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Lips, S. R.; Molenaar, J. M.; Schuitmaker-Warnaar, T. J.

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Transforming maternity care: obstetric partnerships as a policy instrument for integration

S.R. Lips*[,1], J.M. Molenaar[2], T.J. Schuitmaker-Warnaar

Athena Institute for Research on Innovation and Communication in Health and Life Sciences, Faculty of Science, Vrije Universiteit Amsterdam, De Boelelaan 1085, 1081 HV, Amsterdam, The Netherlands

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ABSTRACT

Increasing continuity in Dutch maternity care is considered pivotal to improve safety and client-centeredness. Closer collaboration between the historically relatively autonomous professionals and organizations in maternity care is deemed conditional to reach this goal, both by maternity care professionals and policy makers. Governmental policy therefore strives for organizational and financial integration. One of the policy measures has been to stimulate interprofessional and interorganizational collaboration through local obstetric partnerships. This study aimed to gain insight into whether this policy measure supported professionals in reaching the policy aim of increasing integration in the maternity care system. We therefore conducted 73 semistructured interviews with maternity care professionals in the region Northwest Netherlands, from 2014 to 2016. Respondents expressed much willingness to intensify interprofessional and interorganizational collaboration and experienced obstetric partnerships as contributing to this. As such, stimulating integration through obstetric partnerships can be considered a suitable policy measure. However, collaborating within the partnerships simultaneously highlighted deep-rooted dividing structures (organizational, educational, legal, financial) in the maternity care system, especially at the systemic level. These were experienced to hinder collaboration, but difficult for the professionals to influence, as they lacked knowledge, skills, resources and mandate. A lack of clear and timely guidance and support from policy, counterbalancing these barriers, limited partnerships' potential to unify professionals and integrate their services.

1. Introduction

While most developed countries moved towards hospitalizing childbirth, the Netherlands 'maintained a system in which community-based midwifery played a dominant and essential role' [1,2]. Internationally, this model has been considered an exemplary way to limit the medicalization of maternity care [3]. Depending on whether health risks are expected, or arise during pregnancy or childbirth, women are cared for in primary, secondary or tertiary care. Secondary and tertiary care is provided in (academic) hospitals, in case of medium or high risk. Women considered 'low risk' receive primary care and can choose to give birth in an outpatient clinic ('poliklinisch') or at home. In 2016, 30% of births took place in primary care and home births comprised 13% of all births, declining from 32% in 2003 [4,5]. The different care levels have separated organizational, financial and educational structures and institutions, and can act relatively autonomously. However, as changes in the condition of pregnant and childbearing women are very common, so are referrals between the levels of care, which implies transferring responsibilities from one care professional to another [6]. Table 1 in the methods section gives an overview of professions and tasks in Dutch maternity care.

This system became the subject of debate when European comparative research suggested perinatal mortality rates in the Netherlands to be relatively high and ameliorating more slowly [7,8]. Improving perinatal health became a spearhead of governmental policy. In 2008, a 'Steering Committee Pregnancy and Childbirth' (SZG) was established with the task to analyze the problem and develop recommendations to optimize maternity care

* Corresponding author at: Department of Ethics, Law and Humanities, Amsterdam UMC, Vrije Universiteit Amsterdam, Amsterdam, The Netherlands
E-mail addresses: s.lips@amsterdamumc.nl (S.R. Lips), joyce.molenaar@rivm.nl (J.M. Molenaar), t.j.schuitmaker@vu.nl (T.J. Schuitmaker-Warnaar).
[1] Present address: Department of Ethics, Law and Humanities, Amsterdam UMC, Vrije Universiteit Amsterdam, Amsterdam, The Netherlands.
[2] Present address: a) Centre for Nutrition, Prevention and Health Services, National Institute for Public Health and the Environment (RIVM), Bilthoven, The Netherlands. b) Department of Public Health and Primary Care/LUMC campus The Hague, Leiden University Medical Center, The Hague, The Netherlands.

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Table 1

Respondents per professional group	Total	%	Gender	Age	Tasks and responsibilities	General distribution of professions in maternity care
• Maternity care assistant	**9**	**12,3%**	Female = 8 Male = 1	< 30y = 0 30-40y = 0 40-50y = 5 50-60y = 4 > 60y = 0	Assist midwives in providing primary care during and directly after childbirth, at the woman's home or in a birth center or outpatient clinic. In the following days (mostly until around 8 days post-natal) they provide care for the mother and newborn at home or in a birth center.	In 2015: 9966* maternity care assistants active, of whom: < 30y = 14% 30-40y = 20% 40-50y = 27% 50-60y = 31% > 60y = 8%
• Primary care midwife	**20**	**27,4%**	Female = 20 Male = 0	< 30y = 1 30-40y = 9 40-50y = 6 50-60y = 2 > 60y = 2	Provide primary care to women assessed as low-risk, during pregnancy (at the midwifery practice), labor (at the woman's home or in a birth center/outpatient clinic) and in the early post-natal period (at home). In case of doubt, increased risk or need for specialized expertise, midwives refer clients to secondary or tertiary care, either for occasional consultation or to fully hand over care, at any stage of pregnancy or labor.	In 2016**: 3560 midwives active in health care, of whom: -29% hospital based - 99% female - 63% <40 years - 27% <30 years In 2015 there were 532 midwifery practices in the Netherlands; mostly group practices and 5% solo practices. Practices have a specified working area to guard timely care.
• Clinical midwife	**16**	**21,9%**	Female = 15 Male = 1	< 30y = 1 30-40y = 8 40-50y = 3 50-60y = 4 > 60y = 0	Provide extended midwifery care in a secondary/tertiary medical center, in case of (possible) increased risk, during pregnancy, labor and shortly afterwards, under the supervision of an obstetrician.	
• Obstetrician	**21**	**28,8%**	Female = 16 Male = 5	< 30y = 0 30-40y = 6 40-50y = 13 50-60y = 2 > 60y = 0	Medical doctor specialized in obstetrics, providing secondary/tertiary care in a medical center, who are involved in the care process in case of (possible) increased risk and need for specialized medical expertise, like a cesarean section.	In 2016**: 950 obstetricians / gynecologists active in health care, of whom: - 61% female - 16,8% < 40 years - 0% < 30 years
• Pediatrician	**4**	**5,5%**	Female = 2 Male = 2	< 30y = 0 30-40y = 1 40-50y = 1 50-60y = 1 > 60y = 1	Medical doctor specialized in children's health; in the case of this research specifically in neonatology; providing secondary/tertiary care in a medical center. Involved in the care process if this specific expertise is needed.	In 2016**: 1360 pediatricians active in health care, of whom: - 66% female - 20 % < 40 years - 0% < 30 years
• Other	**3**	**4,1%**	Female = 2 Male = 1	< 30y = 0 30-40y = 1 40-50y = 2 50-60y = 0 > 60y = 0	Additional professions that may (structurally, but mostly incidentally) be involved in obstetric partnerships are: maternity care nurses, residents, general practitioners, youth healthcare, dieticians, ambulance staff, psychiatrists, or other experts needed.	n.a. (too broad to define)
Total	**73**	**100%**	**Female n = 63 = 86%** **Male n = 10 = 14%**	**< 30y = 2** **30-40y = 25** **40-50y = 30** **50-60y = 13** **> 60y = 3**		In 2016**: A total of 275.780 BIG-registered*** professionals active in healthcare, of whom: - 76% (n = 209.735) female - 2% (n = 5870) as a midwife, obstetrician / gynaecologist or pediatrician

Please note that the description of tasks and responsibilities in this table is based on the situation that applied to the professionals collaborating in our research and during that period of time. As a result of developments towards increasing integration, tasks and responsibilities, and hence working areas and the phase during which certain professionals provide care, can change in the future (for instance: primary care midwives caring for mid-risk women). However, this was not (yet) the case for our respondents, at that time.

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https://www.nvog.nl/wp-content/uploads/2018/02/Beroepsprofiel-klinisch-verloskundige-1.0-22-05-2014.pdf.

and reduce perinatal mortality and morbidity [9,10]. The resulting report "A Good Start" pointed out the autonomy of the different care levels -and thus professionals and organizations- as a key barrier for collaboration and coordination [10]. This autonomy was suspected to cause fragmentation and discontinuity of care, and result in suboptimal quality of maternity care, in terms of both safety and client-centeredness [10].

Achieving continuity of care was considered pivotal to overcome this problem, by policy makers as well as maternity care professionals [11,12]. Policy measures therefore aimed at making interprofessional and interorganizational collaboration more structured and binding, ultimately intending 'shared responsibility' and 'integrated maternity care', preferably including a shift from monodisciplinary fees-for-service to multidisciplinary 'bundled payment' [10,13]. These terms were not exactly defined, but bundled payment refers to collaborating care professionals receiving a single, fixed fee from a health insurer for providing a pre-defined set of services [14]. Multidisciplinary and multi-care-level 'obstetric partnerships' (VSV), already in place in some areas, were regarded suitable "instruments" to intensify and formalize collaboration nationwide. The partnerships were expected to make 'binding agreements on quality, registration, accountability and transparency' and, eventually, claim a bundled fee [10,15]. In these local consultative bodies, maternity care professionals gather to discuss provided care and its future development. This is different from collaboration in the workplace, where professionals interact during daily care provision. The Minister followed the Steering Committee's recommendation to make membership of a structured and facilitated obstetric partnership compulsory for maternity care professionals [16,17]. Other measures included (but were not limited to) the introduction of a Perinatal Audit and the establishment of regional 'consortia' and a national 'Perinatal Care College' (CPZ). Also, the 'Dutch Healthcare Authority' (NZa) defined conditions under which deviation from regular funding rules is allowed [18]. This created room for health insurers and maternity care professionals to develop experimental collaborative projects with alternative payment models.

The policy focus on integration is a widely spread, but relatively recent phenomenon [19–22]. In Dutch maternity care, governance historically fostered the establishment and maintenance of professional autonomy and boundaries instead [23,24]. Although improving collaboration and coordination were broadly accepted as commendable goals, the new policy aim of integration raised questions. When introduced, a clear definition of its meaning and operationalization lacked, and the evidence base that integration would indeed improve the quality, safety, cost effectiveness and client centeredness of maternity care was narrow [25–28]. Similarly, it was unsettled which payment model – amongst which bundled payment is but one option – would optimally facilitate integrated care, and how it should be implemented [29,14]. The solution chosen became to study integration and bundled payment in maternity care in local experiments in the Netherlands [25,30]. Policy makers however kept preparing for integration in line with the positive outcomes they expected [13,31–34]. This ambivalence fueled unrest and debate in the field of maternity care, even though no fundamental organizational or financial measures were effectuated during our research period [35–43]. Discussions tempered after the announcement that bundled payment would be introduced as a voluntary (and not mandatory) option, and the release of the long-debated 'Care Standard Integrated Maternity Care' in June 2016 [44,45,25,35]. Based on this standard, the Health and Youth Care Inspectorate (IGJ) monitors the field.

Regardless of the lack of evidence or clear implementation procedures, obstetric partnerships had rapidly been established all over the Netherlands (85 in 2015 [46]). As their design was left to the professionals in the field, and local differences exist (like the number of hospitals and midwifery practices in an area, size, population density and welfare), their appearances and practices varied. Because the formation of these partnerships was considered an essential step in the operationalization of increasing integration, ultimately aiming for improving safety and client-centeredness, it is important to know whether this has in fact supported professionals in reaching this policy objective. In this study we investigated how maternity care professionals experience collaborating in obstetric partnerships. A literature review of studies on collaboration in health care teams, by San Martín-Rodríguez, Beaulieu, D'Amour & Ferrara-Videla (2005), proved helpful to identify in these narratives the elements that encourage or hamper effective collaborative practice [47]. They distinguish determinants on three levels. *Interactional determinants* concern the interpersonal relationships between team members: *willingness to collaborate, trust, communication* and *mutual respect*. *Organizational determinants* are about the conditions within the organization: the *organizational structure, organization's philosophy, administrative support, team resources*, and *coordination and communication mechanisms*. *Systemic determinants* concern the organization's environment: the *social, cultural, professional* and *educational system*. The authors emphasize that all three levels are indispensable and interrelated, and cannot be treated separately if collaboration is to succeed [47]. Unlike for instance the Four-Dimensional Model of Collaboration [48], this approach explicitly includes the systemic level and allows to take into account power dynamics and external and structural factors that interact with the organizational and interactional level. This matches well with our aim to analyze the professionals' (inter-)personal experiences in relation to policy developments. Ultimately, we hope to provide insights that are useful to future development of policy and collaborative practice within, and possibly outside, maternity care.

2. Materials and methods

2.1. Study setting

From 2014 to 2016, 73 semi-structured interviews with maternity care professionals were conducted. Although formally subdivided into three different projects, all interviews were part of one overarching study, aiming to evaluate the development of the Maternity Care Network Northwest Netherlands (MCNNN). The MCNNN is 1 of the 9 regional consortia that were established to stimulate knowledge development and collaboration between maternity care professionals [49]. The MCNNN covers 2 out of 12 provinces, located in the northwestern part of the Netherlands [49–51]. In 2013, the region knew approximately 3,1 million inhabitants, and its 35.000 births comprised around 20% of the national total, making it the largest consortium in the Netherlands [52]. 2 tertiary and 16 secondary care general hospitals were embedded in 18 active obstetric partnerships, which were all included in this study [53,50]. These partnerships were spread throughout the region and had widely varying characteristics with regard to population density and growth, birth rate, age distribution, socioeconomic status, ethnic background and proximity of health care facilities(50). Some partnerships (like around Den Helder) covered a larger but (more) sparsely populated area, while others (like in Amsterdam, where multiple partnerships coexist) covered smaller but densely populated parts of the country.

Fig. 1: Coverage and key characteristics MCNNN

A qualitative research design was chosen to allow for 'rich descriptions of complex phenomena', which is especially interesting in a field of research and practice where fundamental changes are made with yet unforeseen consequences [54,53].

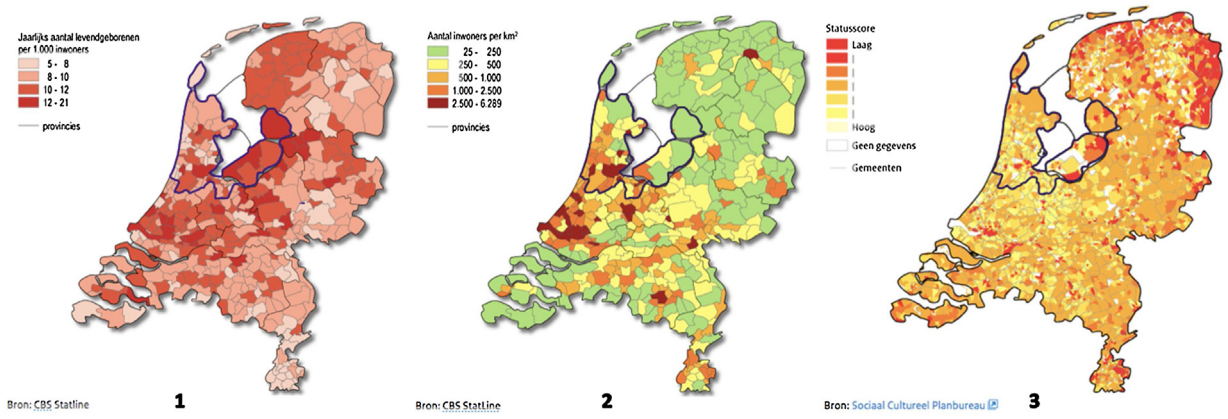

Fig. 1. The MCNNN covers 2 out of 12 provinces in the northwestern part of the Netherlands: North-Holland and Flevoland. This area is marked.
Map 1: Birth rate per district, 2009-2013: yearly alive born per 1000 inhabitants.
Source: https://www.volksgezondheidenzorg.info/onderwerp/bevolking/regionaal-internationaal/geboorte-en-sterfte#node-geboortecijfer-gemeente
Map 2: Population density per district, 2015: number of inhabitants per km2.
Source: https://www.volksgezondheidenzorg.info/onderwerp/bevolking/regionaal-internationaal/bevolkingsomvang
Map 3: Socio-economic status per postal code, 2017.
Source: https://www.volksgezondheidenzorg.info/onderwerp/sociaaleconomische-status/regionaal-internationaal/regionaal

2.2. Respondents

Interviews were held with maternity care professionals who were member of one or more obstetric partnerships within the MCNNN. Some basic preconditions were set, but partnerships mostly determined themselves which professions to involve [10,55]. In the partnerships participating in this study, maternity care assistants, primary care and clinical midwives and obstetricians were always a member. Some additionally or incidentally invited other professionals, like nurses, pediatricians, residents, general practitioners or youth healthcare. We selected candidates in consultation with the coordinator of the MCNNN in order to assure that all partnerships and professions would be represented, and invited them via email. Because initially more actively engaged representatives were most willing to cooperate, additional purposive sampling was applied to also include less involved members. Respondents were in majority female (86%), corresponding with the general gender balance of maternity care professionals.

Table 1 Professional groups and respondents' characteristics

2.3. Data collection

73 semi-structured in-depth interviews were conducted by 9 members of the research team, by phone (n = 54) or face-to-face (n = 19). The interview guide contained a series of open questions concerning professionals' experiences with interprofessional and interorganizational collaboration and coordination within obstetric partnerships (see appendix 1).

2.4. Analysis

All audio-recordings of the interviews in 2014 and 2016 were transcribed verbatim and those of 2015 were summarized. The research team developed a coding frame for data-analysis. For deductive coding, the determinants of collaboration as distinguished by San Martín-Rodríguez et al. (2005) and the Four Dimensional Model of Collaboration by D'Amour et al. (2008) were integrated [47,48]. Additional inductive coding allowed otherwise unmentioned but relevant concepts emerging from the data to be added to the coding frame [56]. Coding was done using qualitative data-analysis software (ATLAS.ti and MAXQDA). Subsequently, all coded data were summarized per code, merged into one document and crosschecked by the main researchers (SL and JM). Contradictory or striking findings where further explored, by searching for underlying explanations. Data saturation was accomplished since no new insights emerged from the final interviews. Additionally, governmental and health insurers' policy documents were studied, to enable interpretation of the empirical findings in relation to policy development.

2.5. Ethical considerations

All respondents gave their informed consent to participate in the study. Before starting each interview, permission to audiotape was verbally asked, and all but one respondent approved. Data were analyzed anonymously. Ethical approval was not necessary for this study, according to the assessment of the Medical Ethics Committee of the VU Medical Center (2014.206) and the Dutch Medical Research Involving Human Subjects Act (WMO), because only consenting health professionals participated.

3. Results

We analyzed professionals' experiences with the development of collaborative practice in obstetric partnerships in order to gain insight into whether this policy measure supported professionals in reaching the policy aim of increasing integration in the maternity care system. We structured our analysis by distinguishing determinants for successful collaboration at the interactional, organizational and systemic level, and subsequently outlining their interrelatedness [47]. The results describe experiences shared by most respondents from all professional groups and partnerships. Important differences are highlighted when relevant to the analysis.

3.1. Interactional determinants

Almost all respondents explicitly expressed **willingness to collaborate**, aligning with the policy goal. Professionals considered 'transfers' of clients – and hence information and responsibilities - between care professionals and levels, to be the weakest link in maternity care processes, causing loss of quality, continuity and safety. The principal motivator to actively invest in strengthening collaboration was the belief that this served the interests of the mothers and babies cared for. Another important driver was representing the expertise and interests of one's own profession in

the process of integration. The energy and (off-duty) time put into participating in obstetric partnerships reflected the professionals' commitment.

> "I think it is very useful, to represent our department as a pediatrician there (. . .) because you're meeting once a month with everyone involved."
> Pediatrician, 2014, R5

Membership of multiple partnerships -common for primary care midwives and maternity care assistants- and high workload however limited willingness and ability to participate, and not all members were (felt to be) equally dedicated. In some partnerships primary care was more dominantly represented; in others secondary/tertiary care.

Trust and **mutual respect** were closely related, and often mentioned as crucial prerequisites for "good collaboration"; especially trusting each other's expertise and decisions. Many considered *knowing each other* as conditional to achieve this. Obstetric partnerships facilitated this by organizing mutual activities, like partnership meetings, team trainings and informal gatherings, thereby simultaneously affecting **communication** between partnership members. "Good communication" was widely acknowledged as vital for good collaboration, and defined as collaborative partners being easily accessible and approachable, willing to listen to each other and equally appreciative of everyone's input. However, communicational difficulties repeatedly emerged and were related to differences between individual professionals and professional groups, in visions and communicative styles and skills.

> "I sometimes hear from people in primary care that they find it a bit scary to give their opinion, because they feel that people from secondary care react very critical."
> Clinical midwife, 2016, R22.

This is especially relevant since many professionals mentioned *openness* as additional important element of good communication and closely related to trust. In order to communicate openly, participants needed to experience confidentiality and feel assured that expressing criticism, doubt or weakness would not lead to repercussions. The fact that they were interdependent and probably would work together again in the future, was mentioned to hinder openness. Competition between and within professional groups was another constraining factor; sharing business information could harm individual entrepreneurial positions.

> *"In my* own region I see [midwifery] practices that do not even want to provide their figures because that would be competition-sensitive."
> Obstetrician, 2016, R7

These interactional struggles were intensified by experienced policy pressure on developing and implementing 'integrated maternity care' and 'bundled payment'. Especially the latter caused resistance and lack of clarity on if, why, how and when policy measures should be implemented undermined commitment.

3.2. Organizational determinants

As policy did not define how obstetric partnerships should be designed, professionals developed this on the local level. This process was in full swing during the research period; some partnerships had recently started; some had a long history, and most had been developing for a few years. Developmental stages thus differed, but all partnerships increasingly fine-tuned their **organizational structure**. Oftentimes, a general partnership was first established and gradually sub-divided by adding a board and project groups to tackle specific issues, like guideline development. **Coordination and communication mechanisms** differed in relation to preferences, regional characteristics, developmental stage and budget. Partnerships could share information via email with all individual members, or appoint representatives to exchange information between the partnership and their colleagues. Some more advanced partnerships developed websites or it-systems for sharing information. It nevertheless remained difficult to structurally inform and involve professionals not attending partnership meetings. Because membership was mandatory but presence at meetings usually was not, participation tended to have an opt-in character, often drawing a limited set of more dedicated members, challenging their goodwill.

> "The ones sitting round the table invest their time, energy and professionalism (. . .) Others can later get a free ride, and it makes me think: for whom am I doing this? For the clients, but what is the added value for me, business- and organization-wise?"
> Maternity care assistant, 2014, R12

Defining who and what is required –and workable- to take legitimate and supported decisions as a partnership remained complex. Initially, a majority of votes of the people *present* at meetings was usually decisive. Over time, participation and decision-making procedures became more formalized and partnership boards were increasingly mandated. However, not all stakeholders were always (sufficiently) represented. On top of that, absent superiors, like hospital boards, could later overrule decisions that had been taken by the professionals in the meetings.

Furthermore, these professionals were not just members of an obstetric partnership, but simultaneously represented their own occupational group and employer. They thus brought specific perspectives, definitions and interests to the meetings, that sometimes conflicted. Especially *within* primary care, competition could be fierce, in addition to competition *between* the levels of care. Respondents viewed this as complicating synchronization within partnerships, both organization- and content-wise. Partnerships tried to tackle this by developing a shared **organization's philosophy**.

> Ït is on paper now (. . .) From there we can say: we all have the same goal. Which is that we want good quality care with a satisfied client."
> Maternity care assistant, 2015, R20

These often quite general phrases concealed a wide range of, often irreconcilable, visions, varying between and within professional groups. Moreover, most respondents considered differences in approach and expertise, between professional groups and care levels, to have added value for clients, and wished to maintain these. The intensity of integration they desired also widely ranged, from limited, where professionals remained employed by their current organizations, to complete mergers. However, all professionals agreed on their wish to take clients' needs and preferences as starting point, and not the way in which care processes are organized. Regardless of the organizational structure preferred, they aimed to improve clearness, continuity and (experienced) quality, and to reduce transfers of clients between professionals and care levels.

Scarcity of **team resources** and **administrative support** limited obstetric partnerships' potential to develop collaborative practice. Respondents felt that participating added to their workload, and that compensation for surplus time was lacking. They nevertheless had to tackle numerous, diverse and intricate issues, on which they lacked relevant expertise. Few partnerships could afford to invest in a secretariat, it-system, (independent) chairman or external expert to support the professionals. They could apply for project funding

by health insurers, but this also was a complex and time-consuming process.

> "You are only trained as a midwife, obstetrician or doctor, but you actually have to set up and maintain a whole consultation structure yourself, while you lack training for that."
> Clinical midwife, 2014, R23

3.3. Systemic determinants

The context in which the professionals had to (re-)organize care at the local level heavily influenced the processes described above. As collaboration and integration are broadly supported and promoted in society in general, the **cultural system** can be considered as facilitating the intended systemic change in maternity care in itself. The professionals' experiences however reflected that many dividing structures persisted, especially at the systemic level. The collaborating professionals had themselves been trained monodisciplinary, by different, independent organizations within a divided **educational system.** Through this, they internalized to think and act along traditional professional boundaries, philosophies and values. Educational levels of the professionals collaborating in partnerships thereby ranged from secondary vocational training to university, which was pointed out as a source of inequality, especially by midwives and maternity care assistants. In some partnerships a "classical" hierarchy was experienced, paralleling educational levels and social status, with obstetricians dominating decision-making. In others, members did experience equality.

Besides educationally, respondents differed in terms of age, gender and social background. Like in the general professional population, midwives were mostly younger females, while medical specialists were older and more often male. Experienced power differences likely also related to inequality that exists more implicitly within the **social system**. However, hierarchy was overall felt to diminish in younger generations and by virtue of the development of obstetric partnerships. Boundaries and hierarchy were nevertheless inherent to how the **professional system** was organized, with strictly demarcated tasks, responsibilities and accountability. Respondents felt that professional, organizational, financial and legal boundaries altogether limited possibilities to provide continuous care that could flexibly respond to women's psychological and physiological needs.

> "What I find frustrating (. . .) you often hand over clients to beginning assistants (. . .) who have much less experience than you, but you are dependent on that person."
> Primary care midwife, 2014, R25

As the partnerships were (re-)designing care practices and policy, it became explicit that between and within professional groups, perspectives differed on how maternity care should ideally be organized, and thus on how tasks, autonomy and authority should be (re-)distributed. It was, however, undisputed that the customary funding system did not foster collaborative practice, but few respondents considered bundled payment an adequate solution. Some suggested that shifting to paid employment for all maternity care professionals would be a better means to overcome competition, particularly between and among community midwives and obstetricians, who often were self-employed entrepreneurs. Others preferred to stay closer to the existing model.

In this complex field with many perspectives and stakeholders, respondents experienced a lack of one central authority giving clear direction. Instead, disputes, especially between the professional associations of midwives and obstetricians, were highlighted in enduring public debates, which reverberated within the partnerships.

> "I actually think it is outrageous that on a high administrative level, they aren't on the same page [. . .] while they do expect us to be so at local level."
> Obstetrician, 2014, R10

3.4. Interrelatedness

The above highlights the close interrelatedness of **interactional, organizational** and **systemic determinants**, like between policy and the development of collaborative practice within obstetric partnerships. The professionals explicitly related interactional improvements to organizational developments. Developmental stages varied, but respondents overall felt that obstetric partnerships fostered mutual insight, understanding, agreement and alignment, by providing a structure in which professionals regularly meet and discuss care practice and policy. In line with that, participants of the more structured and formalized partnerships more positively assessed trust, equality, communication and decision-making. However, respondents from all professions and partnerships desired further enhancement. Communicational tensions persisted, due to differing professional visions and experienced hierarchy, and competition remained an important barrier for collaboration.

The organizational and financial integration that policy makers introduced as a solution instead raised *new* issues for maternity care professionals collaborating in obstetric partnerships. Exploring possible reallocations of tasks, responsibilities and fees was a delicate and difficult task, because it affected financial, organizational and professional autonomy and authority.

> "That integrated fee really is a Sword of Damocles. People fear that they will lose their identity, but also their autonomy."
> Obstetrician, 2016, R21

Respondents questioned whether this debate should be left to the field, where it tended to dominate over substantive discussions and harm interprofessional relationships.

> "We are only arguing about money, about power, about what to do with that integrated funding [. . .] But not: Hey, we have a great new regional protocol, let's take a look at that."
> Primary care midwife, 2016, R6
> "I think clear policy should be made on an administrative or ministerial level, and not that every partnership should devise this individually."
> Obstetrician, 2014, R16

Additionally, although policy makers evidently pursued extensive integration including bundled payment, lack of clarity about "how much integration" would be imposed endured during the research period; especially whether or not bundled payment would (soon) become mandatory. This mix of uncertainty and pressure fueled unrest and resistance among maternity care professionals. Several obstetric partnerships experienced collaborative backlashes as a result, and some paused all integrative developments until the Ministry of Health, Welfare and Sport would provide more clearness.

Summarizing, the vast majority of our respondents, from all obstetric partnerships and professional groups, were willing and trying to intensify interprofessional and interorganizational collaboration. They however experienced a lack of knowledge, skills, resources and mandate, and were confronted with barriers that were largely beyond their control. Especially at the systemic level, underlying organizational, educational, legal and financial structures kept fostering professional distinction rather than integration. Policy insufficiently counterbalanced this with guidance and support experienced as necessary. This limited professionals'

capacity to jointly redesign maternity care within their obstetric partnership.

4. Discussion

This study aimed at gaining insight in whether the policy measure of stimulating interprofessional and interorganizational collaboration through local obstetric partnerships supported professionals in reaching the policy aim of increasing integration in the maternity care system. We found interactional, organizational and systemic barriers and facilitators for collaboration to be closely interrelated. In the region studied, respondents from all professions and partnerships expressed much willingness to intensify interprofessional and interorganizational collaboration. Obstetric partnerships were experienced as a structure that contributed to this. Although developmental stages differed between partnerships, respondents overall felt that participatory safety and equality grew, and communication and coordination improved throughout the years. Still, a need for further progress was also widely shared. A clear vision on the future of the maternity care system, shared and undisputed by all stakeholders, was lacking and competition between and within the levels of care was still experienced as vital. Especially systemic structures (organizational, educational, legal, financial) continued to act as barriers, and were difficult for participants to influence. Policy insufficiently counterbalanced this with guidance and support, thus limiting partnerships' potential to unify professionals and integrate their services.

The tendency in both policy and public debate has been to consider persisting barriers for integration as mainly due to unwillingness to collaborate, and to reduce competition between and among professional groups to a merely financial problem, which would be solved by introducing bundled payment [57,34,58,35]. Based on the results of our study, we argue that this approach disregards the complexity and history of the maternity care system and its intended change, and overlooks the great demand that policy placed on maternity care professionals [59]. Policy made them responsible for developing their partnership and redesigning local maternity care, but could have done more to optimize preconditions. For instance, allocated time and resources to develop as a team, might have favored partnerships' ability to act. Looking back, many years passed without substantial organizational or financial policy measures being effectuated, but pressure towards it was felt from the beginning. Mandatory membership of obstetric partnerships was introduced simultaneously with the message that integrated care and bundled payment were the final goal [13,31]. Attention was thus drawn to complicated discussions on integration, often before basic principles for good interdisciplinary teamwork, like leadership, management, vision and mutual trust, were developed within the partnerships [60]. Also, participating in an obstetric partnership confronted professionals with tasks and responsibilities that were very different from what they had been trained for and were passionate about. As care providers, they lacked knowledge, skills, resources and mandate needed to manage the partnership and govern the complex process of systemic innovation.

Similar difficulties have been reported in other partnerships and regions [53,25,61,62,63]. Summing up all these results, we think that more and especially earlier guidance and support from policy could have fostered partnerships' developmental process. Knowing better the definition, operationalization and demarcation of integrated maternity care from an early stage, might have avoided partnerships to each work this out individually, including the difficulties they thereby encountered. Additionally, policies messages had an ambiguous side. While stimulating and regulating integration on the one hand, free-market forces continued to be highly valued and operationalized through legislation restricting collaborative agreements and practices between competitors. This countered integrative efforts of obstetric partnerships. For example, if one of its members –being an independent entrepreneur- wished to promote individual (deviant) care services, this could not be forbidden, because the incentive to compete should remain intact [64,45,65,66,67]. Competition was thus maintained and encouraged at the systemic level [68].

Fragmentation and ambivalence may be a typical aspect of Dutch policy-making in health care. Lamping et al. (2013) point out that representative organizations (such as associations of consumers, employers and hospitals), instead of governmental agencies, play an important role in policy-coordination in health care in the Netherlands [69]. In Dutch maternity care, an abundant number of stakeholder organizations are representing the perspectives and interests of specific groups. This does, however, not necessarily foster balanced representation, for 'the system allows as well as denies a large number of potential participants access to the policy-making process', which can lead to unbalanced policy [69]. The lack of (timely) guidance and support respondents in our study experienced, may be a similar negative side-effect of policies good intention to involve stakeholders [70].

What our study tells us, is that the policy measure of introducing obstetric partnerships can be considered suitable in itself, but that the policy process as a whole (unintendedly) brought along loss of efficiency and a reaffirmation of existing boundaries [71]. The experiences of the processionals underline the interrelatedness of systemic, organizational and interactional processes, and how structures can be both enabling and constraining [47,72,71]. In line with recent literature, we would warmly welcome future research to shed more light on 'governmental stewardship', 'collaborative governance' and 'the changing relationship between the state, its institutions, actors, users and citizens' [73,74,70,75,76]. More specifically, knowing better how to effectively balance and distribute responsibilities between stakeholders at the systemic, organizational and interactional level, could help future innovative processes to better capitalize professionals' willingness to contribute to the process of change, and foster systemic innovation.

5. Strengths and limitations

A key strength of this study is that a qualitative research design was paired with a large quantity and diversity of respondents, allowing for both in-depth and validated insight. Representatives of all professional groups typically involved in obstetric partnerships participated. Most were actively engaged members though, and likely voiced the more pronounced (both positive and negative) perspectives. However, because these people are crucial actors in implementing policy, their experiences are important indicators for factors enabling and constraining innovation. Our data-collection regretfully ended before the Care Standard Integrated Care was released. We tend to think this brought more rest and clearness to the field and would be interested to see how collaboration within obstetric partnerships developed afterwards. Additionally, integrative policy ultimately aims at improving the safety and client-centeredness of maternity care. Health outcomes are already at the center of attention, but more efforts should be made -in policy ánd research like ours- to incorporate clients' perspectives and ensure that developments in maternity care policy and practice optimally suit their physiological and psychological needs.

6. Conclusions

Maternity care professionals were willing to intensify interprofessional and interorganizational collaboration and experienced obstetric partnerships as contributing to this. As such, these partnerships can be considered a suitable policy instrument for

integration in the maternity care system. However, barriers for collaboration manifested themselves, especially at the systemic level. These were difficult for the professionals to influence, and –unintendedly- reaffirmed rather than alleviated by the policy process. By insufficiently counterbalancing existing barriers with clear and timely guidance and support, policy limited partnerships' potential to unify professionals and integrate their services. More insight in how to effectively balance and distribute responsibilities between stakeholders at the systemic, organizational and interactional level, could help future innovative processes to better capitalize professionals' willingness to contribute to the process of change, and foster systemic innovation.

Declaration of Competing Interest

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CRediT authorship contribution statement

S.R. Lips: Writing - original draft, Methodology, Validation, Formal analysis, Investigation, Visualisation. **J.M. Molenaar:** Writing - review & editing, Methodology, Validation, Formal analysis, Investigation. **T.J. Schuitmaker-Warnaar:** Writing - review & editing, Supervision, Project administration, Funding acquisition.

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Appendix A. Supplementary data

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