering oncological care outside the regional hospital was rising (IKNL 2018). Next to general practitioners, also outbound oncology consultants and physiotherapist, psychologists and home care organizations were starting to provide oncological care services. Some of these professionals were members of umbrella organizations, such as a national home cancer care network, or a regional palliative network. Nevertheless, oncology care in the region was considered fragmented. In this light, professionals that participated in the MuON project sought to (re)organize and integrate the delivery of oncology services in the region. They aimed to do so by mapping interprofessional relations and craft a distinct and comprehensive network of oncological healthcare providers. This mapped network was deemed necessary for: (1) professionals that wanted to refer patients to other professionals; and (2) patients that wanted to know which oncological care was provided in their region (MuON project documents 2009).

The second project was titled 'the Neighborhood Health Profile' (NHP). This project was initiated in a city in the east of the Netherlands. It was introduced in sync with other initiatives to organize multidisciplinary collaboration between primary care professionals for the provision of integrated care, on the level of the city's neighborhoods (Terpstra and Moerman 2013). In these collaboration initiatives, primary care professionals, neighborhood nurses, pharmacists' physiotherapists, dietitians, social workers, municipal health services, clients, and residents, were given 'free space' to experiment on how to collectively tackle health problems that occurred on the level of the neighborhood. In this context, the NHP project sought to give direction to such multidisciplinary collaboration, by mapping health and lifestyle issues on the level of the neighborhood. In a way, this project thus sought to develop a knowledge base on which the multidisciplinary collaboration that was organized on the level of neighborhoods, could be stooled. As described by the project coordinators, mapping lifestyle and health issues on the neighborhood level was therefore only the first step of the project. Thereafter, the developed maps should be used to collectively discuss and identify themes for collaboration and to develop an integrated approach toward tackling the health and lifestyle issues identified (cf. Terpstra and Moerman 2013).

Data collection and analysis

The first and third authors participated in the Primary Focus program as researchers. They were commissioned by the program coordinator to study eight of the 67 funded projects in detail (SMOEL 2015). Their overall aim was to assess how participating professionals worked toward program objectives and to identify best practices (SMOEL 2015). The second and fourth authors supported the first and third authors in analyzing the data gathered and in writing this article. In the coming paragraphs, we specifically describe how data on the two mapping projects, ‘MuON’ and ‘NHP’, was gathered and analyzed.

The first and third authors used qualitative methods to study how participating professionals gave meaning and direction to interprofessional relations (Pink 2007). They started their inquiry with participatory observations. By invitation of the project leaders, they attended project meetings and several mapmaking workshops in which project members participated (12.5 hours). An observation scheme was used to record: (1) the setting in which observations were being made; (2) group compositions; (3) group dynamics; and (4) striking expressions (both verbal and non-verbal) by those that participated. In sync with participant observations, project documents were collected. Project leaders agreed to share their records, including meeting minutes and agendas, project proposals, and implementation plans. The first author was furthermore added to the mailing list of the two projects. The maps that were developed in the two projects were recorded as screenshots.

Participatory observations and collected documents were complemented with semi-structured interviews with the participating professionals. The topic list included: (1) project objectives; (2) professional and personal motives to participate; (3) reflections on the mapmaking process and collaboration amongst project members; (4) project outcomes. Eight participants of the MuON project were interviewed. These included the project leader (a primary care physiotherapist), another physiotherapist, a general practitioner, a specialist nurse from the hospital, a coordinator of a regional palliative care network, a hospital oncology manager, two directors of home care organizations, a nurse (project volunteer), and an oncology nurse. In addition, seven participants of the NHP project were interviewed. These included two general practitioners, a neighborhood nurse, a policy adviser of the local municipality, an epidemiologist, a manager of a home care organization, and a prevention worker from the public health service. All interviews were audio-recorded and transcribed verbatim.

Informed by our theoretical framework, we analyzed the data on the following aspects. (1) Which sites of differentiation were articulated in the two projects and how were these differentiations placed in relation to one another? (2) How did participating professionals represent these differentiations and their relations on the maps developed? (3) What were the organizational consequences of the maps developed? Our empirical section is structured accordingly.

Findings

We start this empirical section with identifying sites of differentiation in the two projects. This, in order to identify categories that emerged as distinct entities to be mapped (cf. Abbott 1995). Thereafter, we discuss how, where and when, these categories were actually articulated and yoked together; particular so during the process of mapmaking (Jones 2009). We close this empirical section with our observations on how the mapmaking process – and the produced maps – contributed to the (re)organization of integrated primary care services (Crampton 2009).

Sites of differentiation

As we argued previously, organized professionalism has often been studied in terms of the traditional professions 'in formation'; thus taking traditional professions as an analytical starting point. This way, scholars have overlooked the fact that individual professionals, professional groups and 'professional others' continuously split, join, merge, or dissolve on different levels and in different time-spaces. Here, we therefore start the other way around and focus on the ways in which individual professionals sought to recraft the content an organization of primary care services, beyond the boundaries of the traditional professions and through the process of mapmaking.

The MuON project, for instance, was initiated by a specialized oncological primary care physiotherapist. She aimed to (re)organize the regional provision of oncological care. Particular so, by constructing a network between the oncology department of the regional hospital and different primary care providers that specialized in oncological care, closer to the homes of patients. Starting with her personal professional network, the physiotherapist organized a project group. This group included several physiotherapists, representatives of the oncology department of the regional hospital, a representative of an oncological patient organization, and an oncological nursing organization that provides oncological patient support at home.

The project group wanted to separate themselves, and their oncology network under construction, from the messy reality of contemporary oncological primary care (physiotherapist, interview transcript 2013). The group stressed the importance for oncological patients and the (secondary) care professionals involved in their treatments, to contact 'the right' oncological primary care providers (www.muon.nl [discontinued]). Therefore, the group wanted to gain knowledge about which providers and which services were actually out there. They decided to develop a map of oncological primary care providers and their oncological primary care services. In this light, the group's main questions were who else (which professionals) and what (which healthcare services) should be considered oncological primary care and be depicted on the map. It is here that several sites of differentiation can be identified:

> [In the hospital/close to home]: the project group wanted to differentiate between oncological care provided in the hospital and oncology care provided close to home. Increasingly, primary care professionals were providing oncological healthcare services outside the hospital's polyclinics and closer to the homes of patients (oncological nurse, interview transcript 2012). It were these professionals that the project group was referring to when discussing collaboration between the regional hospital's oncology department and a plethora of oncological primary care providers.
>
> [Oncological care/non-oncological care]: the project group wanted to differentiate between oncological care and care that might be relevant for individual oncological patients, but which was not specific enough, oncologically, to complement an oncological care network (in the making). Participating professionals in the MuON project for instance discussed whether to include creative therapists into their network, as some of the oncological patients might enjoy painting after being treated (patient representative, interview transcript 2013). Others however aimed to only include what they identified as core healthcare services that were provided in addition to hospital services. Examples are physiotherapy, psychological support and nursing (physiotherapist, interview transcript 2013).
>
> [Qualified/non-qualified]: the project group also wanted to differentiate between who should actually be deemed qualified to provide oncology services close at home and who not. For some members of the group, the hospital should take the lead in this (hospital manager, interview transcript 2013). The hospital indeed proposed a list of criteria including in-service schooling, experience, and being registered. Other profes-

> sionals however argued that it was up to the different professional groups themselves, to identify whether or not an individual professional had specialized itself in providing oncological care. For instance through competence profiles, in-service training and experience (physiotherapist, interview transcript 2013).

On the basis of these sites of differentiation, the group decided that only healthcare providers that were: (1) registered; (2) providing services recognized by the project group as oncological services; and (3) situated outside the hospital and close(r) to the homes of patients, would be depicted on the map (see also figure 11).

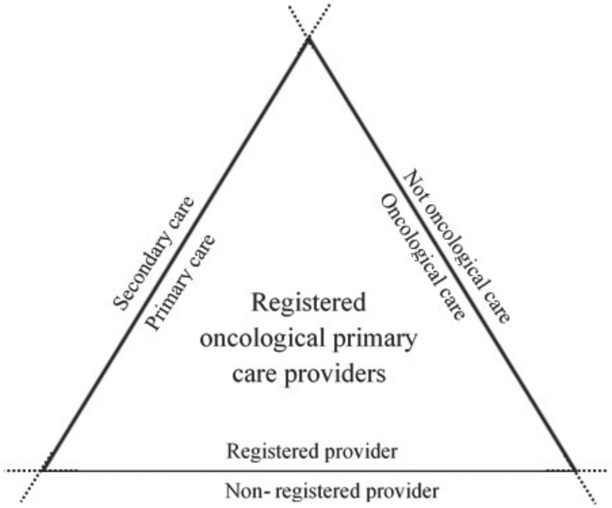


Figure 11: *Example of group formation through yoking between different sites of differentiation*

Also in case of the NHP project, at stake was the generation of knowledge. In the city in which this project was initiated, several 'other' projects had sought to organize multidisciplinary collaboration. Yet the professionals that participated in these projects had articulated the need to focus on specific health and lifestyle issues that could be tackled through collaborative action. Unlike the MuON project, in which a network was organized around the treatment of (individual) oncological patients, these professionals sought to organize collaboration around health and lifestyle issues on the level of the city's neighborhoods. In order to gain insight into the health and lifestyle issues that were out there, the project group wanted to map disease prevalence and lifestyle issues on the level of the neighborhood population. Their maps could subsequently inform which health and lifestyle issues were most stringent, which of these could be tackled through collaborative action and which professionals should collaborate in order to do so (the latter more in line with MuON, but only after heath issues had been mapped).

In the NHP project, sites of differentiations can be identified in three different stages. First, they can be observed in the gathering of health and lifestyle data (what data should inform the profile and how should it be collected). Second, they can be observed in the way in which professionals identified and prioritized care themes (based on the data selected and analyzed). Lastly, they can be observed in the way in which participating professionals discussed who should be included in tackling the care themes identified. Below, we describe sites of differentiation that were part of the first stage, the making of a neighborhood profile:

> [National data—neighborhood data]: the project group wanted to differentiate between national data and neighborhood data. Hence, one of the issues the project group addressed was the level on which data was gathered to inform the neighborhood profile. Previously, the municipal health services had used data gathered on an aggregate level (e.g. national databases on patient registrations) and thereafter extrapolated such data to gain insight into health issues on the level of the neighborhood. In order for the neighborhood profile to become recognized as a distinct body of knowledge, it was deemed necessary to gather data on the neighborhood level itself. The project group referred to such data as 'real neighborhood data' (Terpstra and Moerman 2013: 35).

> [Epidemiological data—professional insight]: the project group wanted to differentiate between what could be measured on the level of the neighborhood with 'appropriate' data sources and what professionals, active in a neighborhood, already knew individually. The group's epidemiologists for instance identified MIMS as a valuable data source. It could be used to map the prevalence of COPD, diabetes and (indications of) depressive disorders on the neighborhood level. Particularly so, because MIMS allowed for the extraction of data via four digit postal codes. In addition, via health insurers, healthcare expenditures (e.g. on pharmacy, general practitioners and mental healthcare) could be mapped on the level of neighborhoods (the latter however not specified through four digit postal codes but as defined by the municipalities). However, four digit postal codes and neighborhoods (as defined by the municipalities), do not always overlap. Moreover, some patients go to healthcare providers in neighborhoods other than their own. Therefore, the project group stressed that the extracted and mapped epidemiological data should always be complemented with the insights of professionals and neighborhood residents.

> [Relevant—non relevant categories]: Once accessible data sources were identified, the project group needed to identify which data was actually relevant to be included in the neighborhood profile, in order to gain insight into health and lifestyle issues. Emphasis was placed on psychosocial data (e.g. the outcomes of strength and difficul-

> ties questionnaires in youth care and anxiety or lowliness scores); lifestyle data (e.g. Body Mass Index and number of residents with smoking habits); health issues (e.g. diabetes, COPD, depressions) and environmental data (e.g. presence of public green spaces). The project group furthermore decided to differentiate between age groups. This, because the disease prevalence and the best way to treat particular diseases, could vary significantly for different age groups.

Based on these sites of differentiation, the project group decided to: (1) use specific databases and monitors to extract real data on the level of neighborhoods; and (2) to analyze the data extracted, making use of categories that were relevant on the level of the neighborhoods population. In addition, the group emphasized that the data gathered should always be mirrored in—and complemented with—insights of professionals and neighborhood residents.

To sum up, both the MuON project and the NHP project used mapping techniques in order to develop and (re)present new knowledge in the context of a particular space. In the first project, this was knowledge about which professionals were providing which oncological primary care services in the region. In the second projects, this was knowledge about health and lifestyle issues on the level of the neighborhood. In line with these different objectives, the first project differentiated between professionals, their competencies and their services. The second project differentiated between different kinds of health and lifestyle data and analytical categories.

Mapmaking

As we will argue in this subsection, the maps developed can be considered representations of the abovementioned differentiations. However, we will also demonstrate that it was during the mapmaking process itself, that abovementioned sites of differentiation were articulated, further specified, and yoked together, in order to give meaning and direction to the organization of multidisciplinary collaboration.

In case of the MuON project, for instance, the map (to be developed) was recognized by the project group as way to represent their primary oncological care network under construction. Here, and in terms of representation, the map was a way to make their network tangible. In the words of a participating physiotherapist:

> '*A network alone is not enough. In a way, getting to know one another in oncological care needs to be made tangible. It needs to be presented somewhere*.' (interview transcript 2013)

The map was to take shape as an interactive website, titled: www.muon.nu (carrying the title of the network [no longer online]). Here, the project group (re)presented the following network description:

> '*The MuON network brings patients and those nearest to them in contact with the right healthcare providers. Moreover, it connects different healthcare providers that are specialized in providing oncological care in contact with one another. Through this network, patients can contact provider(s) and providers can consult one another and learn to provide better care*.' (MuON 2013)

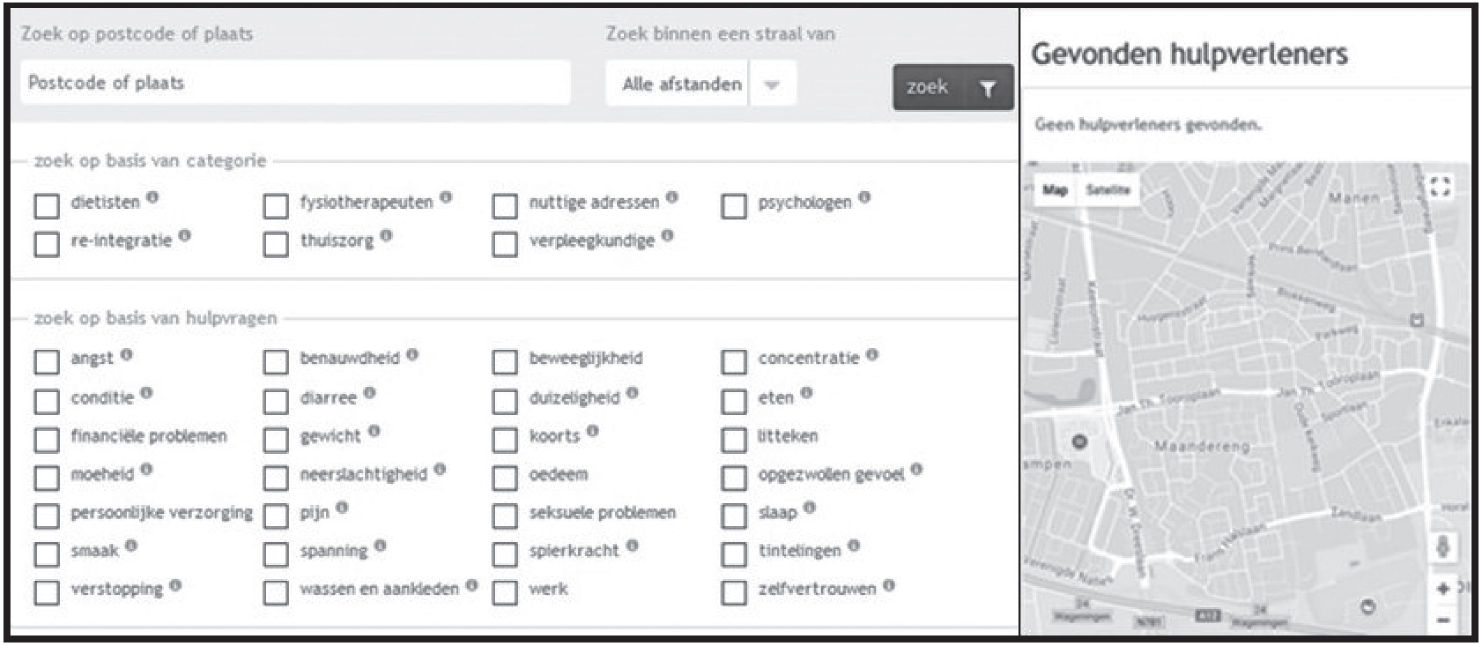
However, the website and its map cannot be approached as mere (re)presentations of an a priori defined network and its underlying sites of differentiation. In fact, mapmaking also shaped the way in which sites of differentiation developed during the project's unfolding. The project group's efforts to develop a map that distinguished their network from secondary oncological care (site of differentiation one) and the messy reality of contemporary oncological primary care (site of differentiation two), for instance, forced participating professionals to articulate, discuss and further specify admittance criteria (sites of differentiation two and three).

> Project group (member 1): '*I think we should follow the competence profiles of oncological nurses and palliative care and additional schooling in oncological care*.'
>
> Project group (member 2): '*What really needs to be added is work experience and additional courses. These furthermore need to meet to certain criteria*.' (fieldnotes, 2 February 2013)

Some of these admittance criteria were published on the MuON website. Only professionals that fitted these criteria could present themselves on the website and be included on the map. A search engine on the website subsequently guided visiting patients and/or professionals to these 'right' healthcare providers. The search engine consisted of three interacting features:

1. Patients and/or professionals could make a selection from predefined categories of registered primary care professionals that could deliver oncological primary care services (e.g. dietitians and physiotherapists that fitted admittance criteria).

2. Visitors could make a selection based on the healthcare questions they wanted to discuss with such a professional (e.g. anxiety, mobility, financial problems, or fever).



Zoek op postcode of plaats

Postcode of plaats

Zoek binnen een straal van

Alle afstanden

zoek op basis van categorie

☐ dietisten ☐ fysiotherapeuten ☐ nuttige adressen ☐ psychologen
☐ re-integratie ☐ thuiszorg ☐ verpleegkundige

zoek op basis van hulpvragen

☐ angst ☐ benauwdheid ☐ beweeglijkheid ☐ concentratie
☐ conditie ☐ diarree ☐ duizeligheid ☐ eten
☐ financiële problemen ☐ gewicht ☐ koorts ☐ litteken
☐ moeheid ☐ neerslachtigheid ☐ oedeem ☐ opgezwollen gevoel
☐ persoonlijke verzorging ☐ pijn ☐ seksuele problemen ☐ slaap
☐ smaak ☐ spanning ☐ spierkracht ☐ tintelingen
☐ verstopping ☐ wassen en aankleden ☐ werk ☐ zelfvertrouwen

Gevonden hulpverleners

Geen hulpverleners gevonden.

Figure 12: The MuON search engine and its map

3. Informed by abovementioned selections, relevant/right healthcare providers would appear on a google maps frame. This way, patients and professionals could find such providers close to the patient's home. To facilitate the latter, visitors could search for professionals within a particular radius (in km) from their six digit postal codes.

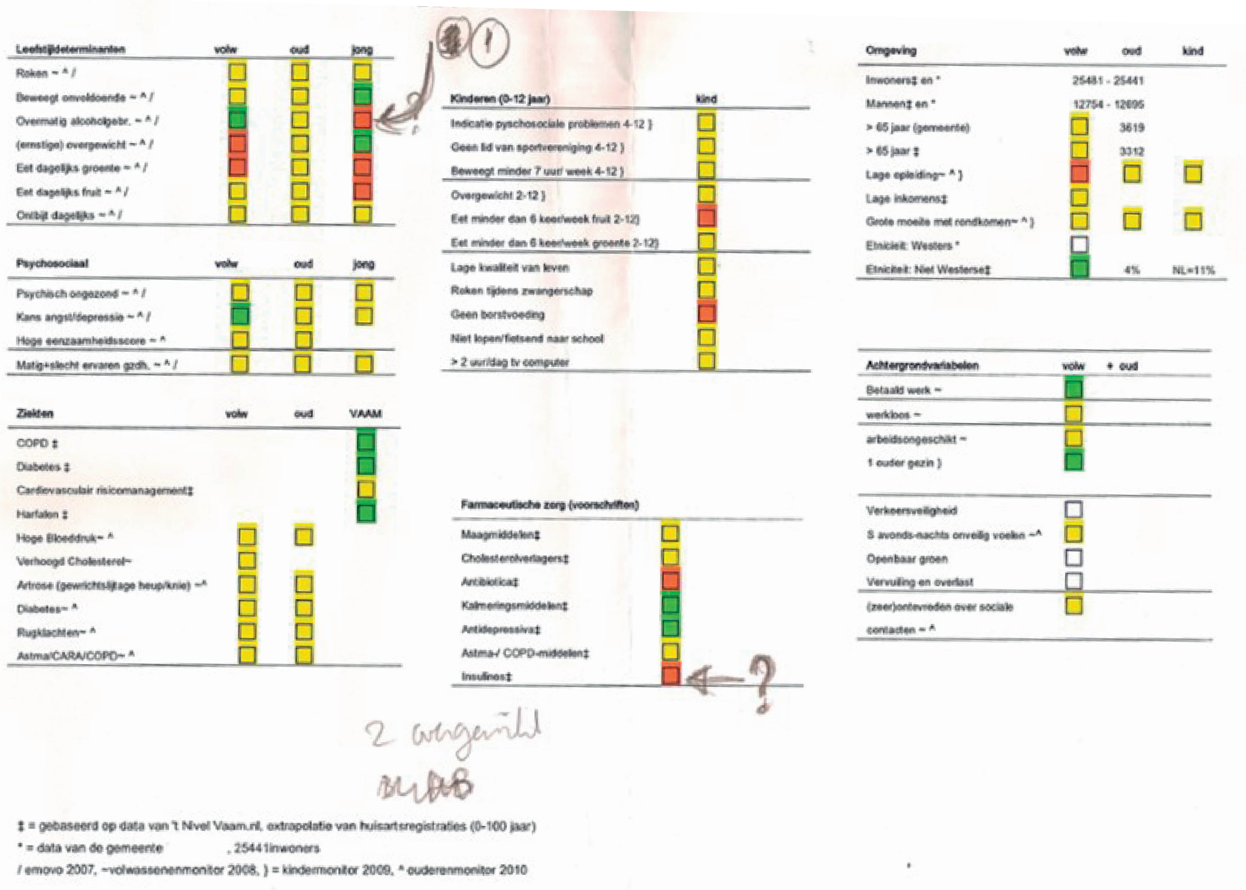
We have presented these different steps in a screenshot of the search engine on the www.muon.nu website (figure 12).

Similar to the MuON project, also in case of the NHP project, a site of differentiation sparked the need to map. In this case, it was the objective to develop new knowledge on the level of the neighborhood, based on real neighborhood data. However also here, new sites of differentiation were articulated as participating professionals sought to develop the map. They for instance, needed to specify which data could be accessed (site of differentiation five) and which of the data that could be accessed, was actually relevant to include in the neighborhood profile (site of differentiation six).

Yet, inclusiveness and accuracy were not the only characteristics that this project group was aiming for. In addition, the mapped neighborhood profile needed to be easy to understand, quickly to read, and helpful for identifying the most stringent health and lifestyle issues (Terpstra and Moerman 2013). In other words, professionals should be able to see on the map, in one glance, what the relevant issues were. The profile should therefore show instantly where the neighborhood population scored similar, better, or worse in comparison to other neighborhoods on a particular health or lifestyle category.

The developed map (see for a general overview figure 13), presents the categories that were had identified as most relevant (the rows). It furthermore distinguishes between children, adults, and elderly (the columns). Moreover, it intends to provide instant insight into how the neighborhood scores in relation to other neighborhoods. Red indicates it scores worse, yellow indicates it scores similar and green indicates it scores better than other neighborhoods do.

Based on these observations of the mapmaking process, we want to stress that some sites of differentiation emerged at the onset of the mapmaking projects (e.g. create an overview of oncological primary care or generate real neighborhood data). Others emerged as the project groups sought to come to terms with that which they actually intended to map (e.g. what actually is oncological primary care or what actually is relevant neighborhood data). Here, the maps actually forced the participating professionals to articulate new sites of differentiation and further specify previously articulated sites of differentiation. In that sense, differentiating and mapmaking were very much intertwined (Crampton 2009; Jones 2009).



Leefstijldeterminanten	volw	oud	jong
Roken ~ ^ /	🟨	🟨	🟨
Beweegt onvoldoende ~ ^ /	🟨	🟨	🟩
Overmatig alcoholgebr. ~ ^ /	🟩	🟨	🟥
(ernstige) overgewicht ~ ^ /	🟥	🟨	🟩
Eet dagelijks groente ~ ^ /	🟥	🟨	🟥
Eet dagelijks fruit ~ ^ /	🟨	🟨	🟥
Ontbijt dagelijks ~ ^ /	🟨	🟨	🟨

Psychosociaal	volw	oud	jong
Psychisch ongezond ~ ^ /	🟨	🟨	🟨
Kans angst/depressie ~ ^ /	🟩	🟨	🟨
Hoge eenzaamheidsscore ~ ^	🟨	🟨	
Matig+slecht ervaren gzdh. ~ ^ /	🟨	🟨	🟨

Ziekten	volw	oud	VAAM
COPD ‡			🟩
Diabetes ‡			🟩
Cardiovasculair risicomanagement‡			🟨
Harfalen ‡			🟩
Hoge Bloeddruk~ ^	🟨	🟨	
Verhoogd Cholesterol~	🟨		
Artrose (gewrichtslijtage heup/knie) ~^	🟨	🟨	
Diabetes~ ^	🟨	🟨	
Rugklachten~ ^	🟨	🟨	
Astma/CARA/COPD~ ^	🟨	🟨	

①

Kinderen (0-12 jaar)	kind
Indicatie pyschosociale problemen 4-12 }	🟨
Geen lid van sportvereniging 4-12 }	🟨
Beweegt minder 7 uur/ week 4-12 }	🟨
Overgewicht 2-12 }	🟨
Eet minder dan 6 keer/week fruit 2-12)	🟥
Eet minder dan 6 keer/week groente 2-12)	🟨
Lage kwaliteit van leven	🟨
Roken tijdens zwangerschap	🟨
Geen borstvoeding	🟥
Niet lopen/fietsend naar school	🟨
> 2 uur/dag tv computer	🟨

Farmaceutische zorg (voorschriften)	
Maagmiddelen‡	🟨
Cholesterolverlagers‡	🟨
Antibiotica‡	🟥
Kalmeringsmiddelen‡	🟩
Antidepressiva‡	🟩
Astma-/ COPD-middelen‡	🟨
Insulines‡	🟥 ← ?

2 ongewild

Omgeving	volw	oud	kind
Inwoners‡ en *	25481 - 25441		
Mannen‡ en *	12754 - 12695		
> 65 jaar (gemeente)	🟨	3619	
> 65 jaar ‡	🟨	3312	
Lage opleiding~ ^ }	🟥	🟨	🟨
Lage inkomens‡	🟨		
Grote moeite met rondkomen~ ^ }	🟨	🟨	🟨
Etniciteit: Westers *	☐		
Etniciteit: Niet Westerse‡	🟩	4%	NL=11%

Achtergrondvariabelen	volw	+ oud
Betaald werk ~	🟩	
werkloos ~	🟨	
arbeidsongeschikt ~	🟨	
1 ouder gezin }	🟩	

Verkeersveiligheid	☐
S avonds-nachts onveilig voelen ~^	🟨
Openbaar groen	☐
Vervuiling en overlast	☐
(zeer)ontevreden over sociale contacten ~ ^	🟨

‡ = gebaseerd op data van 't Nivel Vaam.nl, extrapolatie van huisartsregistraties (0-100 jaar)
* = data van de gemeente , 25441inwoners
/ emovo 2007, ~volwassenenmonitor 2008, } = kindermonitor 2009, ^ ouderenmonitor 2010

***Figure 13**: The neighborhood profile*

The perpetuation of the developed maps into new organizational formats

So far, we have identified how professionals in the two projects differentiated between elements (e.g. professionals, their qualifications, or data sources) in order to develop new knowledge that could support multidisciplinary collaboration. We furthermore observed how this sparked the need to map and how, during the mapmaking process, new sites of differentiation emerged, shaping the map, and the knowledge it (re)presented, in particular ways. However, the developed maps were not only deemed to represent knowledge. In turn, the maps developed were also deemed to give direction to the (re)organization of integrated primary care (Turnbull 2007). Below, we present whether and how these maps actually gave such direction.

MuON started as a project to reorganize the provision of oncological healthcare services in the primary care sector. Here, mapmaking was seen as a strategy to come to terms with, organize and represent a network of oncological primary care professionals and their integrated services. However, during the mapmaking process, intentions to rethink and reorganize professional relations in the context of oncological primary care, changed into something else. In line with the self-referential approaches of the hospital managers and general practitioners, such mapmaking changed into a project to plot different professional services within the existing organizational landscape of oncological care. In this light, mapmaking did not contribute to the reorganization of care beyond the boundaries and hierarchies of traditional professions. Rather, it reinforced such boundaries and hierarchies. Below, we discuss how.

While the MuON project group was discussing which admittance criteria needed to be used in order to allow professionals into the network and onto the map, the regional hospital's oncology department was making their own list of primary care providers, based on their own admittance criteria.

> Project group (member 1): '*This social chart [that of the hospital's oncology department] won't have the website format yet. It will be a leaflet depicting the care provided by oncology nurses*.'
>
> Project group (member 2): '*Well, that's nice. Will only nurses be depicted on the chart or will it show psychologists as well*?'
>
> Project group (member 1): *No, this is just the nursing part*.' (fieldnotes, 2 February 2013)

As a participating physiotherapist (interview transcript 2013) reflected on this development:

> '*The problem is that the hospital is developing its own map, but doesn't want to share it with us. Now, two maps are being developed. That is redundant. We need to make sure ours functions better*.'

In the MuON project, the objective to integrate oncological referrals between the regional hospital and primary care providers—by means of maps—was materialized by the hospital and the MuON project group in different ways. For the hospital managers, a leaflet would suffice. This leaflet could help their medical specialists to refer patients to qualified primary oncological nursing care; in terms of hospital standards (hospital manager, interview transcript 2012). However, for the primary care professionals that participated in the project, the map would be a way to present themselves as part of a specific oncological primary care network. A network in which different kinds of 'the right' professionals collaborated and complemented one another in the provision of integrated oncological care services (physiotherapist, interview transcript 2012).

In addition to the above, general practitioners in the region were reluctant to support the project group. They, for instance, barely joined project meetings (field observations 2012). Those general practitioners that did participate stressed the importance of the different roles and positions in the Dutch healthcare system. General practitioners, for instance, considered themselves (and were often framed as such by policymakers) as the gatekeepers of healthcare services (Klink 2008). They were supposed to refer patients to either the hospital, or to other primary care professionals. From this perspective, the MuON website would be a good way to present to—and discuss with—patients which different oncological primary care services were present in a particular region. However, patients should not be encouraged to contact these professionals directly (when new symptoms would occur) and referrals should be done with a patient's general practitioner's consent (general practitioner, interview transcript 2013).

The general practitioners' objections were incorporated into and displayed on the MuON website. When visitors used the websites search engine, the following text message appeared:

> *'Caution: If you have any new symptoms for the first time, please contact your general practitioner or hospital consultant first.'* (www.muon.nl [no longer online])

In the end, only few professionals have taken the effort to register themselves on the MuON website. The oncological primary care network and its map were thus not reproduced by registering primary care professionals. Neither was the MuON map recognized by others—such as secondary oncological care providers—as the map to use when referring patients to oncological primary care providers. After all, the hospital had developed its own map. Lacking internal structure and external recognition, the oncological primary care network disintegrated. At the time of writing this article, the website and its map have been discontinued.

In contrast to the MuON project, the developed map in the NHP project did give direction to new organizational formats for the provision of integrated care. Instead of directly focusing on the integration of professional roles, this project had sought to develop knowledge about health and lifestyle issues on the level of the neighborhood. This knowledge, represented in the neighborhood profile, could be used to identify health and lifestyle issues on the level of the neighborhood population. This way, the neighborhood profile could support other collaboration initiatives that had already sprouted in the city (see again our case description in section three). This is illustrated by the action scheme illustrated in table 5 (Terpstra and Moerman 2013: 13).

Table 5: *The NHP action scheme*

Step	What	Who
1	Choosing a particular neighborhood.	A collaboration initiative and its group of professionals.
2	Fill in the neighborhood profile using the predefined data sources.	An epidemiologist of the municipality's healthcare services.
3	Discussing the results in a group meeting.	Composition of the professional group is discussed within the collaboration initiative; the epidemiologist presents outcomes; the collaboration initiative's coordinator interprets outcomes.
4	Choosing the three main issues in the neighborhood.	The group of professionals.
5	Discuss the outcomes of the profile and the priority setting (of step 4) with neighborhood residents.	Coordinated by an independent chairperson, attended by the professionals.
6	Decide on the issue to be tackled and discuss the phasing of the project.	The group of professionals.
7	Appoint a local project leader.	One of the professionals.
8	Identify interventions previously undertaken – or being taken – and those involved in them.	The project leader.
9	Develop a project plan for the first theme.	The professionals and organizations involved in this specific project.

The neighborhood profile indeed became an integral part of already initiated collaboration initiatives on the level of the neighborhood:

> '*Making and discussing the neighborhood profiles has induced a sense of connectedness between professionals and the neighborhood. The profiles were therefore not just a project objective, but also an instrument to stimulate collaboration*.' (Terpstra and Moerman 2013)

Moreover, the neighborhood profile also informed the writing and substantiating of the municipality's policies for neighborhood planning and development. In many ways, the NHP project group had: (1) structured how real neighborhood knowledge should be gathered; and (2) organized how such knowledge should inform collaborative action. Moreover, (3) the neighborhood profile developed was recognized by other groups, such as the municipality, as relevant knowledge. In contrast to the MuON case, the NHP thus seemed to have internal structure and external recognition. The map helped to carve out a new object that could be described as: neighborhood population management.

Based on the above, we would like to emphasize that whether and how maps and their underlying differentiations give direction to the (re)organization of healthcare services, seems to depend on three interrelated points. First, does the mapping contribute to an organization's internal structure and logics of reproduction (MuON's admittance criteria/NHP's action scheme). Second, but related to the first, is this internal structure actually recognized and reproduced by (potential) organizational members (MuON's lack of registering providers/NHP's integration of the profile into other collaboration initiatives). Third, is the map recognized by organizational others as a distinct body of knowledge to be dealing with (e.g. MuON's lack of recognition from general practitioners and the hospital/NHP's uptake by the municipality).

Conclusion

In this article, we posed the following research questions: How did professionals shape interprofessional relations through the process of mapmaking and what were the consequences thereof for the organization of integrated primary care? In order to answer these questions, we took two mapping projects as our case studies. Informed by our theoretical framework, we analyzed these cases in a particular order. We first identified which sites of differentiation were articulated in the two projects and how these sites were yoked together (Abbott 1995). Thereafter, we reconstructed how these sites of differentiation and their interrelations emerged from the process of mapmaking (Jones 2009). Lastly, we discussed how the developed maps gave direction to the reorganization of integrated primary care (Turnbull 2007).

We noticed that sites of differentiation differed between the two projects. The MuON project sought to develop knowledge about which professionals were providing oncological primary care services in the region. They differentiated between professionals, their competencies, and their services. The NHP project sought to develop knowledge about health and lifestyle issues on the level of the neighborhood. They differentiated between different kinds of health and lifestyle data and analytical categories. We furthermore observed that in both projects, differentiating, yoking, and mapmaking were very much intertwined (Jones 2009). Some differentiations sparked the need to map (e.g. differentiating between oncological and non-oncological care providers, or real neighborhood data and extrapolated data). Others emerged, or needed to be further specified, during the mapmaking process. Mapping, in that sense, became an ongoing process of including and excluding providers and services (in case of MuON), or data sources and categories (in case of the NHP), from the maps under development.

We also noticed that the developed maps gave direction to the (re)organization of integrated primary care in different ways. In the MuON project, general practitioners problematized the use of the map by individual patients. In addition, the regional hospital developed its own map to cater to hospital needs specifically. Here, mapmaking changed into a project to plot different professional services within the existing organizational landscape of oncological care. Subsequently, the developed map did not contribute to the reorganization of oncological primary care beyond the boundaries of traditional professions. In contrast, the NHP map was integrated into multidisciplinary collaboration initiatives and gave direction to their thematic collaboration projects on the neighborhood level. There, it induced a sense of connectedness amongst professionals. Moreover, the map was recognized by the municipality as an important source of information on which their own neighborhood planning and development policies could be based. The NHP map thus helped to carve out a new collaborative organizational object: neighborhood population management.

Discussion

Our article resonates with current debates in the literature on organized professionalism (Evetts 2003; Waring and Currie 2009; Noordegraaf, Van der Steen, and Van Twist 2014). On the one hand, our analytical framework has been informed by a processual and dynamic reading of organized professionalism; an approach dedicated to revealing the intricacies of shaping professional organizational formats beyond the boundaries of traditional professional groups (Abbott 1995). On the other hand, our case study was informed by scholarship that focusses on the spatial dimensions of organized professionalism (Pinder et al. 2005; Postma 2015; Ivanova et al. 2016; Oldenhof et al. 2016). Combining the two, we intended to better understand how a dynamic, Abbott (1995) inspired analysis of mapmaking, can give insight into the ways in which professionals organize interprofessional relations beyond the traditional boundaries of their professional groups (cf. Jones 2009).

Informed by our data, we argue that maps are indeed good sites to study Abbott's (1995) sites of differentiation and how these are yoked together to tell a particular, possibly alternative organizational story (Sauer 1956; cf. Harley 1988; Jones 2009). Moreover, studying the mapmaking process provided detailed insight into whether and how such maps actually gave meaning and direction to new organizational formats in the provision of care (Turnbull 2007; Crampton 2009). Nevertheless, we want to close this article with three points that need to be taken into account when studying maps and mapmaking in order to gain insight into the (re)organization of care, beyond the boundaries of traditional professional groups.

First, we want to emphasize that maps can take on many forms. In geography, maps are considered representations of the relationships between (pre)defined entities in the context of a particular space (Harley 1988; Crampton 2009; Jones 2009). Some of these representations are static; depicting how such entities are related to one another at a particular point in time by a particular mapmaker and in the context of particular political agendas (Harley 1988). Other representations are more interactive, with entities added or removed over time. As such, maps can take on many forms (e.g. Pinder et al. 2005). In our case, the MuON project developed an interactive website that displayed professionals and their services spatially (on a google/maps interface). In turn, the NHP project developed a structured one-page list of categories assessed on the spatial level of neighborhoods. Both maps thus depicted entities and their relations in the context of a particular time-space, but they did so in very different ways (figures 10 and 11).

Second, when identifying sites of differentiation in order to study professional groups in formation, such differentiations do not necessarily need to concern professional roles and positions, responsibilities and competencies (cf. Abbott 1995). In the MuON project, it were indeed mostly these themes that emerged as sites of differentiation. However, in the NHP project, main sites of differentiation were the relevance and accessibility of data and analytical categories. It were such sites of differentiation that carved out an alternative zone for organized collaborative action: thematic interventions on the level of the neighborhood; giving rise to a new object for (inter)professional work: population health management.

Third, different ways of differentiating and mapping thus seem to have different organizational consequences. In case of the NHP project, exploring and mapping healthcare issues on the level of the neighborhood appeared to induce collaborative action. In contrast and in case of the MuON project, mapping interprofessional relations directly only appeared to invoke the reproduction of traditional professional roles and positions; particularly by those that sought to maintain their professional positions (cf. Felder et al. 2018). More empirical studies are however needed to shed light on the organizational consequences of different ways of mapping (and their underlying differentiations). In this article, based on previous work in the sociology of professions and organizations and social geography, we have laid the groundwork for such an approach.

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7

Conclusion

Recurring demands for healthcare reform

> *‘In the spring of 2015, we started to oppose the suffocating bureaucracy in primary care. We did so by collecting and publishing the everyday experiences of GPs and by presenting these narratives to politicians and health insurers. It was the start of an increasingly inclusive battle against bureaucracy in healthcare (…). Now, we want to give voice to a silent crisis. One that victimizes the vulnerable patients in our counselling rooms. We want to make sure that they do not fall between two stools. Instead, they should receive the integrated care they need through fruitful collaboration between GPs and other healthcare providers (…). Not competition but the will to collaborate should be leading.’* (Het Roer Moet Om 2019: 9-10)

Four and a half years after the GPs taped their first manifesto to the door of the Dutch Ministry of Health, they have gathered in front of the glass door of the Ministry once again. This time, they highlight the fragmentation of care provided to vulnerable patients. They have bundled their experiences in a booklet titled ‘Care for Collaboration’ (Het Roer Moet Om 2019). This booklet does not receive much attention from healthcare professionals and professional others; at least not in comparison to the previous manifesto. Nevertheless, I think it is important to start this concluding chapter by referring to this booklet. Particularly so, because of three observations. Firstly, restoring collaboration was already the main issue addressed by GPs in their first manifesto (see introduction). Secondly, in the last decade, many policy experiments have been organized in order to overcome tensions and stimulate collaboration amongst professionals – and between professionals and professional others. Thirdly, in response to the GPs’ new manifesto, the Minister of Health stated that similar projects to improve collaboration will continue to be organized in the future (Bruins 2020). Together, these observations raise the need to reflect on what happened in the policy experiments that had already been organized and what their contributions were in terms of overcoming contemporary tensions and improving collaboration. In this concluding chapter, I intend to do just that.

Each of the papers included in this dissertation discusses a policy experiment that was aimed at moving beyond contemporary tensions and/or improving collaboration between actors involved in Dutch healthcare governance. An exception is a paper examining the discussion on the role of evidence-based medicine in healthcare decision-making. This paper provided additional insight into the tensions between healthcare professionals and professional others and helped me to place the policy experiments into an institutional context. In this concluding chapter, I use these different papers to provide a multifaceted answer to the overarching research question posed in the introduction:

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

To answer this research question, I formulated three more specific questions:

- *I) What do Dutch healthcare actors mean with 'policy experimentation' when organizing and participating in such experiments?*
- *II) What do Dutch healthcare actors actually do within an experimental context?*
- *III) What do policy experiments produce in terms of resolved tensions and improved collaborations in Dutch healthcare governance?*

I have structured this concluding chapter as follows. First, I address the three research questions. Importantly, I answer them in reverse order; starting with question three and thereafter answering questions one and two. I choose to do so because I first want to address – in more general terms – whether and how the policy experiments I studied contributed to improving collaboration and overcoming contemporary tensions in layered healthcare governance; and thereafter discuss – in more detail – the mechanisms by which they tended to do so, or not. I will end my conclusion discussing the implications of my findings for those that (plan to) engage in policy experimentation.

Policy experiments and their contribution

As a start, I want to posit that policy experiments do not necessarily contribute to overcoming tensions between actors involved in layered healthcare governance. In the previous chapters, I have described cases of deteriorating relations between healthcare actors (chapter 4); healthcare actors protecting their own organizational continuity and therefore the continuation of a status quo (chapter 5); and – to be fair – also signs of organized collaboration around new healthcare issues (chapter 6). In order to explain why these observations are important for both science and practice, I first return to the literature on policy experimentation and thereafter address how my observations divert from it.

Well documented in the experimentalist literature is a turn from approaching policy experiments as testing grounds (Martin and Sanderson 1999), towards approaching them as collaborative practices in which temporary solutions are crafted for situated problems (Sabel and Zeitlin 2012). Although several authors have stressed the affective and material conditions in which such crafting takes place (Marres 2013; Iedema and Caroll 2015), emphasis is often placed on deliberative rationality and the sharing of knowledge within the time-space of a policy experiment (Sabel and Zeitlin 2012; cf. Callon 2009). A similar approach is taken by Dutch policymakers. They tend to approach policy experiments as a method to bring healthcare actors together, facilitate the sharing of knowledge and produce more situated and inclusive configurations for the provision of care (Houppermans 2017; cf. RVenS 2017; Vilans 2020).

However, as the empirical chapters in this thesis have shown, policy experiments are not the rational and inclusive endeavors that supporters of deliberative rationality would let us believe (cf. Mouffe 2005; Jasanoff 2012). Instead, they are emotional, normative and political processes with emotional, normative and political outcomes (Voβ and Simons 2018; Jasanoff 2012). In this light, I particularly want to point out three kinds of politics I identified in the analyzed policy experiments.

The first I encountered was *capital P politics* (cf. Marres 2013). It concerned acts such as the ways in which politicians used policy experimentation to mobilize actors around an intervention, pushed something through the House of Representatives or left responsibility for what happens in the hands of the many and divided. The second was a *politics of learning*. It concerned the way in which certain experimental logics fitted better with – and tended to produce and reproduce – certain healthcare logics and market logics (cf. Butler 2010). Doing policy experimentation in a certain way thus produced certain paths of learning whilst foreclosing others (chapter 4). The third was a *politics of positioning*. It concerned professionals and professional others aiming to maintain or improve their institutional position by interpreting and translating institutions and experimental objectives idiosyncratically (chapter 5; cf. Lawrence and Suddaby 2006).

In the next two subsections, I will provide more detailed descriptions of the abovementioned politics. First however, I want to emphasize one more point about the contribution of policy experiments; one that explains why it is important to look at such politics in detail.

Even though the abovementioned politics do not necessarily fit the policymakers' account of bringing people together and sharing knowledge (Houppermans 2017), they can still be considered a productive aspect of policy experimentation in the wild (cf. Callon 2009). Indeed, some experimentalist scholars have emphasized that policy experiments tend to heighten instead of solve controversy (Zuiderent-Jerak 2015; Wehrens 2018). Importantly, these scholars stress that such controversy does not has to be a wicked thing. It is a matter of redefining what is at stake. In this light, policy experiments should not be aimed at capturing or taming institutional complexity. Instead, they should be aimed at organizing situated responses to challenges in context (Ferraro et al. 2015) – in this dissertation the uncertainties and tensions between actors pertaining to layered healthcare governance. Policy experiments then become time-spaces in which new modes of ordering emerge without working towards a definite solution (Clegg et al. 2015). Such experiments allow for actors and things to flow and keep flowing (cf. Star and Griesemer 1989) in a world that seems to be layered, stratified, even sedimented.

Yet even though policy experiments have become commonplace in Dutch healthcare governance (e.g. ZonMw 2009; Schippers 2011; RVenS 2017; RIVM 2018; Bruins 2020; Vilans 2020), actually cutting through vested interests and moving beyond the status-quo seems to be a rare event. It are such rare events that most scholars of policy experimentation seem to attend to, want to describe and help to account for (cf. Latour 1996; 2005). Moreover, it are such rare events that policymakers want to celebrate as best practices (ZonMw 2009; RIVM 2018). However, I would like to argue that, in a governance context in which everybody seems devoted to moving beyond contemporary tensions and to improving collaboration, understanding why such tensions remain unresolved – and organizing collaboration proves more difficult than anticipated – deserves a similar amount of attention. Particularly so, there where such 'lack of flow' occurs in the time-space of a policy experiment. In the next two subsections, I intend to do just that.

Policy experiments are multiple

Policy experiments can be just as multiple as the worlds they are supposed to bring together. Some approach them as tests in which to observe and evaluate the effects of an intervention (Cornet and Webbink 2004). Others approach them as protective time-spaces to stabilize new or refurbished governance principles (NZa 2009; ZonMw 2009). Yet others might approach them as instruments to stimulate situated responses to complex problems and highlight these as best practices (RIVM 2018). But recognizing such multiplicity is not enough to understand why policy experiments do not necessarily contribute to moving beyond vested interests or overcoming tensions between healthcare actors. There is more to it and this can be observed in the ways in which these different approaches shape learning; a process I introduced in the previous subsection as a politics of learning. Below, I reflect on this process.

In chapter 4, I analyzed an experiment with free pricing arrangements in dental care. I first traced how participating actors approached both the object of experimentation (a dental care market) and policy experimentation differently (e.g. testing versus stabilizing). Thereafter I traced how such different approaches structured what participants observed in the policy experiment, crafted and demonstrated as experimental outcomes and took as starting points for further action (cf. Muniesa and Callon 2007). During the first quarterly evaluation of the dental care experiment, consumer organizations and professional organizations, for instance, demonstrated very different things. Consumer organizations approached the market as an external force that needed to be contained and the experiment as a test to see whether the market could be contained. They used numbers to highlight increased prices (which they deemed undesirable) and lack of transparency (which they interpreted as the cause of increased prices). They concluded that the experiment had successfully proven that the market could not be contained. In contrast, the professional organizations approached the market as something that needed to be carefully crafted and the experiment as a time-space to learn how to do so. They used their own experiences to highlight product innovation (which they framed as the reason to introduce free prices in the first place) and steps taken to improve transparency. The professional organizations celebrated these observations and called for more time and additional interventions. Importantly, the experiment itself was not the protective time-space within which these different insights were demonstrated and discussed amongst participants. Instead, each of them actively sought to demonstrate *their* observations to *a* wider public.

Based on the abovementioned reconstruction, I concluded that the dental care experiment was actually two different experiments, unfolding at the same time, but in different epistemological regimes. It did not bring the worlds of consumer and professional organizations together. Instead, the experiment had different meanings and purposes for each of them and they learned different things from it. Moreover, lessons learned did not inform policymakers and politicians deliberatively or rationally. In fact, some demonstrated observations became entangled in an opportunistic struggle between left-wing and right-wing politicians. Based on the parliamentary vote, the experiment was cancelled. For the dentists, a liberated dental care market was lost, and everything seemed to return to the old. On closer inspection however, the quality transparency that consumer organizations had been highlighting as a deficiency in the experimental setup (there was lack of it), did emerge as *the* new challenge in organizing and regulating healthcare markets (Schippers 2015). In fact, quality transparency was suddenly deemed of critical importance for healthcare markets to work properly. It changed from something that could be created *vis a vis* price liberalization, into a prerequisite for price liberalization. Dental care became a critical example of that lesson learned. I have termed the dynamics by which some lessons are reproduced at the cost of others, a politics of learning.

The dental care experiment thus seemed to have produced an important lesson: the importance of quality transparency. But the politics of learning by which this lesson emerged did not help to alleviate tensions between healthcare actors or move beyond vested interests. Instead, it fueled distrust between policymakers, consumer organizations and dentists; particularly alienating the disillusioned dentists in the process. In resonance with my previous conclusion, this politics of learning explains how it can be possible that we attribute much potential to policy experimentation, whilst the tensions between actors involved can remain unresolved, or even deteriorate. This observation has two important consequences.

Firstly, policy experiments *might* produce lessons from controversy (Zuiderent-Jerak 2015), but these lessons do not have to be *inclusive* or *collaborative*; as some authors propose them to be (cf. Sabel and Zeitlin 2012). Productive as experiments *can* be, they thus do not necessarily help to move beyond contemporary tensions between actors involved. Nor do they produce the *inclusive* solutions that policymakers seem to be aiming for (cf. Houppermans 2017). Therefore, I warn against *a priori* approaching policy experiments as protective time-spaces for open dialogue and inclusive learning (Regeer et al. 2009; Arkesteijn et al. 2015), especially there where policy experimentation is introduced to push things through and/or move beyond vested interests.

Secondly, those that participate in policy experimentation usually fail to stabilize and control what they initially set-out to do (Latour 1996; 2005). In this light, experimentalist scholars have emphasized the importance of opening-up and give words to the unexpected (Wehrens 2018). However, based on the abovementioned insights, I want to posit that we do not only need to give words to what is learned from a policy experiment but also need to try to come to terms with what is lost in the process; e.g. new treatment combinations in dental care or improved collaboration between professional organizations, consumer organizations and policymakers (cf. Mouffe 2005; Butler 2010). Only then can we better understand what policy experiments produce in terms of lessons learned, but also in terms of voices silenced and actor relations reformed (for better or worse).

Healthcare actors participate in policy experiments together alone

In the previous subsection, I concluded that different ways of approaching policy experiments can have consequences for the ways in which they help to move beyond vested interests, improve collaboration and produce inclusive solutions. A typical response to this conclusion could be that the dental care experiment did not seek to improve collaboration in the first place and that experiments that specifically focus on organizing collaboration would turn out differently. Another response could be that solutions need to be found in the coordination and evaluation of policy experiments; for instance, explicating or discussing what the experiment is and better coordinating how results should be demonstrated. In fact, these were the suggestions we provided in chapter 4.

In this subsection, I will, however, point out that even when those who participate in policy experimentation seem to approach the experiment and the object of experimentation similarly – for instance as a protective time-space to bring actors together, share knowledge and produce inclusive organizational configurations – that does not necessarily mean that such policy experiments lead to the alleviation of tensions, the production of new organizational formats, or inclusive solutions for the uncertainties that stem from institutional layering. As shown in the empirical chapters, whilst studying the practices of those that sought to organize new forms of collaboration within the time-space of policy experiments, I encountered many closures, boundaries and uncertainties.

To describe such practices, I used concepts from institutional theory. Doing so, I particularly related to scholars that tried to move beyond accounts of institutions shaping professional behavior, or in contrast, professionals purposively creating, maintaining or destroying institutions (Hall and Taylor 1996; cf. Smets and Jarzabkowski 2013). Informed by these scholars, I intended to study how actors related to the governance principles introduced in policy experiments (e.g. collaboration and patient-centeredness) and how such principles simultaneously shaped professional identities, roles and relations (Lawrence et al. 2013; Zundel et al. 2013).

Studying such dynamics within policy experiments proved to be a double-edged sword. On the one hand, the literature sensitized me to the politics of (re)positioning actors within such experiments (Lawrence and Suddaby 2006). On the other hand, the experiments allowed me to collect and analyze *in vivo* data on how professionals worked with governance principles introduced. Importantly, such data allowed me to move beyond historical accounts of institutional determinism and retrospective accounts of purposive and strategic action; accounts that still prevail in the institutional literature (Smets and Jarzabkowski 2013). Instead, I could reveal acts of coping and improvisation, as well as the translation and internalization of governance principles introduced (chapters 3, 5 and 6).

Informed by the institutional literature, I observed that participating in policy experimentation is a collective act, but not necessarily a collaborative one (cf. Sabel and Zeitlin 2012). In fact, it was also a way to (re)position oneself as a professional within a layered institutional context; one in which other professionals and professional others were doing the same. Indeed, I observed professionals protect conventional governance principles in order to maintain a particular position (e.g. collaboration is important, but the GP is *the* gatekeeper and *the* compass for patients [chapter 5]). I observed professionals problematize conventional governance principles in order to restore their institutional position (e.g. professional others have started to relate to evidence-based medicine, but evidence-based decision making is an illusion [chapter 2]). And I observed professionals support new governance principles in order to make sure they were not missing out (e.g. participating in the development of integrated referral systems [chapters 5 and 6]).

The abovementioned observations fit well with the institutional work literature (cf. Lawrence and Suddaby 2006); particularly so with those accounts that try to move beyond institutional determinism or purposive action (e.g. Lawrence et al. 2013; Smets and Jarzabkowski 2013; Zundel et al. 2013). There are however two important lessons

I want to contribute to this institutional work literature. Firstly, in a layered institutional context, institutional *creation* or *maintenance* work cannot be reduced to the *creation* or *maintenance* of one institution. Instead, actors need to deal with a plethora of institutional arrangements simultaneously. Moreover, they can relate to these arrangements differently, at different times and for different reasons (Van de Bovenkamp et al. 2017). For example, I observed professionals relate to market mechanisms in order to describe other professionals as competitors, whilst not much later, the same professionals related to professional self-regulation in order to defend their counseling room as the place were altruistic healthcare decisions are made. Secondly – and particularly so in relation to policy experimentation – *creation* or *maintenance* work does not singularly relate to the institutional status of a doer; e.g. *marginalized* actors conducting institutional *creation* work or *privileged* actors conducting institutional *maintenance* work. Something that institutional work scholars have tended to do (cf. Lawrence and Suddaby 2006). Instead, I observed that in order to *maintain* a *privileged* position, one might need to participate in the *creation* of new institutional arrangements (e.g. not missing out as emphasized in the previous paragraph). In this light, experimentally introduced governance principles seem to prompt both privileged and marginalized professionals to conduct (re)positioning work, whilst simultaneously providing them with something to work with in order to *maintain* or *improve* positions. A typical example is provided in chapter 5. It concerns the ways in which both *privileges* and *marginalized* healthcare professionals described themselves as more 'patient-centered' than others in order to strategically position themselves at the heart of the collaborative organizational formats under construction.

To be fair, in all the cases I studied, healthcare professionals participated in policy experimentation – and related to governance principles introduced – to overcome tensions and improve healthcare services. But their investments also tied into the maintenance or improvement of their own positions. Ironically, such investments meant that professional boundaries were maintained, instead of dissolved or ordered on another level of organization. Even more so, policy experimentation helped to legitimize such boundaries maintained (chapter 3). Policy experiments turned political work into experimental outcomes that could be accounted for *as* experimental outcomes (e.g. as best practices; but see also Jerak-Zuiderent 2015a, who argues that experimental outcomes need to be accounted for). Through the ways in which healthcare actors participated in the policy experiments I analyzed, these experiments thus tended to reproduce and (re)legitimize vested interests and conventional modes of ordering, instead of moving beyond them.

Importantly, the above does not mean that healthcare professionals themselves did not change from participating in policy experiments. To improve or maintain positions and reproduce boundaries, participating professionals needed to adapt to a changing institutional environment (Evetts 2003). In that sense, they needed to open-up towards new governance principles whilst simultaneously interpreting them through – and bringing them in line with – their conceptual and normative frames of reference already in place (La Cour and Højlund 2013). In chapter 5, I described such self-referential modes of observation as structurally open and operationally closed (Van Assche et al. 2014). From this point of view, it was easy to observe how the governance principle of patient-centeredness was internalized by professionals as professional quality. At the same time, structural openness and operational closure also helped to explain how – in the multidisciplinary context of the Primary Focus program – such patient-centeredness turned from a shared objective into a contested professional quality.

Likewise, institutions and experimentally introduced governance principles did not stay stable either. The way in which professionals interpreted some institutional arrangements (e.g. market mechanisms), influenced the way in which they worked on introduced principles (e.g. multidisciplinary collaboration and patient-centeredness). Some professionals for instance pondered over approaching other professionals as competitors, collaborators or even future employees in the provision of integrated and patient-centered care. These professionals did not merely create, maintain or oppose governance principles and institutional arrangements. Rather, they gave meaning to new governance principles in the context of their interpretation of institutional arrangements already in place. As Van de Bovenkamp and colleagues already observed (2017), it is through such interpretations and translations that new regulatory arrangements interact with already existing arrangements and can have unpredictable consequences.

The latter two paragraphs highlight why it is easy to understand that we value policy experiments as productive time-spaces. There are enough examples to illustrate change on the level of professionals and institutions. But the politics of (re)positioning discussed also make clear that, even though actors and institutions might change in/through policy experimentation, boundaries and tensions tend to remain stable. Organizing collaborative formats for the provision of integrated care thus proves to be a difficult task, even in policy experiments aimed at improving collaboration (SMOEL 2015).

So is there no hope?

Ironically, policy experiments that were particularly aimed at improving collaboration between established healthcare actors did not seem to be fruitful endeavors in terms of producing alternative organizational formats for the provision of collaborative and integrated care (SMOEL 2015). Because such attempts started with *predefined* actors and targeted the relationships *between* these actors, they easily turned into the protection of professional heartlands, the explication of hierarchies and the maintenance of boundaries.

Typically, topics for discussion concerned the division of professionals' and professional others' roles and positions, responsibilities, competencies and who should and should not be included. In a layered institutional context, actors could easily draw on a plethora of rules and regulations to legitimize such claims. And if that did not suffice, they could resort to problematizing the institutional claims of others by relating to scientific claims and counterclaims (Deacon 2002; Halffman 2003; Bacci 2012). In the policy experiments I studied, I indeed observed many healthcare actors working on multidisciplinary collaboration, patient-centeredness and evidence-informed decision-making by digging-in.

Nevertheless, I did encounter situations in which healthcare professionals and professional others were able to move beyond the boundaries between traditional professional groups (chapter 6) or between professionals and professional others (chapter 3). This was particularly the case there where these actors intended to organize themselves around new healthcare issues. Such projects started with attempts to define what these new healthcare issues were in the first place. An example is the establishment of a Neighborhood Health Profile discussed in chapter 6. Typical topics for discussion then became the relevance and accessibility of data and the analytical categories through which such issues should be made explicit and understood. Meanwhile, how actors should relate to such issues and participate in collaborative action remained open for discussion. Importantly, such new healthcare issues lacked the presence of established institutional and scientific frameworks on which divisions of labor and professional control could be *a priori* legitimized. Instead, these issues opened-up for new forms of conduct and their justification (cf. Boltanski and Thévenot 2006; Oldenhof et al. 2014). The Neighborhood Health Profile for instance helped professionals and municipalities to carve out a new and collaborative organizational object: neighborhood population management.

It is around such emergent healthcare issues that potential seems to reside for moving beyond vested interests and develop alternative organizational formats for the provision of care (cf. Abbott 1995). At the same time, however, I also contend that it would be naïve to assume that the politics observed in the previous subsections would be absent from such policy experiments. Sensitized by my own observations and those of Mouffe (2005), Butler (2010) and Jasanoff (2012), the analytical categories through which new healthcare issues are made explicit will produce new distinctions (e.g. what is and what is not part of the issue). These distinctions will privilege some emergent groups over others (e.g. what should be done in light of the issue defined and who should be involved) and will silence some voices whilst amplifying others. Tensions in the governance of healthcare will then not be alleviated but rather displaced; there will be different tensions between different actors that gather around new issues. What matters most, in that case, is whether such alternative organizational formats produced indeed support the provision of integrated care that many professionals, policymakers and patient representatives are calling for (Het Roer Moet Om 2019; Patientenfederatie Nederland 2019; Bruins 2020).

Theorizing change

There is one additional contribution I want to make to the experimentalist and institutional literature already discussed. This point is however not limited to these strands of literature and is addressed to all those that want to study, describe, evaluate and account for what happens in policy experiments.

Over the last twenty years, institutional and experimentalist scholars (e.g. Lawrence and Suddaby 2006; Sabel and Zeitlin 2012), as well as sociologists of organized professionalism (e.g. Evetts 2003; Noordegraaf 2015), have placed emphasis on studying how institutions and professions change over time and in response to one another. Whilst doing so, these scholars have been guided by several sociological principles through which such change can be observed and explained. Two of these principles have featured in this dissertation. The first resonates with Social Systems Theory (e.g. Luhmann 1997; Rasch 2000) and has informed chapters 3 to 5. The second resonates with Actor Network Theory (e.g. Gieryn 1995; Latour 2005) and has informed chapter 6. I used both principles – but in different papers – to understand what happens in policy experiments. However, these principles do not produce a comprehensive explanation of professional change. In fact, they produce rather contradictory observations (cf. Latour 2005). Below, I discuss them in turn. Thereafter, I argue why it is important to be aware of these principles when studying professional and institutional change within and beyond policy experimentation.

The first sociological principle is aimed at describing how professional groups adapt the content of their professions to a changing environment (e.g. including new technologies, principles, and insights as part of a professional domain). Scholars that follow this principle take professional groups as analytical starting points. Of analytical concern is the way in which these professional groups observe their changing environment and: a) differentiate between what is and what is not relevant on the basis of their already established frames of reference; and b) embed whatever is deemed relevant within such frames of reference. Through such mechanisms of differentiation and indication, professional organizations adapt to and keep up with a changing environment (Rasch 2000; La Cour and Højlund 2013). Professional heartlands evolve and boundaries are redrawn, but always based on historically contingent frames of reference. Professional change – in this sense and even in policy experiments – is thus very much path dependent and self-referential. In chapter 5, I have described such dynamics of professional change as structurally open and operationally closed (Rasch 2000; Van Assche et al. 2014; cf. Luhmann 1997). Structurally open here refers to the structural couplings between professionals and their institutional environments, allowing (new) principles, such as multidisciplinary collaboration and patient-centeredness to flow from policy programs to professional practice. Operational closure in turn refers to how professionals observe and deal with such principles in their own profession' specific ways (La Cour and Højlund 2013). As demonstrated in chapter 5 and recaptured in the second subsection of this conclusion, structural openness and operational closure fit well with the institutional work literature (Lawrence and Suddaby 2006). Particularly so, as the latter tends to take actors as an analytical starting point; e.g. GPs aiming to maintain and midwives aiming to improve their position in primary care.

Reasoning the other way around, one can also argue that the institutional work literature tends to take professional groups as an analytical starting point and therefore produces accounts of institutional and professional change that are path-dependent and self-referential. Consequently, these scholars struggle to explain how professional groups dissolve or how new groups are formed (Abbott 1995; Gieryn 1995; Hudson 2002; Latour 2005). At best, they provide accounts of professional groups splitting up, being displaced, or failing to reproduce themselves (change equals fragmentation like an evolutionary tree).

Some scholars have therefore abandoned to take professional groups as an analytical starting point. Instead, they follow a different sociological principle. They start with the identification of events of differentiation (e.g. between relevant and irrelevant data; between what is part of and not part of an analytical category; or between what is and what is not an appropriate response to something observed). Thereafter, they study how such differentiations are yoked together (e.g. data; categories; acts) and what such yoking leads to in terms of professional groups in formation (Abbott 1995; Latour 2005). These sociologists approach professional groups – or any form of organized practice – as the temporary and accidental outcome of an accumulation of all kinds of differentiations (Gieryn 1995). In chapter 6, this principle allowed me to reveal how individual professionals, professional groups, and 'professional others' split, merge or dissolve on different levels, in different time-spaces and in relation to different developments in the governance of care (cf. Adler et al. 2008). Importantly, this second sociological principle fits well with the experimentalist literature (Zuiderent-Jerak 2015; Wehrens 2018). Particularly so, as it tends to focus on how actors and things flow and assemble on different levels of organization and in different time-spaces.

Both sociological principles are based on mechanisms of differentiation. The first emphasizes the mechanism of differentiation and indication (Rasch 2000). The second emphasizes the mechanism of differentiation and yoking (Abbott 1995). Both however address the consequences of such differentiations differently. The first emphasizes the self-referential ways in which professional groups deal with challenges in their institutional environments. For instance, the previously mentioned ways in which professionals adapt to new governance principles by bringing them in line with the conceptual and normative frames of reference already in place for their profession (chapters 3 - 5). The second is attuned to identifying and understanding organizational formats and professional groups in formation. For instance, the previously mentioned ways in which differentiations are made between healthcare issues to be solved, bodies of knowledge to be developed and practices to be facilitated (chapter 6). The first helps to explain why professionals do not understand one another and struggle to produce integrated organizational formats beyond the boundaries of their professional groups (chapter 5). The second helps to identify the very acts and moments in which professionals do try to move beyond the boundaries of their professional groups and organize themselves around new issues and challenges (chapter 6).

Palpable as the contrasts between these principles might be, I believe that institutional and experimental scholars do not often reflect on them in their work; nor the consequences they have for their analyses. At least, in my own dissertation, it took me quite some time to distance myself from the first principle, study policy experimentation informed by the second principle and come to terms with the different kind of observations it produced. In this light, I particularly want to highlight that the first principle prompted me to produce rather skeptical accounts on policy experimentation. This skepticism is echoed in the title of this dissertation (Together Alone) and in the accounts of institutions and professionals changing whilst boundaries being maintained (chapter 5 in particular). In contrast, the second principle helped me to identify and highlight moments in which professionals did seem to be able to move beyond contemporary organizational and institutional boundaries. Such hope features in the title of the previous subsection and in accounts of professional groups in formation (chapter 6 in particular).

Importantly, I do not highlight these different principles in order to claim that they are just another way of looking at empirical phenomena. One could then argue that these principles can be combined to produce a more inclusive theory on institutional and professional change in and beyond policy experimentation. However, as already emphasized, these principles are rather contradictory (e.g. can one simultaneously change oneself and move beyond oneself, reproduce a professional boundary and move beyond it?). Nor do I want to claim that the choice of one theoretical principle over another would depend on the case one is confronted with. This would cancel out the normative dimensions of choosing one principle over another (and consequently foregrounding stasis over change or the other way around). Such a choice might be iteratively informed by the empirical intricacies of a case but is ultimately made by those that study it. Even more so, such choices are not made in isolation, but rather in an environment in which there are others observing the same case (if anything, chapter 4 has taught us that) and funding organizations might prefer some forms of scientific engagement over others (cf. Wehrens 2016). There are no straightforward answers here. However, in the next subsection, I will discuss how I think that we should deal with such theoretical differences and their productive and normative consequences when studying institutional and professional change in and beyond policy experiments.

Implications for policymakers, professionals, evaluators and social scientists

The different kinds of politics illustrated in the first three subsections, and the contradictory ways of understanding professional and institutional change discussed in the previous subsection, have several implications. Below I address four of them. Although they are very much related to one another, I discuss them in turn. Moreover and for the sake of clarity, I direct each of them to either policymakers, professionals, evaluators or social scientists (in this order). I close this subsection with some reflexive notes on my own dissertation.

Implication for policymakers

To policymakers, I want to point out that policy experimentation is not a *deus ex machina*[7] for coping with institutional uncertainties or for cutting through vested interests and moving beyond boundaries. Where and when to introduce a policy experiment therefore needs careful consideration, also when such experimentation seems to entail more open methods of policy intervention. Instead of neutral and innocent, such experiments are highly political and can be (counter)productive. When considering the introduction of a policy experiment, one should take into account that using an experiment as a way to push things through, ease tensions or mobilize actors around contested governance principles (such as price liberalization) can have adverse consequences for relations amongst actors involved in Dutch healthcare governance. Moreover, introducing collaboration as experimental objective does not seem to be productive in terms of alternative organizational formats produced. Instead, more potential seems to reside in mobilizing actors around new healthcare issues, made explicit through new categories that allow for and resonate with alternative organizational formats in formation.

Implication for healthcare professionals

I would like to call upon those healthcare professionals (and professional others) that participate in policy experimentation to try and bracket their own positions and professional frames of reference and start instead with an experimental issue in mind. To be fair, many healthcare professionals highlight the importance of improving collaboration amongst

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[7] *Deus ex machina* (which literally translates to god from the machine) refers to an entity brought into a plot from the outside and magically ending the tensions that had been festering within the plot (see cover).

healthcare professionals and between professionals and professional others. In that sense, the call of the GPs (Het Roer Moet Om 2019) has become mainstream. However, I encountered many challenges that hinder the organization of professional collaboration. Some of these challenges are induced by the layered institutional context in which healthcare professionals operate. For instance, the way in which market mechanisms made GPs wonder if they should see other primary care providers as competitors or collaborators in healthcare provision. Nevertheless, such observed challenges cannot be reduced to institutional layering alone. Participating professionals in the experiments I studied also tended to take their own professional frames of reference as starting points, particularly searching for ways through which other professionals could help them in strengthening their own professional roles and positions. This approach has not been very productive in developing new organizational formats for the provision of integrated care (cf. SMOEL 2015).

Implication for evaluators

To those that (intend to) coordinate and evaluate policy experimentation, I would like to point out that policy experimentation is no *laissez faire* endeavor. Many scholars have already highlighted that turning uncertainties and controversies into something productive within the time-space of a policy experiment means careful investment on the level of coordination and evaluation (Zuiderent-Jerak 2015; cf. Regeer et al. 2009; 2016; Arkesteijn et al. 2015). In this light, more emphasis has been placed on the principle of *ex durante* evaluation. Such evaluation allows to bring into focus experimental processes and paths of learning and open-up new problem spaces by questioning what others take for granted during an experiment's unfolding (Wehrens 2016; Zuiderent-Jerak 2015). Such evaluation should however not only focus on what emerges in terms of categories (re) produced and lessons learned. Instead, it should also try to come to terms with what is lost in the process. This means being sensitive to voices amplified and silenced, directions of learning continued and disrupted. Based on the chapters included in this dissertation, I therefore propose that *ex durante* evaluators should address at least six basic questions, in dialogue with the actors involved (including policy makers and politicians), in repetitive stages during an experiment's unfolding (see also Flyvbjerg 2001; n.d.). These are: (1) what kind of experiment is it according to whom? (2) what is the object of experimentation for whom? (3) what do participants say and do and why do they say and do that? (4) what role does evaluation have in the experimentation process? and (5) what is materializing, who is learning and how does that relate to the previous questions? Meanwhile (6) evaluators should consider during each of these questions whether voices are silenced or amplified and what the consequences might be thereof. This is not an easy task and it involves being sensitive to traces of exclusion and displacement (e.g. something and/or someone that is laughed away, deemed irrational, painstakingly avoided, or opted out; cf. Jerak-Zuiderent 2015b).

Implication for social scientists

My last point is directed at social scientists; particularly those that are involved in policy experiments as *ex durante* evaluators. Such involvement fits a tradition of social scientists that call for *phronetic engagement* (cf. Flyvbjerg 2001), *irritation* (cf. Van Assche and Verschraegen 2008) or *artful contamination* (cf. Zuiderent-Jerak 2015). There are however two things I want to point out here. Firstly, social scientists and their *ex durante* reflections are not removed from those who participate in policy experimentation. In fact, ideally, such reflections become intertwined with the experimental process as participants observe, interpret and respond to the scientists and their *ex durante* evaluations; and the other way around (cf. Van Assche and Verschraegen 2008). In many ways, these scientists thus become participants themselves and become implicated in whatever is produced. Secondly, in the previous subsection, I argued that basic sociological principles can generate very different sociological insights. They can help to foreground change or stasis, boundary breaking transformations or self-referential adaptations. They can highlight new organizational formats produced or traditional boundaries maintained. Of course these are examples that featured in this dissertation. There are many more out there. The point is that, whatever social scientists demonstrate in their *ex durance* evaluations, it is never an absolute representation of an experimental state of affairs. Below, I briefly discuss what – I believe – this means for the engaged and implicated social scientist.

Sociological principles are relative, but this does not mean they have no value or do not matter. The thing about experimental practices is that they are intricately folded and complex (cf. Latour 2005). The thing about the social sciences is that there are different frames of reference that can be harnessed to identify and specify matters of concern (cf. Latour 2004; 2005). In this light, Zuiderent-Jerak (2015) already emphasized the importance of using sensitizing concepts in the evaluation of policy experiments (cf. Blumer 1954). Theoretically informed e*x durante* evaluation could then be understood as a way to foreground problems and challenges whilst not reducing them to either (objective) science or (subjective) politics (cf. Hendriks et al. 2009). Of importance, then, is that we realize that such *ex durante* evaluation is not just an instrument to reflect on (best) practices; it is no mirror and it does not produce a mirror image. It is much more than that. Such *ex durante* evaluation could provide theoretically informed interpretations of participants' concerns, activities, demonstrated outcomes and their consequences in terms of starting points for further action as well as in terms of voices included and excluded. In doing so, such evaluations help to open up to new problem spaces and directions of learning (Zuiderent-Jerak et al. 2009). It goes without saying that social scientists should not claim neutral ground for such work (Flyvbjerg 2001; n.d.). Instead, the robustness of their evaluative contribution is acquired through the careful formulation and reformulation of insights over time and in interaction with others engaged (Marres 2018).

In this light, some scholars have emphasized the importance of organizing dialogue between participants, with their first order observations, and social scientists, with their second order observations (e.g. Van Assche and Verschraegen 2008; cf. Luhmann 1997). First order observations then refer to the observation of things (e.g. participants in policy experiments observing and working on new governance principles) and second order observations refer to the observation of such observations (e.g. social scientists observing how participants approach such governance principles). In this line of thought, scientists and practitioners indeed interact with one another, but the boundaries between science and practice are well preserved. Others have instead started to break down such boundaries, emphasizing the importance of partial connections (Zuiderent-Jerak 2015). These scholars reimagine the relationship between engaged social scientists and scientific others as an integrated configuration, but, importantly, not as a single unit (cf. Strathern 2004; Harraway 1985). I emphasize the latter because it allows for such connections and configurations to differ in time and space. As such, it allows social scientists to relate to those they study in different ways. In case of policy experimentation, social scientists can for instance help to open-up new problem spaces together with others who participate in such experiments. They can also collect data and write evaluations reports for those who fund such experiments, and they can publish scientific articles based on the data collected and with peer scientists in mind. Such partial connections, however, also deserve critical scrutiny. For instance, how does one influence others and how should such influence be interpreted and valued? Of course, answering such questions starts with a careful reflection on *how* evaluation reports and scientific output are partially shaped by the scientist's own engagement in the policy experiment and the other way around (please note that I write how and not whether). In the last paragraphs of this dissertation, I intend to do so for my own work.

Some reflexive notes on my own dissertation

In the different chapters included in this dissertation, I have related to those I studied in different ways. In the previous subsection, I already discussed the different sociological principles used and their consequences. But beyond that, I also had a different relationship with each case I studied. For instance, in the case of the design thinking experiment and the evidence-based medicine discussion, I was very much engaged and implicated. The primary output of these engagements was policy advice (cf. Felder and Meerding 2017; RVenS 2017) and designed solutions for the experienced problems of a health insurer, a homecare organization and the Dutch Healthcare Inspectorate (chapter 3). My role in these projects entailed conducting background studies, asking questions, identifying differences between others participating – and once in a while – successfully bringing such difference under the attention of participating others, influencing the experimental process along the way. Although I have used the data gathered during these engagements for scientific papers, I also observe that I stay rather close to the empirical intricacies of these cases and in these papers (chapters 2 and 3). Likewise, the targeted journals for these papers profile themselves as platforms for science-practitioner engagement.

In contrast, whilst studying the dental care experiment (chapter 4) and Primary Focus program (chapters 5 and 6), I was separated in time and space from those that participated in these experiments. Such removal allowed me to rigorously and retrospectively examine historical and secondary data. I could do so in my own time (of which I had plenty as a PhD student) and undisturbed by any new developments that could suddenly place things in a different light or push me to shift my attention elsewhere. I used such removal and time to explore how the historical and secondary data resonated with the scientific literature. Consequently, the papers based on these analyses primarily engage with institutional and experimentalist literature. The insights produced however did not really feed back into experimental and professional practice. At least not directly and beyond the confines of a member check. How could it, given the fact that the dust stirred by these experiments had long settled? For me, such removal was both a limitation and a blessing. It limited my social impact, but I also felt more freedom to study these policy experiments critically. Of course, the latter is a rather strange confession; particularly so given the fact that critical sociological engagement is often associated with attempts to have social impact (e.g. Box 2004).

Because of the above, I am left wondering whether some of my rather removed and belated sociological observations made in chapters 4, 5, and 6 could make a difference in future policy experiments and their *ex durante* evaluation. Particularly there where participants struggle to move beyond contemporary professional boundaries and develop new and more collaborative organizational formats for the provision of healthcare. In this light, I particularly want to refer to the two-dimensional model used in chapter 5 and the analysis of professional mapmaking presented in chapter 6. Both methodological approaches were retrospectively applied to secondary data. But I think that they could very well be used during the *ex durante* evaluation of policy experiments as well. The two-dimensional approach could for instance sensitize social scientists (engaging in *ex durante* evaluation) to the different institutional arrangements already in place and interacting with a policy experiment introduced. The mapmaking approach could sensitize them to the differentiations made by the participants involved and critically examine why these differentiations are made and what these differentiations could lead to in terms of (preliminary) experimental outcomes (cf. chapter 6, in which we identified more and less productive forms of differentiation). In this light, such methodological approaches could help to bring into light experimental objects and actor relations in formation (either within or beyond contemporary professional and institutional boundaries).

What remains to be seen, of course, is whether and how such interpretations make a difference during a policy experiment's unfolding. Moreover, I continue to wonder what making such a difference means for the participating social scientist; particularly for those that engage in the *ex durante* evaluation of policy experiments. In other words, how can the partial connections celebrated above (e.g. the scientists as participant, evaluator and scholar), be cultivated without one undoing the others? These questions have already been asked and are being explored by other scholars (e.g. Zuiderent-Jerak 2015; Haraway 2016). In the years to come, I take it upon myself to join these scholars and explore such questions further in the context of healthcare policy experimentation. In this dissertation, I have laid the groundwork for such a research agenda; particularly so by exploring different theoretical frameworks, methodological approaches and forms of scientific engagement, whilst trying to come to terms with their consequences.

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Summary

In the Netherlands, different regulatory frameworks have been introduced beside one another in order to regulate healthcare practices. Examples are professional self-regulation, state-based regulation and market regulation. Not only has such institutional layering produced a proliferation of actors involved in Dutch healthcare governance, it also resulted in a proliferation of rules and standards. Moreover, these rules and standards are used by healthcare actors in different ways, creating tensions amongst them in the everyday provision of healthcare services. This process has resulted in a call amongst healthcare professionals and professional others to overcome tensions, move beyond vested interests and improve collaboration. Policy experiments are being organized to make this happen.

The dissertation critically analyzes three policy experiments that were aimed at moving beyond such vested interests and/or at improving collaboration amongst healthcare professionals and professional others. On the one hand, informed by the literature on institutional theory, it aims to describe and understand how healthcare professionals and professional others participated in these experiments and worked on the introduction and stabilization of governance principles; such as patient centeredness, multidisciplinary collaboration and price liberalization. On the other hand, informed by the experimentalist literature, this dissertation also aims to critically examine what these policy experiments produced in terms of changed professional roles and relations, or alternative organizational and institutional formats for the provision of healthcare.

The central research question is: *How does policy experimentation contribute to overcoming contemporary tensions amongst actors involved in Dutch healthcare governance?*

In order to answer this research question, case-studies were conducted. Three cases were policy experiments that each – in their own ways – aimed to overcome tensions, move beyond vested interests and/or improve collaboration amongst healthcare actors. In addition, one case concerned a heated discussion amongst these actors about the role of evidence-based medicine in healthcare decision-making. Together, the four cases highlight different aspects of policy experimentation and the institutional context in which this is done. Different qualitative research methods were used to study these cases. Some of these methods were aimed at reconstructing policy experiments that had already taken place. Other methods were aimed at observing tensions amongst healthcare actors first-hand, or at experiencing the social dynamics within policy experimentation whilst being an observing participant.

Together, the empirical chapters demonstrate that, even though policy experiments have become commonplace in Dutch healthcare governance, cutting through vested interests, moving beyond the status-quo and actually organizing collaboration seem to be rare ac-

complishments. To understand such stasis, this dissertation particularly highlights three kinds of politics. The first is *capital P politics*. It concerns acts such as the ways in which politicians use experimentation to mobilize actors around an intervention, push something through the House of Representatives or leave responsibility for what happens in the hands of the many and divided. The second is a *politics of learning*. It concerns the ways in which certain experimental logics fit better with – and tend to reproduce – certain healthcare logics whilst foreclosing others. The third is a *politics of positioning*. It concerns professionals and professional others aiming to maintain or improve their positions by interpreting and working on experimentally introduced governance principles in an idiosyncratic manner.

The three kinds of politics observed help to explain why boundaries and tensions amongst professionals – and between professionals and professional others – tended to be reproduced instead of dissolved in the cases studied. This observation is reflected in the somewhat cynical title of this dissertation: *Together Alone*. But beyond such skeptical accounts, the dissertation also identified moments in which professionals and professional others did move beyond vested interests and organizational boundaries. Not only does this dissertation try to understand these moments empirically, it also reflects on the ways in which theories used to analyze the policy experiments were, themselves, implicated in foregrounding and backgrounding the stasis and changes observed.

Based on these empirical observations and theoretical reflections, the dissertation closes with several implications for policymakers, healthcare professionals, evaluators and social scientists. Most importantly, it stresses that policy experimentation is not a *deus ex machina* for coping with the uncertainties that prevail in layered healthcare systems. When contemplating the introduction of a policy experiment, one should therefore always consider that such experiments can have adverse consequences for relations amongst – and tensions between – actors involved. In contrast to current convictions that policy experiments always produce something good, this dissertation calls for a critical (re)valuation of experimentation as a policy method.

Samenvatting

In het Nederlandse zorgstelsel worden verschillende sturingsmechanismen aangewend om de zorg in goede banen te leiden. Voorbeelden zijn professionele zelfregulering, staatsregulering en marktregulering. Door deze opeenstapeling van sturingsmechanismen is een gelaagde, soms chaotische institutionele context ontstaan. Zo hebben verschillende reguleringsmechanismen niet alleen geleid tot een wildgroei aan regels en normen, ook zijn er steeds meer partijen betrokken geraakt bij besluitvorming in de gezondheidszorg. Deze partijen hebben allemaal hun eigen rolopvattingen en zienswijzen en verhouden zich op verschillende manieren tot regels en normen. Door deze institutionele gelaagdheid zijn spanningen ontstaan tussen zorgpartijen. Deze spanningen hebben geresulteerd in een oproep van zorgprofessionals om eenzijdige belangen te parkeren en samenwerking in de Nederlandse gezondheidzorg te verbeteren. Er worden beleidsexperimenten georganiseerd om dit voor elkaar te krijgen.

Dit proefschrift analyseert drie beleidsexperimenten die gericht waren op het overstijgen van eenzijdige belangen en het verbeteren van de samenwerking tussen zorgprofessionals onderling en tussen deze professionals en andere zorgpartijen. Geïnformeerd door institutionele theorieën wil dit proefschrift beschrijven en begrijpen hoe zorgprofessionals en andere zorgpartijen hebben deelgenomen aan deze beleidsexperimenten en samen hebben gewerkt aan de introductie van nieuwe sturingsprincipes; zoals patiëntgerichtheid, multidisciplinaire samenwerking en prijsliberalisering. Daarnaast wil dit proefschrift, geïnformeerd door opkomende discussies in de literatuur over beleidsexperimenten, ook onderzoeken waar deze experimenten toe hebben geleid; bijvoorbeeld in termen van veranderde professionele rollen of alternatieve organisatievormen voor het verlenen van gezondheidszorg.

De centrale onderzoeksvraag is: *hoe dragen beleidsexperimenten bij aan het overwinnen van de huidige spanningen tussen partijen in de Nederlandse gezondheidszorg*?

Om deze onderzoeksvraag te beantwoorden zijn er casestudies uitgevoerd. Drie casussen waren beleidsexperimenten die elk – op hun eigen manier – gericht waren op het overwinnen van spanningen, het overstijgen van gevestigde belangen, of het verbeteren van de samenwerking tussen actoren in de gezondheidszorg. De vierde casus ging over een verhitte discussie tussen zorgpartijen met betrekking tot de rol van *evidence-based medicine* in de besluitvorming in de zorg. Samen belichten de vier casussen verschillende aspecten van beleidsexperimenten en de institutionele context waarin deze experimenten plaatsvinden. Tijdens de analyse van deze casussen zijn verschillende kwalitatieve onderzoeksmethoden gebruikt. Sommige van deze methoden waren gericht op het doorgronden van reeds uitgevoerde beleidsexperimenten. Andere methoden waren participatief van aard en gericht op het observeren van spanningen tussen zorgpartijen en het ervaren van de sociale dynamiek in beleidsexperimenten.

Hoewel beleidsexperimenten gemeengoed zijn geworden in de Nederlandse gezondheidszorg, tonen de empirische hoofdstukken in dit proefschrift aan dat het overstijgen van gevestigde belangen, het doorbreken van de status-quo en het daadwerkelijk organiseren van samenwerking, zeldzame uitkomsten zijn. Om deze stagnatie beter te begrijpen belicht dit proefschrift drie soorten politiek. De eerste vorm van politiek wordt ook wel *politiek met een hoofdletter P* genoemd. Het gaat hierbij om strategische handelingen van politici, zoals de manier waarop experimenten worden gebruikt om zorgpartijen achter een beleidsinterventie te scharen, om iets door de Tweede Kamer te krijgen, of de verantwoordelijkheid voor beleid neer te leggen bij een menigte die verdeeld is. De tweede vorm van politiek is een *politiek van leren*. Deze vorm van politiek is lastiger te herkennen. Het benadrukt dat bepaalde vormen van beleids-experimenteren beter passen bij bepaalde perspectieven op gezondheidszorg en de manier waarop deze georganiseerd moet worden. Op die manieren plaatsen beleidsexperimenten sommige zorglogica's op de voorgrond terwijl anderen worden verdrongen. De derde vorm van politiek is een *politiek van positioneren*. Het betreft de manier waarop zorgprofessionals en andere zorgpartijen hun positie in het zorgstelsel of binnen een samenwerkingsverband willen behouden of verbeteren. Dit doen zij door experimenteel geïntroduceerde sturingsprincipes, zoals patiëntgerichtheid, op een strategische manier te vertalen naar nieuwe organisatievormen.

De drie vormen van politiek helpen te verklaren waarom grenzen en spanningen tussen zorgprofessionals onderling, en tussen deze professionals en andere zorgpartijen, vaak blijven bestaan in zorgexperimenten; zelfs daar waar het expliciete doel van deze experimenten is om eenzijdige belangen te overstijgen en nieuwe vormen van samenwerking te organiseren. Deze observatie is onderliggend aan de enigszins cynische titel van dit proefschrift: *samen alleen*. Desondanks worden in het proefschrift ook momenten besproken waarin zorgprofessionals en andere zorgpartijen wel degelijk in staat waren om over organisatiegrenzen en eenzijdige belangen heen te kijken en tot nieuwe samenwerkingsvormen te komen. Niet alleen probeert dit proefschrift deze momenten empirisch te begrijpen, het reflecteert ook op de manieren waarop de sociale theorieën die werden ingezet om de beleidsexperimenten te analyseren, zelf van invloed zijn geweest op het waarnemen van stagnatie en verandering.

Op basis van deze empirische observaties en theoretische reflecties sluit het proefschrift af met verschillende aanbevelingen voor beleidsmakers, zorgprofessionals en sociale wetenschappers. Bovenal benadrukt het proefschrift dat beleidsexperimenteren geen *deus ex machina* is voor het oplossen van de spanningen die voortkomen uit de gelaagdheid van het Nederlandse zorgstelsel. Bij het overwegen van de invoering van een beleidsexperiment moet er daarom altijd vanuit worden gegaan dat dergelijke experimenten ook nadelige gevolgen kunnen hebben voor de relaties tussen betrokken zorgpartijen. Beleidsexperimenten moeten dan ook zorgvuldig worden vormgegeven en weloverwogen worden ingezet. In tegenstelling tot de heersende denkwijze dat beleidsexperimenten altijd iets (goeds) opleveren, pleit dit proefschrift dus voor een kritische herwaardering van het experiment als beleidsinterventie.

Dankwoord

Antoinette en Hester, ik zou dit dankwoord graag met jullie willen beginnen. Wat heb ik namelijk een geluk gehad met jullie als mijn promotor en copromotor. Ondanks mijn slechte start – ik verscheen in pak op het sollicitatiegesprek – hebben jullie mij toch onder jullie vleugels genomen. Antoinette, bedankt voor jouw vertrouwen in mij en de ruimte die je mij gaf om dingen op te pakken en uit te pluizen. Ik heb erg genoten van onze discussies. Hester, bedankt voor je grote bereidheid om met mij mee te denken en voor je geduld met het omdraaien van mijn 'achterstevoren redeneren'. Samen hebben jullie mij geleerd om een argumentatielijn op te bouwen en mijn, soms wat meanderende theoretische affiniteiten, om te zetten tot publiceerbare artikelen. Iets dat ik heel erg waardeer! Ook op het persoonlijke vlak waren jullie betrokken. Ik weet bijvoorbeeld nog goed dat jullie je zorgen maakten over het feit dat ik een motor had gekocht om de files te trotseren. Hoewel ik jullie bezwaren in de wind heb geslagen, voelde ik me gewaardeerd. Die waardering is wederzijds.

Roland, bedankt voor het meedenken, het uitdagen en de mogelijkheden die je mij hebt gegeven om dingen te doen naast wetenschappelijk onderzoek; zoals meelopen bij de RVenS en de OVV. Ik weet nog goed dat je mij in het tweede jaar aanspoorde om ook de beleidspraktijk op te zoeken, in plaats van alleen in theoretische verhandelingen en historische documenten rond te neuzen. Je had gelijk, ik heb ervan genoten! Daarnaast wil ik je bedanken voor het opbouwen van zo'n leuke en inspirerende vakgroep. Ik ben ontzettend blij dat ik hier nog even deel van uit mag blijven maken.

Wat betreft de vakgroep. Marcello, Kor, Rik, Lieke en Robert, veel dank voor het lezen van mijn conceptartikelen en het voorbereiden van maandagmiddag discussies op basis van deze stukken. Deze middagen waren soms spannend en altijd waardevol. Iris en Annemiek, ik mocht direct aan de slag als tutor in jullie vakken op bestuurskundig en methodologisch gebied. Niet alleen leerde ik zo veel meer over het geven van onderwijs, maar ook over de manier waarop de vakgroep vraagstukken in de zorg benaderde. Ik ben jullie blijven opzoeken met vragen en jullie hebben mij altijd geholpen, dank daarvoor! Jan-Willem, Bert, Marianne, Violet, Maarten, Jitse, Johanna, Paulus, Diana, Ian, Richard, Bert, Kim, Paul en Pauline, dank voor jullie inspirerende suggesties, teamspirit en het delen van ervaringen op het gebied van onderzoek en onderwijs. Bianca en Susan, dank voor al jullie hulp bij het plannen van afspraken en het delen van informatie vanuit de organisatie.

Dara, Josje, Tineke en David, we zijn ooit begonnen als club 2018 (het beoogde promotiejaar), maar we kunnen inmiddels vaststellen dat we club 2020 zijn geworden. Tegelijkertijd is het ook een beetje misplaatst om nog langer van een club te spreken. De PhD gemeenschap van de vakgroep is immers veel groter geworden en tegelijkertijd ook hecht gebleven. Marcello, Robert, Tessa, Marjolijn, Sabrina, Nienke, Jolien, Gijs, Marthe, Jaqueline, Jannine, Hugo, Leonoor, Hanna, Koray en Oemar, samen hebben we cursussen gevolgd, strategisch overleg gevoerd en ervaringen gedeeld. Maar ik kijk vooral ook met veel plezier terug op spontane middagjes strand, de etentjes tussendoor, een schrijfweekend in Friesland en wandeltochten op Urk en bij mij thuis. Iris, Teyler en Syb, welkom bij de club!

Marlies, Willem-Jan, Tineke en Marthe, superleuk dat we samen data hebben verzameld, gedeeld, geanalyseerd en omgezet in artikelen. Niet alleen was het heel leerzaam om te kijken hoe jullie nou eigenlijk dingen aanpakken, ook was het natuurlijk gewoon gezellig. Ragini en Bryan, dank voor jullie bereidheid om mijn stukken na te lopen op Engels taalgebruik. De stukken zijn er beter van geworden en zelf heb ik er ook veel van geleerd. De onderzoekers en editors die mijn ingezonden artikelen hebben gereviewed en de commissieleden die naar mijn (concept) dissertatie hebben gekeken wil ik bedanken voor hun opbouwende kritiek. Ook dit heeft de hoofdstukken en het geheel goed gedaan.

Lucas, Willem, Ruben, Marieke en Elsabé, ik kijk met veel plezier terug op het jaar dat ik jullie team heb mogen komen versterken bij de OVV. Ik vond het erg leuk en interessant om samen onderzoek te doen en aan een adviesrapport te werken. Een team dat ik zal missen! Ook bij de RVenS mocht ik meewerken aan een interessant vraagstuk, Willem Jan, Leo, Jan en Liesbeth, veel dank daarvoor.

De VvAA zou ik graag willen bedanken voor het financieren van mijn proefschrift. Daarnaast hebben jullie mij meerdere malen ontvangen in Utrecht en uitgenodigd om mee te doen aan door jullie georganiseerde bijeenkomsten met zorgprofessionals. Ook hebben jullie je netwerk ingezet wanneer ik respondenten nodig had. In het bijzonder wil ik Harm en Edwin bedanken. Samen hebben we tijd besteed aan de (vervolg)vraagstukken die mijn eerste analyses opriepen.

Op het gebied van onderzoek zou ik tot slot graag iedereen willen bedanken die bereid is geweest om mij te woord te staan en gegevens te delen. Omwille van vertrouwelijkheid zal ik geen namen noemen. Wel wil ik benadrukken dat ik tijdens het benaderen van respondenten tegen weinig deuren aan ben gelopen en over het algemeen zeer hartelijk ben ontvangen. Ik heb dan ook een grote bereidheid om dingen te delen ervaren. In tegenstelling tot de titel van dit proefschrift, zegt ook dit iets over het zorgveld!

Hoewel ik mijn PhD heb gedaan in Rotterdam, ligt het vertrekpunt van mijn wetenschappelijke affiniteiten bij de Culturele Geografie Groep van Wageningen Universiteit. Martijn, Chin Ee, Hamzah, René en Claudio, jullie hebben mijn interesse voor wetenschappelijke vraagstukken aangewakkerd en mij gevoed met prachtige sociologische benaderingen. Er is in de drie jaar dat ik met jullie heb mogen werken een wereld voor mij opengegaan.

Iulian en Arjaan, het meest mis ik de pauzes waarin we er een sport van maakten om de waardige gesprekken tussen collega's binnen een paar minuten af te laten glijden tot 'niets'. We hebben een boel meegemaakt, van drie dagen durende bruiloften in Roemenië tot ellenlange discussies over sterrenstof in de kroegen van Wageningen. Nu staan we met z'n drieën voor de grote commissie, alweer!

Vrienden uit Oosterwolde, waarvan iedereen inmiddels is verhuisd, we zien elkaar onregelmatig, van motorweekenden tot bierproeverijen, maar ik voel me altijd welkom, thuis en op mijn gemak. Bedankt voor jullie humor, geduld, ideeën en open deuren. Duikvrienden Ed en René, naast het bouwen aan een gezellig duikteam heb ik van jullie heel veel geleerd op het gebied van didactiek. Jullie hebben wellicht enig geduld nodig met mijn gebrek aan focus, maar er is nou eenmaal zó veel te ontdekken.

Victor, Ina en Lianne, een warmer gezin om in op te groeien had ik mij niet kunnen wensen. Jullie namen mij al vroeg mee op pad en hebben mij later – met het nodige geduld –mijn eigen routes laten bewandelen. Altijd heb ik op jullie kunnen rekenen! Volgens mij ligt de bakermat van mijn nieuwsgierigheid bij de sloot achter het huis waar we samen op ontdekkingstocht gingen. Steeds een stukje verder, elke keer een nieuw beestje erbij.

Tot slot, Liesbeth, zonder jou had ik dit niet voor elkaar gekregen. Ik bewonder je voor je geduld, bijvoorbeeld wanneer ik weer eens om 11 uur 's avonds besloot dat ik een idee had dat ik toch echt nog even op moest schrijven. Maar ik hecht vooral waarde aan die geweldige avonturen die we samen beleven tussen de bedrijven door. Van wildkamperen tussen de beren in Alaska tot het rijden in een Volkswagen Polo over de binnenwegen van Namibië. Ik heb die momenten echt nodig (gehad) om even afstand te doen van mijn werk. In vele opzichten is dit boek één van de dingen die we samen voor elkaar hebben gekregen. Hidde, papa zal niet alleen maar in de boeken zitten, beloofd!

Curriculum Vitae

PhD Portfolio

Name: Martijn Felder
Department: Erasmus School of Health Policy & Management
PhD period: 2014 – 2020
Promotor: Prof. dr. Antoinette de Bont
Copromotor: Dr. Hester van de Bovenkamp

Courses

Netherlands Institute of Government (NIG)

NIG Content analysis	2015
NIG Interpretative policy analysis	2015
NIG Operationalization	2015
NIG Formulating the research problem	2015
NIG Answering explanatory questions	2016
NIG Getting it published	2016
NIG Integrity and responsibility in research and advice	2016
NIG Classics in public administration	2016
NIG Network governance: Theories methods and practice	2017

Other courses

Critical perspectives on social theory (Wageningen University)	2014
Project management for PhD’s (Hertz)	2015
How to obtain a NWO Veni grant (Erasmus University)	2016
Group dynamics/teaching small groups (RISBO)	2015
Basic didactics (RISBO)	2017
UTQ – University teaching qualification (RISBO)	2020

Conference contributions

Felder, M., Van de Bovenkamp, H. M., Maaijen, M. M. H., and de Bont, A. A.: The incentive, the other and the primary care providers project: struggles to become "the" patient-centered primary care provider. EGPA Conference (24-26 August 2016), Utrecht, the Netherlands.

Felder, M., Van de Bovenkamp, H. M., and de Bont, A. A.: Politics of policy learning: evaluating an experiment on free pricing arrangements in Dutch Dental care. ISA interim conference (8-10 June 2017), Oslo, Norway.

Felder, M., Van de Bovenkamp, H. M., Meerding, W. J. and de Bont, A. A.: Who contextualizes clinical epidemiological evidence? A political analysis of evidence-based medicine in governance networks. EGPA Conference (5-7 September 2018), Lausanne, Switzerland.

Peer reviewed articles

Maaijen, M. M. H., Felder, M., de Bont, A. A., and Bal, R. (2018). Mapmaking and the (re) organization of professional practice: a case study of Dutch primary care. *Journal of Professions and Organization, 5*(3), 230-247.

Felder, M., Van de Bovenkamp, H. M., Maaijen, M. M. H., and de Bont, A. A. (2018). Together alone: organizing integrated, patient-centered primary care in the layered institutional context of Dutch healthcare governance. *Journal of Professions and Organization, 5*(2), 88-105.

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Contributions to policy reports

Faillissement MC Slotervaart en MC IJsselmeerziekenhuizen: Risico's voor patiëntveiligheid (2019). Den Haag: Onderzoeksraad voor de Veiligheid.

Zonder context geen bewijs: Over de illusie van evidence-based practice in de zorg (2017). Den Haag: Raad voor de Volksgezondheid en Samenleving.

Een toekomst voor evidence-based medicine (2017). Achtergrondstudie bij het RVS adviesrapport 'Zonder context geen bewijs'. Co-authored with W. J. Meerding. Den Haag: Raad voor de Volksgezondheid en Samenleving.

Other publications

Felder, M., and Pellis, A. (2014). *Textbook for nature entrepreneurship: product of the WURKS project Nature Entrepreneurship and Tourism within Green Education (Nature-ToGo)*. Groen Kennisnet (www.groenkennisnet.nl). Wageningen: Wageningen University.

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Felder, M. (2012). *Four wooden walls and a displaceable roof: the event and a practised, multiple object* (MSc thesis). Wageningen: Wageningen University.

Felder, M. (2011) Een erfgoedkameleon. *MMNieuws 2*, 8-9.

Teaching activities

Co-coordination and development of an AVV course on qualitative methodology (bachelor)	2019-2020
Co-coordination and development of a course on healthcare quality (bachelor)	2019
Co-coordination and development of a simulation game (bachelor)	2019
Supervision of master theses	2017-2020
Workgroups Qualitative research methods (bachelor)	2018-2020
Workgroups Discourse analysis (bachelor)	2019
Workgroups Critical perspectives on management and innovation (premaster)	2018
Workgroups Advanced research methods (master)	2018
Workgroups Public administration in Dutch healthcare governance (bachelor)	2014-2016
Workgroups Qualitative research methods (bachelor)	2014-2017
Workgroups Introduction into qualitative research methods (bachelor)	2014-2015
Workgroups Critical perspectives on management and innovation (bachelor)	2016-2017
Lecture ‘Kwalitatieve onderzoeksmethoden’ in the course Health and Illness (bachelor)	2020
Lecture ‘Analyseren en coderen’ in the course Health and Illness (bachelor)	2020
Lecture ‘Participatory observations’ in the course Management of Healthcare (bachelor)	2020
Lecture ‘Analyseren en coderen’ in the course Care and Welfare (bachelor)	2019
Lecture ‘Analyseren en coderen’ in the course Methods and Techniques (bachelor)	2016-2018
Lecture ‘Ethnographic research methods’ in the course Advanced Research Methods (master)	2017
Invited lecture *Heritage from Below: wreck diving in the North Sea.* Bachelors program: Historical Geography, Wageningen University, the Netherlands.	2015-2016

Additional activities

Researcher at the Dutch Safety Board (Onderzoeksraad voor de Veiligheid), The Hague, the Netherlands (temporary position).	2018-2019
Researcher at the Council for Health and Society (Raad voor Volksgezondheid en Samenleving), The Hague, the Netherlands (temporary position).	2016-2017

About the author

Martijn Felder was born on the 4th of July in 1985. He studied Tourism Management at Stenden University (Leeuwarden) between 2004 and 2009 and obtained a Master of Science degree in Leisure Tourism and Environment at Wageningen University in 2012. When writing his master's thesis, he became particularly interested in social theory and different conceptions of heritage, politics and practice. After finishing his thesis, he continued working for the Cultural Geography Group at Wageningen University. There he conducted a historical analysis of the different disciplinary functions of Lloyd Hotel in Amsterdam. In 2014, Martijn Felder began a PhD project at Erasmus School of Health Policy & Management. He continued to focus on politics and practice, this time in relation to policy experimentation and healthcare governance. Whilst doing a PhD, he also worked as an advisor at the National Council for Public Health and Society and at the Dutch Safety Board. Martijn Felder has published academically in international peer-reviewed journals and has contributed to two policy reports. He taught various courses, such as qualitative research methods, policy sciences and critical perspectives on management and innovation. Martijn Felder continues to work as an Assistant Professor at Erasmus School of Health Policy & Management.

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Together Alone: In this book, Martijn Felder critically examines whether and how policy experimentation contributes to overcoming tensions amongst actors involved in Dutch healthcare governance. He does so by analyzing different policy experiments aimed at moving beyond vested interests and improving collaboration between healthcare professionals and professional others. The different policy experiments analyzed reveal that, even though such experiments have become commonplace in Dutch healthcare governance, actually cutting through vested interests and organizing collaboration seem to be rare accomplishments. To understand such stasis and change, the book highlights three kinds of politics and identifies different mechanisms through which institutions and healthcare professionals do and do not seem to change through policy experimentation. The book will be of interest to those that study policy experiments, institutional and professional change and the organization of collaboration amongst healthcare actors.