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

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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 policy-makers 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 behaviour (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 programme 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 programme. 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 behaviour 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 2; 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 improvization 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, improvization, 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.

METHODS

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 signalled 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 field notes 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

Table 1. 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 ($N = 2$)

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 1).

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 field notes. 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 2). Informed by this scheme, we analyzed the transcripts and field notes on descriptions of activities that potentially flagged the conduct of institutional work.

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 2.

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 programme 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 multi-morbidity – this inward-looking orientation led to

Table 2. Schematic representation of different forms of institutional creation and maintenance work (Lawrence and Suddaby 2006).

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

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 (cf. 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'.

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.

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, 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 2).

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 '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 2).

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 (personal communication 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
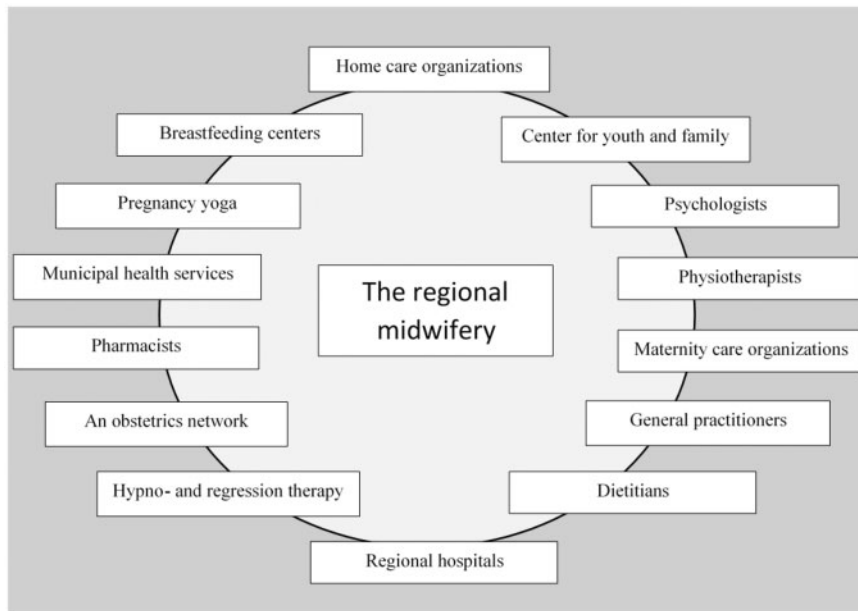
Figure 1. Visual presentation of the multidisciplinary pregnancy care network (source: http://dezwangerecentraal.nl).

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 documentation, 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 1).

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 (personal communications 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 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
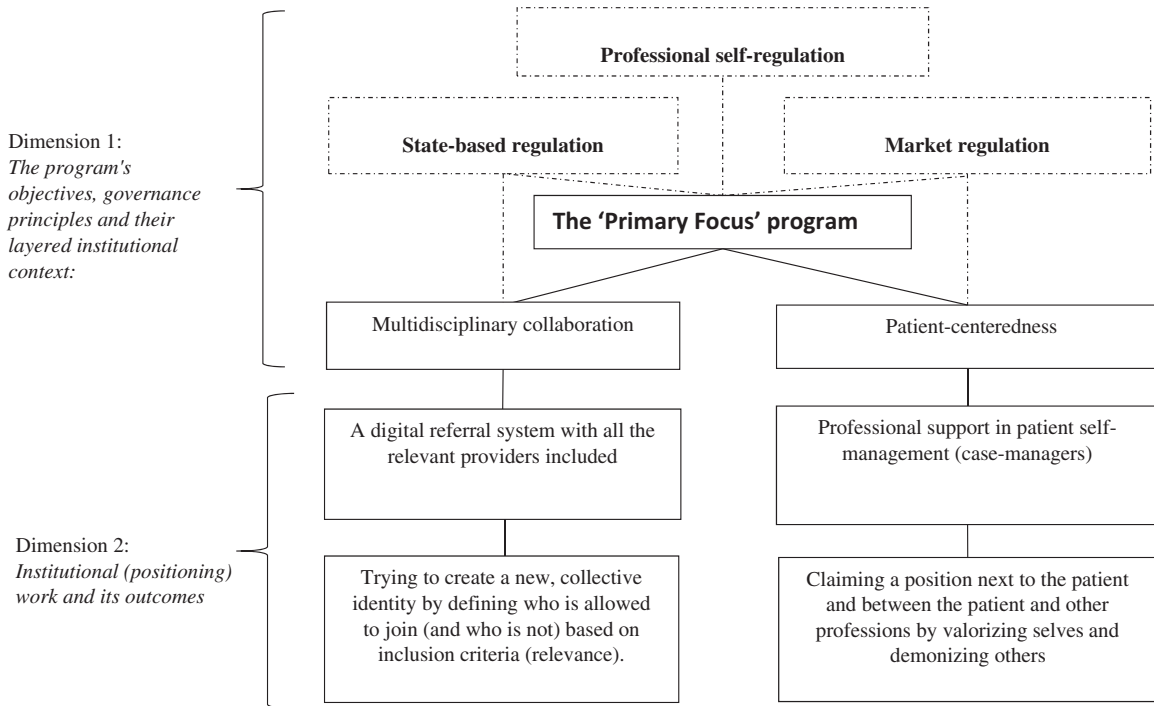
Figure 2. Institutional work in the 'Primary Focus' program and its layered institutional context.

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, personal communications 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, personal communications 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, personal communications, 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 1).

> 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).

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, personal communication 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, personal communication 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 improvization 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 policy-makers 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 policy-makers had been aiming for. Instead, the program produced adapted articulations of professional selves. Professionals had literally been working together alone.

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