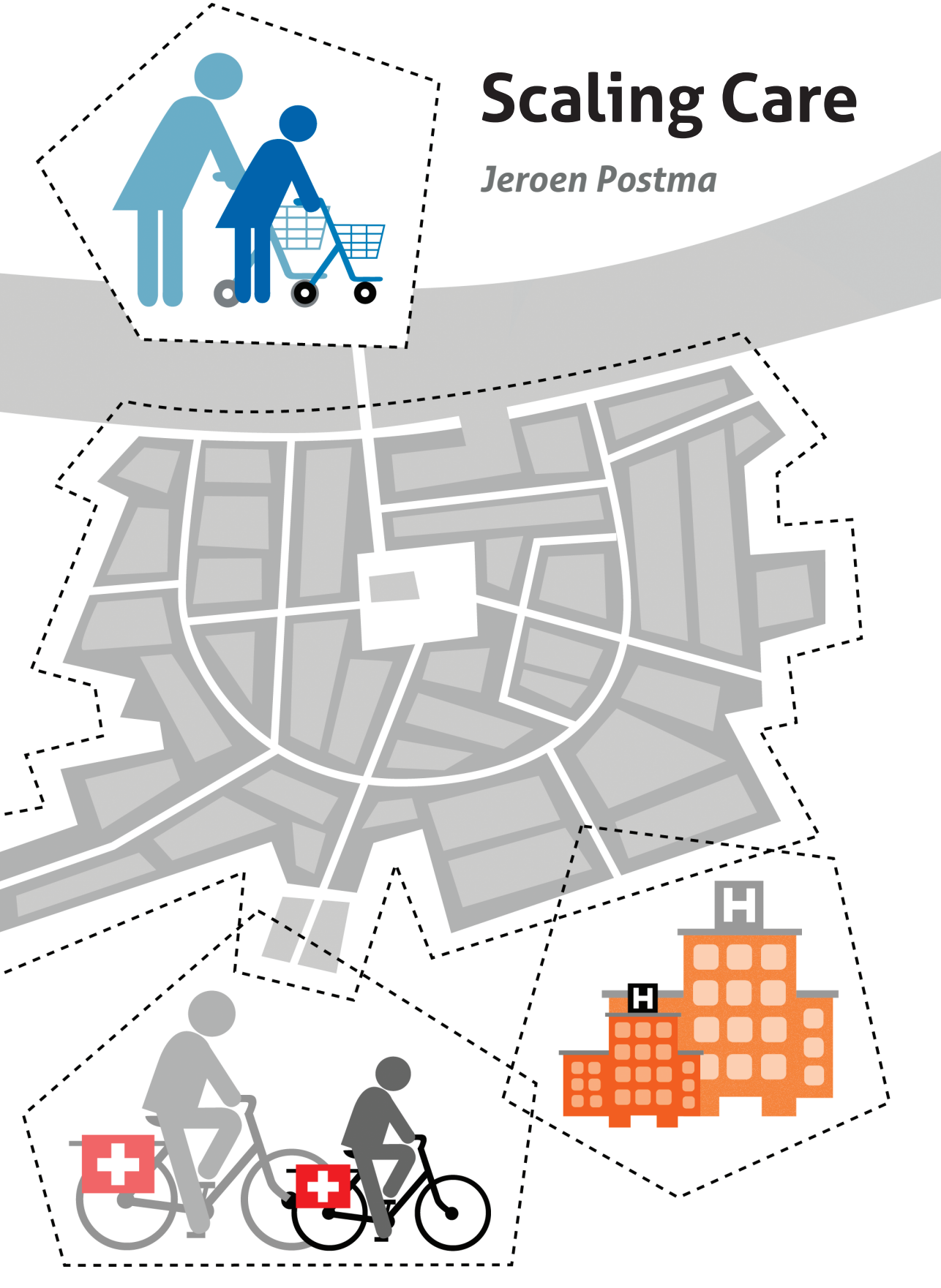
Scaling Care

Jeroen Postma



Scaling Care:
An analysis of the structural, social and symbolic dimensions of scale in healthcare

Jeroen Postma

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Schaal in de zorg:
Een analyse van de structurele, sociale en
symbolische dimensies van schaal
in de gezondheidszorg

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CHAPTER 1

Introduction: Exploring scale

High expectations of scale in Dutch healthcare

> "The Cabinet will promote small-scale healthcare institutions. An optimal scale of healthcare institutions will lead to more efficiency, lower costs, more integrated care, higher customer satisfaction and better care. The Cabinet will ensure the optimisation of the scale of healthcare institutions. The rise of healthcare giants will be halted." (VVD-CDA Coalition Agreement 2010: 36)

This quote comes from the Coalition Agreement of the Liberal (VVD) and Christian-Democratic (CDA) cabinet ('Rutte I') that took office in the Netherlands in 2010. In the quote, the cabinet expresses several assumptions about scale. "Small-scale healthcare institutions" are preferred over "healthcare giants" because the former have an "optimal scale". Moreover, this optimal scale results in "more efficiency, lower costs, more integrated care, higher customer satisfaction and better care". These assumptions are exemplary for current thinking about scale in Dutch healthcare. In particular, the quote illustrates that a lot is expected of scale. According to the quote, scale can contribute to efficiency, affordability, integration, customer satisfaction and quality. As the following extracts from Dutch newspapers exemplify, this is a reflection of the public and political debate about scale (see also Postma, Putters and Van de Bovenkamp 2012). Especially the (positive) expectations of small-scale care are high: it is supposed to be "beneficial to healthcare" (Boersma 2005) because it entails "flexibility and a better working atmosphere" (Volkskrant 2001) and a "human, individual approach" (Lubbers 2009). In contrast, large-scale healthcare is frequently typified as "inhumane" (De Haan and Haagsma 1996) because it is based on a "production mind set" (Noordhuis 2008) and is "bureaucratic" (Van Dijk 2009). But actors also argue in favour of large-scale care because it ensures "better quality" (Hoekman 2008) and against small-scale care due to "problems of discontinuity" (Wammes 2009). The opinions that people express about scale are different, but have one thing in common: the high expectations of what scale can accomplish for the organization and provision of care.

The importance of scale in health policies and organizational strategies

In line with the high expectations, the quote from the Coalition Agreement points to the importance of scale in Dutch healthcare. In particular, there are several major developments in which scale is used to achieve political and organizational goals. In these developments, policy makers, executives and other actors have high expectations of the relation between (changes in) scale and positive outcomes, like quality and efficiency of care. To meet the expectations, they 'upscale' and 'downscale' the organization and provision of care on both organizational and geographical scales. However, the outcomes of these policies and strategies turn out to be uncertain and contested. In this section, I discuss four developments in Dutch healthcare in which scale plays an important role: (1) mergers between healthcare organizations, (2) de-institutionalisation of long-term care, (3) decentralisation of care from the state to municipalities and (4) concentration of hospital care.

The first development is the great number of *mergers* between healthcare organizations now taking place in the Netherlands. Mergers are often seen as one of the most important developments affecting scale, not only in Dutch healthcare (Blank et al. 2008; Fabbricotti 2007) but also in healthcare systems in other countries (Bazzoli et al. 2002). In a merger, ownership of two or more previously independent organizations is combined into a larger legal entity. In some mergers, also healthcare services that were previously delivered in separate facilities (e.g. hospitals), are combined in one facility. Until the early 2000s, the Dutch government stimulated healthcare mergers, other things to integrate different types of home care and to reduce excess capacity in hospital care (Huijsman 1999). Over the last years however, merger activity has fuelled a debate about the consequences of mergers, the motives of executives and the pros and cons of large- and small-scale organizations (e.g. Gaynor and Town 2012). The quote at the start of this introduction exemplifies this debate.

The second development is the *de-institutionalisation* of care for people with dementia and those with a mental or physical disability. Traditionally, western countries modelled long-term care and housing on hospital care, provided in large-scale institutions and isolated from society (Finnema et al. 2000). In recent decades, due to changing preferences of clients and stimulated by new government policies, care and housing have become de-institutionalised and

community-based (Emerson 2004). This has led to downscaling of care from large-scale institutions to small-scale care homes in neighbourhoods (Te Boekhorst 2011). The societal and political expectations of small-scale homes are high: they are supposed to improve self-determination, social integration, health and quality of life. At the same time, the empirical evidence about the benefits of small-scale care for the elderly and people with a disability is mixed (e.g. Te Boekhorst 2011; Verbeek 2011) and recent research has shown that small-scale care is under increasing financial pressure due to budget cuts (Oldenhof and Putters 2011).

Third, there is a trend of *decentralisation* of care from the state to municipalities and a growing importance of 'neighbourhood care'. Increasingly, long-term care is being downscaled from the national and regional scales to the local scale, where care is provided by networks of organizations and professionals (Putters et al. 2010). Decentralisation is taking place across Europe and in the US, where neighbourhoods have emerged as important sites for the organization and provision of public services (Saltman and Bankauskaite 2006; Lowndes and Sullivan 2007). At the same time, the scale of the neighbourhood is "highly charged, able to generate considerable debate about its definition and constitution as well as its potential contribution to the achievement of policy goals" (56). Although the benefits of service delivery in the neighbourhood are uncertain, once again the expectations of what it can achieve are high: more empowered citizens, a diminished distance between citizens and political leaders, integration of public services, more cooperation between providers and a better fit between citizens' needs and available services (Lowndes and Sullivan 2007).

Fourth, there is a development of *concentration of medical care*. Concentration entails the upscaling of medical care from multiple hospital facilities to fewer, more specialized ones. Increasingly, hospitals are stimulated to concentrate care because of minimum volume standards that professionals and healthcare insurers have set (Zuiderent-Jerak, Kool and Rademakers 2012). Only hospitals that achieve a certain volume (in terms of number of treatments) are allowed to provide those treatments. The espoused aim of concentration of care is to improve quality and lower costs, urging hospitals to focus on the treatments in which they are specialized (Sauerzapf et al. 2008). So far, the empirical results of concentration are mixed, only providing evidence for the benefits of concentration of care for a small number of (complex) treatments. At the same time, hospitals and

professionals seem to use the calls for concentration strategically, for example to expand their market share (Zuiderent-Jerak, Kool and Rademakers 2012).

The description of the four developments shows that scale is an important element of current healthcare reforms in the Netherlands. In the different developments, large-scale, small-scale, upscaling or downscaling are easily equated with positive or negative outcomes. In other words: accompanying the high expectations of scale in health policies and organizational strategies is the assumption that there is a clear causal relation between scale and certain outcomes (e.g. better quality of care). This points to an important underlying mechanism in these developments, namely that Dutch policy makers, healthcare executives and others implicitly and explicitly search for the *optimal scale*. The optimal scale is the scale that maximizes positive outcomes (see also the quote from the Coalition Agreement). I discuss this perspective in detail in the following section. However, as the description of the developments above already implies, the effects of changes in scale are far less clear in practice. I therefore also reflect on the downsides of the optimal scale approach.

The search for the optimal scale

The idea of the 'optimal scale' is manifest in a range of studies that try to calculate the optimal scale for Dutch healthcare organizations on the basis of such measures as productivity and material, capital and labour costs. For example, it is argued that between 100 and 200 beds is the optimal scale for nursing homes (Blank and Eggink 2001), between 200 and 300 beds for hospitals (Blank et al. 2008) and approximately 60,000 visits a year for emergency departments (Blank, Van Hulst and Wilschut 2013).[1] This technocratic approach can be traced back to traditional economic studies on scale that originate from Ricardo's (1815) classic *Essay on the influence of a low price of corn on the profits of stock*. He was among the first to show how and when an extra unit of production or a unit less results

1 The leading party in this discussion is IPSE (Innovation and Public Sector Efficiency) Studies (mainly Blank and colleagues), but other stakeholders in the policy debate, such as the Council for Public Health and Healthcare (RVZ 1998), the Netherlands Institute for Social Research (SCP 1998), the consultancy firm KPMG (2003) and the Netherlands Bureau for Economic Policy Analysis (CPB 2013) have also tried to find the optimal scale in healthcare.

in a scale that is suboptimal in terms of efficiency. Subsequent studies on scale are dominated by an economic discourse that focuses on 'economies of scale' and sees 'efficiency' as the most important factor in decisions regarding scale. In this strand of literature scholars equate scale with size, defined in terms of population, number of employees, or turnover. They try to find "the optimal scale" (Bain 1968) or the "scale optimum" (Jensen and Meckling 1976) as something that can be measured and calculated objectively. In this perspective, an organization reaches its optimal scale when the average costs of production are the lowest, i.e. when economies of scale are maximized.

In a slightly different way, this technocratic approach to scale is also prevalent in a large number of studies in organization and public administration literature. That is, although these studies go beyond looking at scale just in terms of efficiency and also take other variables into account, they still (implicitly) assume there is an 'optimal scale' for organizations and governments. An example is a study by Kuemmerle (1998), who tries to find the optimal scale of Research & Development (R&D) laboratories by analysing the relation between scale and performance. He finds that larger R&D laboratories perform better than smaller ones due to better communication between research groups and improved access to scientific support. However, when a laboratory gets too large, informal contacts with colleagues decrease and bureaucracy rises and at a certain point (beyond 'the optimal scale'), the disadvantages outweigh the economies of scale. Other studies that fit this line of thinking have focused on the relation between scale and variables such as organizational structure, human behaviour, performance and democratic legitimacy (e.g. Boyne 1995; Byrnes and Dollery 2010; Cullinane and Khanna 2000; Guthrie 1979; Pugh et al. 1968). In this approach, scale is measured in terms of geographical boundaries, physical capacity (e.g. number of beds), number of personnel, organizational inputs or outputs (e.g. number of patients and citizens) or the resources and funding that an organization or a government has. Although these studies take a broader perspective than a strictly economic one, the assumption that there is an optimal scale is still the basis of their thinking. However, the optimal scale approach is problematic in three ways.

The problems of the optimal scale approach

First, the idea of an optimal scale does not take the multiplicity of organizational forms in Dutch healthcare into account. There are differences between sectors, but also within sectors. The hospital sector, for example, contains academic hospitals, top clinical hospitals, general hospitals, specialized hospitals and independent treatment centres ('ZBCs'). Every organization contains its own specific facilities, departments, wards, etc. Furthermore, each organization focuses on certain patient groups, is located in a geographical area with unique characteristics and cooperates with various other facilities and organizations. As healthcare is organized on multiple organizational (e.g. facilities, departments) and geographical scales (e.g. regions, neighbourhoods), each with its own and unique characteristics, it is impossible to establish one optimal scale that is applicable within one healthcare sector, let alone across sectors.

The second problem of the optimal scale approach is that it obscures the multiple values that are at stake in healthcare. In studies on the optimal scale, 'efficiency' is often the only value taken into account. In practice, healthcare organizations have to deal with a variety of values, such as quality, accessibility, innovation, equity and affordability (Oldenhof and Putters 2011; Van Egmond and Bal 2011). But even studies on the optimal scale that take multiple values into account, are problematic. Since values can be intrinsically conflicting (Bozeman 2007; Van der Wal, De Graaf and Lawton 2011), so do the definitions of optimal scale based on these different values. One scale that might be optimal in terms of efficiency or affordability might be sub-optimal in terms of quality or accessibility. These different definitions cannot easily be reconciled as values are not only often conflicting, but also incommensurable (Berlin 1982). This means that "there is no single currency or scale on which conflicting values can be measured" (Lukes 1989: 135). Thus, a technocratic exercise to determine 'objectively' what the optimal scale is, is misleading as it suggests that political conflicts between incommensurable values can be reduced to a rational cost-benefit analysis.

A third problem of the optimal scale approach is that it leaves no place for the multiple, subjective and changeable perceptions of scale that people have. In other words, it ignores processes of 'sensemaking' (Weick 1995) that are happening in and around organizations. Sensemaking "involves the ongoing retrospective development of plausible images that rationalize what people are doing" (Weick, Sutcliffe and Obstfeld 2005: 409). In this perspective, scale is

perceived differently by different people. A good example is 'Neighbourhood Care' (in Dutch: 'Buurtzorg'). In 2013, the Neighbourhood Care organization provided home care to 15,168 clients and had a turnover of 217 million euros (Buurtzorg 2013). Based on these numbers and compared to other home care organizations, Neighbourhood Care can be viewed as a large-scale organization. Still, many people perceive the organization as small-scale. A nice example is a 2013 blog post by Dutch Member of Parliament Jacques Monasch, entitled: "Long live small-scale neighbourhood care" (http://www.pvda.nl). He writes: "My visit to Neighbourhood Care in Bolsward was wonderful. The human scale is coming back to healthcare. This is the evidence that large-scale healthcare has had its day." Somehow, Monasch perceives Neighbourhood Care as small-scale, although it is the same size as other organizations that are frequently typified as 'large-scale'. The 'optimal scale' perspective cannot explain such perceptions.

In sum, the expectations of scale are high and scale is an often-used instrument to improve the quality and efficiency of healthcare. The rationale behind these changes is that there is a causal relation between scale and certain outcomes and that there is an optimal scale that can be achieved. However, the dominant approach of the optimal scale has three major problems. In particular, by reducing issues regarding scale to a technocratic and one-dimensional exercise, this approach fails to account for the *multiple scales* in healthcare, the *multiple values* that are at stake and the *multiple ways in which people make sense* of scale. As a consequence of this multiplicity, the process and outcomes of changes in scale are more dynamic, contested and unpredictable than often thought. That is not to say it is impossible to study scale and derive meaningful conclusions from the study. It does mean that we should not focus on finding the optimal scale but need a perspective that allows for *exploring the multiplicity of scale*. For that purpose, I will discuss insights about scale from the field of human geography in the next section.

The social construction of scale

Scale is a central object of study in human geography. Here, scales are commonly defined as "nested hierarchical structures of organization" (Harvey 1982: 423, in: Robertson 2003) or "graduated series, usually a nested hierarchy of bundled spaces of different sizes, such as the local, regional, national and supranational

[...] each with a distinct geographic scope, that is, territorial extent" (Leitner 1997: 124–125, in: Spicer 2006). Scales are described in terms of a continuum, layers or a hierarchy – for instance micro, meso and macro; large, medium and small; and local, regional, national and global.[2]

Although the concept of scale is easily taken for granted, for example in discussions about 'globalised' trade, 'regional' development and 'local' action, these studies show that scale is not a neutral set of pre-given levels on which social processes take place. Instead it is a subjective, contingent way of seeing and organizing (Smith 1992; Delaney and Leitner 1997; Herod and Wright 2002). Human geographers stress that it is important to realise that scales are *social constructions* (Brenner 2001; Marston 2000). That is, the existence of scale is the result of human (inter)action, sensemaking, language and the use of materials: "[A phenomenon] need not have existed, or need not be at all as it is. [It] is not determined by the nature of things; it is not inevitable" (Hacking 1999: 6). What we call micro, macro, local, regional, small and large is not inherent to the world, but a consequence of how we perceive, define and classify things. For example, Dutch hospital organizations can be perceived as large-scale when compared to the scale of hospitals several decades ago. However, when one takes hospital organizations in the US into account, Dutch hospitals are small-scale. People use the notion of scale to make sense of reality: "large-scale environments, extending from rooms through houses, neighborhoods, cities, countrysides, to the whole universe in size [...] require some process of spatial and temporal summation" (Ittelson 1973: 13, in: Montello 1993).

Human geography scholars have studied the social construction of scale in a variety of cases, including political parties (Agnew 1997), labour unions (Herod 1997), social movements (Masson 2006), cities (Kaiser and Nikiforova 2008) and the European Union (Johnson 2008). For example, Masson (2006) shows how the Quebec women's movement responded to a state project that delegated policy making to the region. By organizing, mobilizing and making claims re-

2 On http://htwins.net/scale2 there is an interactive animation by Cary and Michael Huang that provides a nice application of scale.You can scroll from the smallest thing currently known, a string estimated to be 10^{-33} cm. long (a millionth of a billionth of a billionth of a billionth of a centimetre) to the size of the observable universe, an estimated diameter of 96 billion light years, and everything in between. For a similar experience, see https://www.facebook.com/photo.php?v=701885149860397&fref=nf for a wonderful animation of the scale of the universe by the American Museum of Natural History.

gionally instead of nationally as they used to, the women's movement was able to make the region a relevant and legitimate scale for feminist politics. Johnson (2008) offers another example, where he argues that European Union economic policy aims to reorganize scale by creating new regions, thereby transcending national borders. He shows how governments and organizations from Germany, the Czech Republic and Poland struggle to engage in trans-boundary arrangements, thereby constructing a '3-CIP region' (3 Countries Innovation Push) as a new scale. The examples show that from a social constructivist perspective, scales only become real and meaningful as a result of social (inter)action. 'The region' is not an ontologically given scale for feminist politics, but becomes so after a range of activities by the women's movement (Masson 2006). Similarly, the scale of the trans-boundary region in the study of Johnson (2008) only exists as a result of European Union policy.

The notion of scale as a social construction emphasizes that what scale is, on what scale(s) healthcare is provided, and how, is an outcome of the interplay between the multiple interests, values and perceptions of the people that are involved and broader social and political processes. This perspective thereby addresses the three problems in the 'optimal scale' approach that I identified above. It takes the multiplicity of scale as a starting point by acknowledging that there are always multiple scales that have to be dealt with, multiple values that play a role and multiple perceptions of people. It then focuses on how changes in scales take place and what the underlying rationales, accompanying social processes and (unintended) consequences are. This can be further illustrated by insights from cartography. Although the use of a certain scale on a map appears objective, Harris and Hazen (2006: 101) argue that maps are "neither neutral nor unproblematic with respect to representation, positionality and partiality of knowledge." The way maps are designed, what they do and do not show, and how certain areas are labelled, always displays ideology and influences the way we perceive reality (Harley 1989). Consequently, a map is not a neutral representation of a piece of land on another scale, but a political instrument that inevitably and purposely distorts our perspective.[3] A map illuminates some elements (e.g. castles and parks) and ignores others (e.g. prisons and rubbish dumps), drawing attention to the places that the makers of the map want to emphasize. Harley

3 For some examples, see http://amazing-maps.tumblr.com or follow @amazinmaps on Twitter.

(1989) shows that historical societies have placed their own territories at the centre of world maps, trying to naturalise their dominant position. He calls this the 'rule of ethnocentricity'.

An amusing example of the social construction of the scale of maps can be found in the TV series 'The West Wing'. In one episode, representatives of a fictional organization called 'Cartographers for Social Equality' try to convince White House press secretary Claudia Jean (C.J.) Cregg and deputy chief of staff Josh Lyman to forbid the use of the traditional 'Mercator projection world map' (Figure 1) in public school geography classes. The cartographers argue that the Mercator projection map misrepresents the world and "has fostered European imperialist attitudes for centuries and created an ethnic bias against a Third World" (The West Wing transcripts 2001):

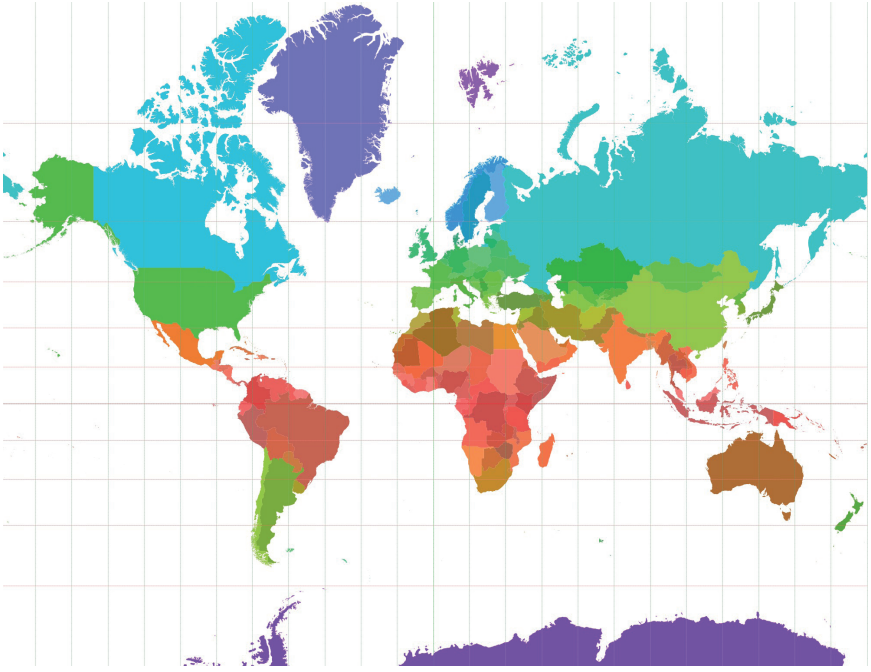

Figure 1. Mercator projection world map

C.J. Are you saying the map is wrong?
Cartographer 1 Oh, dear, yes. Uh, look at Greenland.
C.J. Okay...
Cartographer 1 Now look at Africa.
C.J. Okay...
Cartographer 1 The two landmasses appear to be roughly the same size.
C.J. Yes.
Cartographer 1 Would it blow your mind if I told you that Africa is in reality 14 times larger?
C.J. Yes.
Cartographer 2 Here we have Europe drawn considerably larger than South America when at 6.9 million square miles South America is almost double the size of Europe's 3.8 million.
Cartographer 3 Alaska appears three times as large as Mexico, when Mexico is larger by .1 million square miles.
Cartographer 2 Germany appears in the middle of the map when it's in the northernmost quarter of the Earth.
Josh Wait, wait. Relative size is one thing, but you're telling me that Germany isn't where we think it is?
Cartographer 1 Nothing's where you think it is.

The Cartographers for Social Equality go on to plead for the use of the 'Peters projection world map' to teach geography, instead of the Mercator projection. To the bewilderment of C.J. Cregg, they even present the Peters projection upside down (Figure 2). The cartographers argue that due to the Mercator projection, Third World countries are valued less not only because they are shown smaller than they are in reality, but also because they are positioned at the bottom of the map. Unfortunately for the cartographers, they do not succeed in convincing the White House to support their agenda.

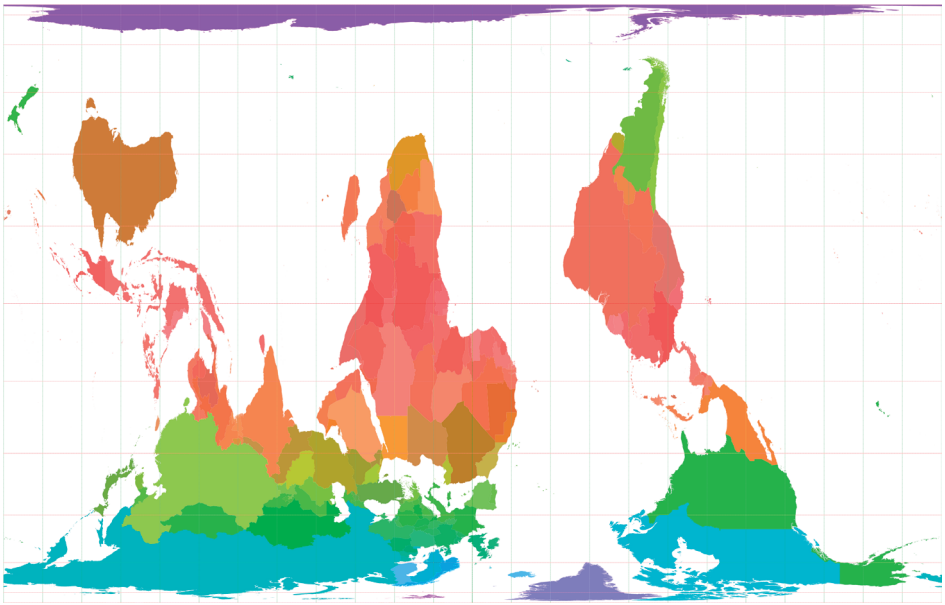

Figure 2. Peters projection world map, upside down

The social construction of scale in organization and public administration studies

Although the majority of studies on scale in organization and public administration literature implicitly or explicitly use the 'optimal scale' approach, a small number of studies conceptualise scale as a social construction. These studies are inspired by the human geography literature on scale that I discussed in the previous section. Similar to the human geography literature, these studies emphasize that what scale is and means depends on the interplay between human (inter) action, sensemaking, language and the use of materials. Also, they pay attention to the impact of broader social and political processes on scale. These studies have generated interesting insights in the multiplicity of scale in organizational practice and public administration and provide several directions for my research of scale in Dutch healthcare.

In *organization literature*, the work of André Spicer is noteworthy. In a reflection on globalization (2006), he argues that spatial scales, for example the neighbourhood, the city, the nation and the global, are crucial for understanding how

organizational logics are transformed in and across countries. Through changes in capital flows, regulation and discourse, organizational logics are positioned on different scales and thereby gain different meanings. As an example, he discusses a study of the efforts of a pharmaceutical company to reposition itself from the national scale to the European and global scales (Zeller 2000). The company did so by attracting funds from global financial markets, introducing new regimes of internal regulations and mobilizing a new discourse of a 'global' pharmaceutical firm (Spicer 2006).

In addition, Taylor and Spicer (2007) argue for an 'integrated theory of organizational space', in which scales are central. They suggest that studying organizational spaces on macro (e.g. national economy), meso (e.g. inter-organizational relations) and micro scales (e.g. daily work practices) can make an important contribution to a better understanding of modern-day organizations. Although this presentation of scale implies a neat vertical structure like Russian 'matryoshka' dolls, Taylor and Spicer (2007) emphasize, in line with insights from human geography, that there is no inherent and absolute hierarchical relation between scales. Sometimes 'lower' levels are much more important than 'higher' levels, as exemplified by the rise of the urban scale at the expense of the national scale in some countries. Crucial is how the multiple scales relate to each other and are made more or less important over time.

Unfortunately, the theoretical exercises of Spicer (2006) and Taylor and Spicer (2007) have not had much empirical elaboration. Although there is a wealth of studies in organization literature that touches upon the concept of scale – for instance on the relation between the small and the large, the micro and the macro, the local and the global – scale is predominantly (implicitly) treated as 'given' levels of analysis on which social action takes place. Empirical studies that take scale seriously as an object of study in itself, are lacking.

Public administration studies that conceptualise scale as a social construction focus on the political role that scale plays in governance processes. They build on studies in human geography that focus on the political nature of scale. For example, Gualini (2006) argues that major new governance activities are often accompanied by creating new scales or by making existing scales more important (cf. the empirical studies from human geography that I discussed in the previous section). He poses that the European policies that have mobilized regions as social and political actors have led to new and unpredictable 'inter-governmental-supraregional' and 'inter-organizational-intraregional' dynamics. These

dynamics both enable and disable new policies. This study, and similar ones on 'multi-level governance' and 'adaptive governance' (Termeer, Dewulf and Van Lieshout 2010), have showed that the social construction of scale, making scales real and meaningful, is highly political and involves struggles over interests and power. As also the influential human geography scholar Erik Swyngedouw (2010: 32) argues, issues of scale lie on "the terrain of the political where these tensions [are] fought, mediated and negotiated, resulting in ever-changing forms of territorial or geographical organization and the emergence of territorially shifting forms of governance."

Furthermore, public administration scholars have pointed to the discursive nature of scale. Based on the work on scale frames and counter-scale frames by Kurtz (2003) in human geography, Van Lieshout et al. (2012; 2014) analyse how actors in policy processes try to frame phenomena on a certain scale to achieve their goals. In a study of a new environmental policy in a rural area, Van Lieshout et al. (2012) show how actors use different scale frames to define problems and solutions as local, regional/provincial, national or global. They thereby try to strategically manage responsibility and accountability for the implementation of the policy. In a similar study, of the political and public debate on the future of Dutch intensive agriculture, Van Lieshout et al. (2014) show how dominant actors are able to use their power to emphasize some and downplay other scale frames. In particular, the Minister of State frames the issue of 'mega stables' as a local one, with local problems and solutions, entailing notions such as 'quality of the surroundings' and 'societal embedding'. This enables him to stay away from setting limits on farm size in a national policy.

Building on insights from human geography, these organization and public administration studies account for the multiplicity of scale: they show that organizations have to deal with several scales at once; that upscaling or downscaling is informed by a variety of organizational and political processes, actions, discourses and values; and that actors attach different meanings to scale. They thereby provide interesting directions for exploring the multiplicity of scale in Dutch healthcare. In particular, these studies emphasize that definitions of scale are contested and that changes in scale "cannot be univocally referred to the 'planned' spatial ordering of defined activities: it is largely an unintended outcome, which is contingent upon these activities, but not primarily dependant on them" (Gualini 2006: 895). In other words: changes of scale in Dutch healthcare are not rational shifts in functional tasks and responsibilities from the one scale

to the other that have predictable outcomes, as Dutch policy makers, executives and other actors often assume. Because of the high expectations and the frequent use of (changes in) scale as a governance instrument, empirical studies of the workings of scale in practice are necessary. Such studies should explore how scale is defined and perceived, how dynamic and politically informed processes of changes in scale take place and what the consequences are for the organization and provision of care.

Research question

In this dissertation, I present such empirical studies on scale, drawing on a social constructivist perspective. From this perspective, I analyse what role scale plays in the four major developments that I described above, how scale is perceived by different actors, what the rationales and social dynamics of changes in scale are and what consequences this has for the organization and provision of care. In order to do so, I focus both on how people in everyday situations make sense of scale and what the influence of broader political and societal forces is. I study several empirical issues that are associated with scale in depth. I do not aim to compare the different cases, but intend to explore the multiplicity of scale in Dutch healthcare in a variety of settings. I bring the different findings together in the final chapter of this dissertation. This leads to the following research question:

> How is scale in Dutch healthcare socially constructed and what are the consequences for the organization and provision of care?

Methodology

To explore the multiplicity of scale, I employed a multi-method research design. Just as one navigates through an online map, zooming in and out of different places, this research design makes some features more or less important and visible. At various degrees of granularity, certain social patterns and processes appear and disappear (cf. Noyes 2013). This allows me to analyse the 'plural connotation' of scale (Brenner 2001), which refers to the multiple meanings of scale and the

relations between different scales. This design is necessary to explore the social construction of scale from various viewpoints and actors in the public debate, health policies, organizational strategies and daily practices. By zooming in and out, I was able to study on multiple organizational and geographical scales what role scale plays in the organization and provision of care, how scale is perceived by the people involved, how and why changes in scale take place and what the consequences are. Notably, I did not mean to capture the entire political, societal and scientific discussion about scale. Instead, by analysing the differences and similarities between a number of practices on this imaginary map where scale is debated, decided on and experienced, I aimed to explore the (relations between) multiple manifestations and meanings of scale.

First, I 'zoomed in' on the organizational scale by conducting a *survey study* to analyse mergers in Dutch healthcare. Administered to nearly 850 executives, the survey posed questions on merger trajectories that have taken place between 2005 and 2012. It focused on the rationales that executives provide for completed and abandoned mergers in a changing social and political context. Second, I 'zoomed out' and performed a *critical discourse analysis* of 867 Dutch newspaper texts over the period January 1990 – June 2014 to study how scale is discussed in media accounts. I analysed 1,235 extracts from newspaper texts in which a variety of actors, including policy makers, executives, scientists, professionals, columnists and editors of newspapers debate scale in healthcare. Third, I 'zoomed in' on the work floor by *interviewing* managers and professionals and conducting *observations* to study scale in daily healthcare settings that are influenced by processes of de-institutionalisation, decentralisation and concentration of care. Together with fellow researchers, I conducted interviews with 38 professionals in home care and emergency care, 17 middle managers in long-term care and emergency care and 13 executives in long-term care. Furthermore, we conducted a total of 119 hours of observation in emergency care settings. The observations included about 30 *ethnographic interviews* with managers and professionals. I provide more detailed explanations of (the motives for) the research methods in each empirical chapter.

Outline

In the second and third chapters, I discuss mergers in Dutch healthcare. By providing insight in the rationales behind mergers processes, which often remain hidden, I aim to contribute to debates about organizational scale in health services and health policy literature. In *Chapter 2,* I analyse the motives for mergers that Dutch healthcare executives provide. I look both at the differences in motives between mergers and at how motives relate to developments in the environment. In particular, I reflect on the influence of the introduction of market incentives to Dutch healthcare, the declining influence of the state and decentralisation of care to municipalities. In *Chapter 3*, I analyse why some merger trajectories in Dutch healthcare are abandoned. I also compare the organizational characteristics (e.g. healthcare sector, turnover and previous merger experience) of abandoned and completed merger trajectories.

In *Chapter 4*, I study the public debate on scale in Dutch healthcare using theory on the production of space (Lefebvre 1991). I do so to gain insight in the broader social and political developments that influence scale. I analyse which actors are involved in the public debate, in which healthcare sectors scale is subject of discussion and how the public debate on scale evolves over time. In particular, I pay attention to the language that people use when they discuss scale and what assumptions and political goals underlie the use of certain language. In doing so, I make an empirical and theoretical contribution to organization literature on the social construction of scale in media accounts.

In the next three chapters, I discuss the role of scale in daily healthcare practices. I contribute insights from micro-level analyses to organization and public administration literature. In *Chapter 5*, I focus on the scale of homes for the elderly and people with a disability. In particular, I look at the work that executives and middle managers perform to provide small-scale care. When I studied their daily work, I noticed that they encountered several value conflicts. I use theory on justification (Boltanski and Thévenot 2006) to show how they deal with those conflicts and how this influences small-scale care. In *Chapter 6*, I study the geographical scale of the neighbourhood. In particular, I analyse how neighbourhood nurses do their work in a new project (the 'Visible link'). I found that they not only provide healthcare services, but also organize their own work. I use the concept of articulation work (Strauss et al. 1985) to understand what organizing/care work neighbourhood nurses exactly perform and what the con-

sequences are. In *Chapter 7*, scale refers to emergency departments in hospitals. I discuss professional work in and around small-scale emergency care facilities and analyse how a new policy on emergency care relates to this work. When I empirically found that the new policy provides a selective representation of the work performed in emergency care, I used the concept of (in)visibility of work (Suchman 1995) to understand how this influences (the perception of) small-scale emergency care. In *Chapter 8*, I answer the research question, discuss the theoretical and practical implications and provide recommendations for future research and practice.

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Figures

Mercator projection world map. By Koenb at Dutch Wikipedia (Original text: productie van de afbeelding uit het .shp-bestand: Koenb 2009) [Public domain], via Wikimedia Commons. Link to file: http://upload.wikimedia.org/wikipedia/commons/c/c5/ World_borders_mpr.png.

Peters projection world map. By Koenb at Dutch Wikipedia (Original text: productie van de afbeelding uit het .shp-bestand: Koenb 2009) [Public domain], via Wikimedia Commons. Link to file: http://upload.wikimedia.org/wikipedia/commons/b/bb/ World_borders_cilv2.png.

CHAPTER 2

Why healthcare providers merge

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Abstract

In many OECD countries, healthcare sectors have become increasingly concentrated as a result of mergers. However, detailed empirical insight into why healthcare providers merge is lacking. Also, we know little about the influence of national health policies on mergers. We fill this gap in the literature by conducting a survey study on mergers among 848 Dutch healthcare executives, of which 35 per cent responded (resulting in a study sample of 239 executives). 65 per cent of these respondents was involved in at least one merger between 2005 and 2012. During this period, Dutch healthcare providers faced a number of policy changes, including increasing competition, more pressure from purchasers, growing financial risks, de-institutionalisation of long-term care and decentralisation of healthcare services to municipalities. Our empirical study shows that healthcare providers predominantly merge to improve the provision of healthcare services and to strengthen their market position. Also efficiency and financial reasons are important drivers of merger activity in healthcare. We find that motives for mergers are related to changes in health policies, in particular to the increasing pressure from competitors, insurers and municipalities.

Introduction

Since the 1980s, healthcare sectors in many OECD countries have become increasingly concentrated as a result of mergers (Garside 1999; Gaynor and Haas-Wilson 1999; Fulop et al. 2002; Bazzoli et al. 2002). The Netherlands are no exception to this (Noordegraaf, Meurs and Stoopendaal 2005; Fabbricotti 2007). Both in the Netherlands and internationally, merger activity has fuelled a public and scientific debate about the consequences of mergers and the desirability of further concentration of healthcare sectors (e.g. Gaynor and Town 2012; Postma, Van de Bovenkamp and Putters forthcoming). Although there is an increasing amount of research on the effects of healthcare mergers (e.g. Gaynor and Town 2012), detailed empirical insights in why providers merge and how mergers are influenced by health policy, are lacking. Our study aims to fill this gap in the literature by answering the following research questions: (1) *Why do healthcare providers merge?* and (2) *How do (changes in) health policy influence motives for mergers?* The answer to these questions is important as a growing number of European healthcare systems are in the midst of reforms (Saltman et al. 2012), including measures to increase competition either on the delivery side, on the insurance side, or on both (Propper 2012). This means that organizations that first operated in a more or less regulated and sheltered environment are now increasingly exposed to competition and financial risks. It is likely that these reforms influence merger activity, but little is known how and to what extent. The Netherlands provide an excellent case for such research as the Dutch healthcare sector is consolidating rapidly while important reforms are being implemented.

We answer the research questions by analysing the results of a survey study among Dutch healthcare executives (i.e. end-responsible managers). We focus on providers, so mergers between healthcare insurers, pharmaceutical companies and other organizations that are part of the healthcare sector are not included in the study. The contribution of our study to the literature is threefold. First, it provides empirical evidence on motives for healthcare mergers, which have received little scholarly attention so far. Second, it presents findings on merger motives from different healthcare sectors, while the focus of most studies so far has been limited to hospital mergers. Third, our study contributes to a better understanding of the relation between motives for healthcare mergers and health policies.

This chapter proceeds as follows. First, we provide an overview of literature on merger motives. We then describe the most important policy changes in the Dutch healthcare sector that occurred during our study period (2005-2012). Third, we specify the methodology used. After that, we present the findings of our empirical study and we finish with a conclusion and a discussion of the implications of our study.

Motives for mergers in healthcare

This study is about motives for mergers. A merger differs from an acquisition in the sense that in the former, two or more previously independent organizations consolidate into a single legal entity. In the latter, an organization acquires ownership rights of a second organization. The terms 'merger' and 'acquisition' are often used interchangeably (Angeli and Maarse 2012). Because the term 'acquisition' is hardly used in Dutch healthcare, we use the term 'merger' in this chapter to describe both mergers and acquisitions.

Theories on motives for mergers in healthcare

The current literature on health policy posits three main theories to account for mergers. The first is improved efficiency by realising economies of scale, for example by reallocating resources between different locations in response to excess capacity or other changing conditions (Barro and Cutler 1997; Spang, Bazzoli and Arnould 2001; Vogt and Town 2006; Cutler 2009). Also, by reducing management and administrative overhead, concentrating care in a smaller number of locations, sharing expertise and increasing volume of treatments within locations, mergers may increase efficiency (Dranove and Shanley 1995; Barro and Cutler 1997; Robinson 1998; Harrison, McCue and Wang 2003; Choi and Brommels 2009; Hayford 2012).

The second theory is that mergers represent strategic attempts by organizations to gain market power (Bogue et al. 1995; Barro and Cutler 1997; Brooks and Jones 1997; Gaynor and Haas-Wilson 1999). This explanation posits that a merger leads to a greater market share of a provider, for example by merging with a competitor, and consequently strengthens its market position. Healthcare providers with greater market power have an enhanced ability to set prices as they are likely to be in a stronger bargaining position vis-à-vis payers and other

stakeholders (Bogue et al. 1995; Dranove and Shanley 1995; Barro and Cutler 1997; Fulop et al. 2002).

A third potential reason for healthcare mergers is pressure from a third party. For example, in a national health system like the National Health Service in the UK, government may force providers to merge for a variety of reasons, including the reduction of capacity (Harris, Ozgen and Ozcan 2000; Fulop et al. 2002; Gaynor, Moreno-Serra and Propper 2013). Although governmental pressure is likely to be less important in competitive healthcare systems, it is possible that other external stakeholders, such as health insurers, influence merger decisions. Also, pressure from internal stakeholders (such as physicians and management) is a potential reason for merger. Oldenhof, Postma and Putters (2014) and Witman et al. (2011) show that internal stakeholders are key players in the governance of healthcare providers and therefore likely influence strategic decisions such as mergers.

Empirical studies on motives for mergers in healthcare

Only few studies empirically examine merger motives in healthcare and these studies mainly focus on hospital mergers. The findings are mixed. Based on interviews with executives of all major hospitals in the Boston area of the US, Barro and Cutler (1997) find that both the need for a stronger market position and efficiency concerns motivate hospital mergers. In contrast, Brooks and Jones (1997) find in their study on 17 US hospital merger cases no proof of either market power or efficiency considerations. Harrison (2007) suggests that the primary goal of consolidation is to increase market power rather than to decrease inefficiencies. Fulop et al. (2002) study nine mergers between hospital trusts in the UK and find a variety of motives, including cost savings, safeguarding the quality and amount of services provided, external pressure for concentration of healthcare services and lobbying from stakeholders (including national government and pressure groups).

In the survey studies of Bogue et al. (1995) and Bazzoli et al. (2002), hospitals rated strengthening the financial position, achieving operating economies, consolidating services, expanding scope of services provided, expanding market share and obtaining access to new technology as the six most important reasons for merger. These rationales might all be defined as efficiency and market considerations. However, Bogue et al. (1995) and Bazzoli et al. (2002) show that distinguishing a 'healthcare services' category is consistent with how healthcare

providers motivate mergers. For example, Bazzoli et al. (2002) show that 54 per cent of the healthcare providers reported that expanding market share was among the most important reasons for merger, while 44 per cent of the providers reported that expanding the scope of services provided was among the most important reasons. These reasons are closely related, but providers apparently perceive them differently. Also other studies show that providers motivate mergers with reasons that are related to the provision of healthcare services (Fulop et al. 2002; Hayford 2012). Finally, the findings of Bogue et al. (1995) and Bazzoli et al. (2002), but also of Robinson (1998), Harrison, McCue and Wang (2003) and Choi and Brommels (2009), suggest that 'strengthening the financial position' may be a motive for merger.

In sum, empirical studies on motives for hospital mergers identify efficiency, market power and pressure by stakeholders as drivers for mergers, but also distinguish a range of other motives, including motives related to the provision of healthcare services and financial considerations. Still, a sector-wide, systematic understanding of why healthcare providers (other than hospitals) merge is missing. Also, little is known about the relation between merger motives and health policies, although several studies suggest that such a relation is present (Barro and Cutler 1997; Fulop et al. 2002).

Policy changes in Dutch healthcare

In order to answer the question how merger motives relate to policy changes, we first describe the most important developments in Dutch health policy that took place during our study period (2005-2012). The year 2005 served as a starting point because of major healthcare reforms that were enacted in the Netherlands since that year. Until 2005, Dutch healthcare organizations operated in a strictly regulated environment in which hospital care and long-term care (LTC) were financed by different social insurance schemes. Social health insurance carriers were obliged to contract with any willing provider and faced limited risk for expenditures on hospital care and were at no risk for expenditures on LTC. Also, most healthcare providers received fixed budgets for delivering care. Since 2005, the environment of providers is rapidly changing due to a series of policy measures aimed at strengthening competition and increasing financial risk for providers. The goals of the market-oriented reform are to stimulate entrepreneur-

ship, increase the system's efficiency and improve its responsiveness to patients' needs, while maintaining equal access (Helderman et al. 2005; Van de Ven and Schut 2009).

Besides the market based reforms, healthcare is undergoing a variety of other changes that possibly influence mergers. These include de-institutionalisation of LTC and mental healthcare and decentralisation of home care to municipalities (Putters et al. 2010; Kroneman, Cardol and Friele 2012; Oldenhof, Postma and Putters 2014). In the sections that follow, we describe the policy changes that took place between 2005 and 2012 in the sectors that we included in our study: hospital care, long-term care and mental healthcare. We focus on the consequences that those developments might have had on mergers. The policy changes are summarised in table 1.

Table 1. Policy changes in Dutch healthcare (2005-2012)

Hospital care	Long-term care	Mental healthcare
- Introduction and gradual expansion of provider-insurer negotiations over quantity and prices - Increased competition from Independent Treatment Centres - Increased financial risks for hospitals	- Introduction of regional budget constraints - Introduction of provider-purchaser negotiations over quantity and prices - Decentralisation of household services to municipalities - Ongoing trends of de-institutionalisation and downscaling	- Increased financial risks for providers through reduction of budget guarantees - Increased competition from new entrants - Ongoing trend of downscaling

Hospital Care

In 2006, the Dutch health insurance system was reformed by the introduction of the Health Insurance Act (Zvw), comprising a mandatory basic health insurance scheme. The aim of the reform was to encourage health insurers to increase the efficiency of healthcare provision by becoming prudent buyers of health services on behalf of their enrolees (Van de Ven and Schut 2009). Since then, health insurers and hospitals have been provided with incentives and tools to negotiate over the price and quality of hospital care. For example, in 2005, prices for elective hospital care products (e.g. knee, hip and cataract surgeries), jointly accounting for 10 per cent of hospital revenue, became freely negotiable. The prices for the remaining products were regulated. After 2005, the share of freely negotiable hospital services increased to 20 per cent of hospital revenues in 2008, 34 per cent in 2009 and 70 per cent in 2012. Furthermore, health insurers

were allowed to selectively contract with hospitals and to reimburse only part of the care provided by non-contracted hospitals. Around 2010, health insurers started using minimum volume standards for a small number of treatments (such as complex cancer surgery) as an instrument for selective contracting. Only hospitals providing a certain number of these treatments are being contracted for these services. The uptake of selective contracting for other treatments has been limited so far.

In addition to growing pressure from health insurers, competition between providers increased. In particular, Independent Treatment Centres (ITCs)[4] were allowed access to the hospital market in 2006, resulting in a rapid growth of the number of ITCs from 149 in 2007 to 288 in 2012 (NZa 2012a; 2013). These small-scale providers typically focus on non-complex elective procedures, such as varices surgery and cataract surgery, for which health insurers and hospitals are allowed to freely negotiate prices.

Finally, hospitals became exposed to financial risks for capital expenses. Until 2008, hospitals were not at risk for their capital expenses since these were fully reimbursed once the hospital acquired permission by the government to build or renovate hospital facilities. Starting in 2008, the compensation of capital expenses will be phased out in ten years' time.

As a result of the policy changes, hospitals are increasingly exposed to financial risk and under pressure from health insurers and competitors. This became evident in several cases of hospitals that got into serious financial problems over the last years, even leading to the first ever bankruptcy of a general hospital in the Netherlands in 2013. In the past decades, the Dutch hospital sector also consolidated rapidly. As a result of mergers, the number of hospitals decreased from 160 in 1985 to approximately 100 in 2007 and 80 in 2012 (Blank et al. 2008; RIVM 2013). In this chapter, we aim to study to what degree mergers between 2005 and 2012 were motivated by the changing context. Changes may have increased the need to strengthen market/bargaining power vis-à-vis health insurers and other providers, to meet insurers' requirements of a minimum volume of treatments or to strengthen the hospital's financial position.

4 ITCs are comparable to the freestanding Ambulatory Surgery Centres (ASCs) that operate in the US and UK healthcare markets (e.g. Carey, Burgess and Young 2011; Gaynor and Town 2012).

Long-term Care

Similar to hospitals, inpatient and outpatient LTC providers (nursing homes, disability care providers and home care providers) are under increasing competitive and financial pressure, albeit less strongly than in the hospital sector. Until the end of 2014, long-term care was financed through a separate public LTC insurance scheme (AWBZ). The scheme was carried out by regional insurance carriers or contracting entities. Regional insurance carriers contracted with LTC providers within a regional budget constraint, which was set in 2005 by the national government to contain the fast rising LTC expenditures (Schut and Van den Berg 2010). By the end of 2004, the government repealed the legal requirement for regional insurance carriers to contract with any willing licensed provider of outpatient LTC (e.g. home care providers). As a result, since 2005, regional insurance carriers are allowed to selectively contract with outpatient LTC providers. To accommodate the transition to competition for a share of the regional budget, all regional insurance carriers started with high budget guarantees (on average about 95 per cent) for existing outpatient LTC providers (Varkevisser, Van der Geest and Schut 2007). These guaranteed budgets were gradually reduced in subsequent years.

Furthermore, the Social Support Act was introduced in 2007. Household services – comprising about 30 per cent of total home care expenditure – were carved out of the public LTC insurance scheme and transferred (decentralised) to municipalities. This is in line with decentralisation trends in other European countries (Kroneman, Cardol and Friele 2012). Facing budget constraints, most municipalities introduced competitive bidding procedures for household services. As a result, municipalities saved about 12 per cent of the original expenditures on household services (about 1.2 billion euros) and many home care providers faced a substantial drop in revenues or were not contracted at all (Pommer, Van der Torre and Eggink 2009). The reduction of budget guarantees for incumbent providers and the tendering of household services by municipalities attracted many new providers. As a result, the number of home care providers increased by more than 60 per cent between 2007 and 2012 (Actiz 2012).

Finally, the LTC sector is undergoing trends of de-institutionalisation and 'downscaling'. As a result of de-institutionalisation, the number of people that live in institutions like nursing homes and large-scale facilities for disability care has steadily declined over the past decades. For example, the number of available places in nursing homes dropped by 20 per cent between 1980 and 2010, despite

the fact that during this period the number of people over 80 years of age more than doubled from about 300,000 to about 650,000 (Tweede Kamer 2013). Furthermore, LTC is downscaling: institutional care is increasingly provided in small-scale homes (Oldenhof, Postma and Putters 2014). For example, in 2010 25 per cent of the people with dementia that received institutional care lived in small-scale homes, marking a 178 per cent increase from 2005 (Te Boekhorst 2010). The trends of de-institutionalisation and downscaling reflect a changing societal attitude towards LTC. Values like self-determination, social integration and quality of life in regular domestic settings have replaced the traditional model of LTC that was aimed at seclusion, protection and quality of care in large-scale institutions (Oldenhof, Postma and Putters 2014).

Also LTC providers engaged in mergers. As a result, between 1998 and 2004, the number of standalone nursing homes in the Netherlands decreased from 100 to 21, the number of standalone residential homes decreased from 599 to 222 and the number of home care providers decreased from 107 to 55 (Fabbricotti 2007). In light of the policy changes presented above, mergers may offer a way out for LTC providers: they may help outpatient care providers to enhance their market/bargaining position vis-à-vis regional insurance carriers, municipalities and competitors and they may offer inpatient care providers opportunities for improving efficiency by reducing overcapacity and investing in small-scale homes.

Mental Healthcare

Also mental healthcare providers face increasing pressure from purchasers and competitors. Until 2008, mental healthcare was largely covered by the public LTC insurance scheme (AWBZ). Since then, mental health services with a treatment period of less than one year was transferred from the LTC insurance scheme to the mandatory basic health insurance scheme (Zvw) that was introduced in 2006. Approximately two thirds of mental healthcare is now financed through the Zvw (Trimbos-instituut 2011). In contrast to the other providers covered by the Zvw (e.g. hospitals), mental healthcare providers have to negotiate a budget with a representative of all health insurers rather than individual health insurers. Hence, they are still confronted with a single buyer. Although health insurers guaranteed to maintain budgets at the level of the preceding year in 2008, over time they gradually reduced these budget guarantees (Mosca and Heijink 2013).

Furthermore, new entrants have entered the market for mental healthcare during our study period. New entrants providing mental health services have to

negotiate contracts with individual health insurers, including the price per service. While new entrants had a market share in terms of expenditure of only 0.3 per cent in 2008, this increased to 10 per cent in 2012 (Mosca and Heijink 2013; NZa 2012b). Nevertheless, the market for mental healthcare is highly concentrated. In 2009, the average regional market share of the largest mental healthcare provider was 62 per cent (NZa 2010). After a range of mergers between inpatient and outpatient mental healthcare providers in the 1990s, about 85 per cent of mental healthcare in the Netherlands is now provided by 31 regionally organized providers (Trimbos-instituut 2011).

Finally, the mental healthcare sector is undergoing a trend of downscaling. Although the number of inpatient places for patients with mental disabilities has not decreased during our study period (NZa 2012b; 2014a), inpatient mental healthcare is increasingly provided in small-scale 'protected homes' instead of large-scale psychiatric hospitals. Protected homes are located in regular neighbourhoods and comprise clustered apartments with a shared living room. The number of places in protected homes increased from 4,000 in 1993 to 7,000 in 2004 and 14,000 in 2009, now comprising over 60 per cent of inpatient places (Trimbos-instituut 2011).

Hence, similar to hospitals and LTC providers, mental healthcare providers face increasing pressure from purchasers and competition with other providers. Furthermore, they are in a transition from inpatient mental healthcare in psychiatric hospitals to protected homes. It is therefore possible that mergers between providers are motivated by an urgency to strengthen their market/bargaining position vis-à-vis health insurers and competitors and a need to improve efficiency by reducing overcapacity in psychiatric hospitals.

Methods

To study why healthcare providers merge, we sent a survey to Dutch healthcare executives. The survey contained questions on the background of executives, the characteristics of the providers involved in mergers and merger motives. The survey was sent out electronically in April 2012 (with two reminders in May) to all 740 members of the Dutch Association of Healthcare Executives (NVZD) and another 108 executives whose contact details were obtained from a Dutch consultancy firm (BMC). We focused on healthcare executives because they

are key players in merger processes and have unique inside information on why mergers are initiated. To limit the risk of social desirability bias (respondents may wish to provide a preferred image and answer questions accordingly), the survey was processed anonymously.

There is no public information on the total number of healthcare executives in the Netherlands. Based on undisclosed documents of the NVZD, we estimated that we have sent the survey to about 70 per cent of Dutch healthcare executives. In the same documents, the NVZD analysed the representativeness of their membership list. They concluded that their sample is fairly representative for all healthcare executives, only slightly over representing executives of large healthcare organizations within some healthcare sectors. We extended the reach of the survey by also using the contact details that we received from BMC, a consultancy firm providing services to (small and large) healthcare organizations. By that, we were able to survey a unique population. The healthcare executives in our study worked throughout the field of healthcare in private not-for-profit organizations that provide (a combination of) mental healthcare, disability care, nursing home care, hospital care and other forms of care (including home care and primary care).

The final sample consisted of 239 respondents, of which 155 (64.9 per cent) had been involved in at least one merger case between January 2005 and April 2012[5]. To limit the risk of recall bias, we asked the executives that participated in more than one merger (42.6 per cent of all executives that participated in mergers) to focus on the most recent merger case. The executives that participated in the survey are mostly male (n=163; 73.1 per cent). The mean age of our respondents is 55.6 years (std.dev.: 5.44; min.:32; max.:70). The executives' length of career varies strongly in the sample. On average, respondents have 13 years of experience in end-responsible positions in healthcare, but the standard deviation is 8.89 and there are also respondents that have less than one year or over 40 years of experience[6]. Our findings on the executives' age and gender are similar

5 The survey was sent to 848 executives of which 831 received the email and 296 filled out the survey (response rate 35 per cent). In 17 cases the e-mail was returned as undeliverable. After excluding respondents who did not work in organizations providing healthcare services at time of the merger or who did not provide full information, the remaining study sample consisted of 239 respondents.

6 These proportions are based on 223 respondents because 16 respondents did not fill out the questions on age, gender and experience.

to those in a previous survey study among Dutch healthcare executives (Van der Scheer 2007).

Table 2 displays information on the healthcare organizations in which the executives worked during the merger.

Table 2. Background characteristics of the executives' organizations that were involved in a merger (n=155)[1]

	# and % of respondents' organizations		# and % of partnering organizations	
	#	%	#	%
Turnover before merger				
Less than EUR 15 million	25	16	46	30
EUR 15 – 50 million	45	29	43	28
EUR 50 – 100 million	44	28	38	25
EUR 100 -125 million	14	9	13	8
EUR 125 – 150 million	5	3	4	3
More than EUR 150 million	22	14	11	7
Healthcare sector before merger				
Nursing homes	29	19	23	15
Mental healthcare	23	15	20	13
Hospitals	21	14	19	12
Disability care	12	8	8	5
Other[2]	24	15	29	19
Healthcare conglomerates[3]	44	28	56	36

[1] Notice that the unit of observation is the executive and not the organization. Since several executives may have been involved in the same merger, the numbers do not refer to unique organizations.

[2] Healthcare sector 'other' includes organizations providing youth care, home care and rehabilitation care. The number of providers in these healthcare sectors was too small to perform meaningful analysis on the sectors separately.

[3] Healthcare conglomerates are organizations that provide different types of care (e.g. both mental care and disability care).

Almost three quarters of the executives were involved in mergers between providers with a turnover of less than EUR 100 million (most of which less than EUR 50 million). Furthermore, executives were primarily involved in mergers between healthcare organizations that provide (partly) the same type of care (n=141, 81 per cent). Over half of the executives took part in single-sector mergers (i.e. mergers that do not involve healthcare conglomerates) (n=77). Finally, only 9

per cent (n=14) of the executives were involved in mergers between two or more healthcare providers that are not active in the same healthcare sector(s). Hence, we find that most mergers between Dutch healthcare providers between 2005 and 2012 were aimed at integration: mergers involving organizations in the same or an adjacent stage of service delivery (Angeli and Maarse 2012). Only a limited number of mergers is aimed at diversification (mergers between organizations in other markets; Angeli and Maarse 2012).

Questions about merger motives

We asked the respondents: 'What was (were) the most important motive(s) to engage in a merger?' Respondents were able to tick one or more of the answer categories that followed from the literature: (i) Efficiency; (ii) Market/bargaining position; (iii) Pressure from internal and/or external stakeholders; (iv) Healthcare provision and (v) Financial reasons. The five main categories were subdivided into 23 motives. The motives were based on the reasons for merger that Bogue et al. (1995), Bazzoli et al. (2002) and others found and supplemented with merger motives that were identified in a discourse analysis of newspapers texts about organizational scale in Dutch healthcare (Postma, Van de Bovenkamp and Putters forthcoming). For each category of motives, we also provided an open question (which we named 'other'). The five categories and the list of motives can be found in table 5.

Results

Merger motives

In table 3 we present what categories of motives healthcare executives rate as the most important one(s) for engaging in a merger. Of the five categories of merger motives, healthcare executives most often mention the category related to healthcare provision (n=107; 69 per cent). This indicates that executives regard merger as an instrument to change the organization and delivery of healthcare services. By realising a broader/more specialized range of services or by providing services to new groups of patients, they seem to aim at attracting new patients and/or offer more or better services to their existing patients. Almost equally frequently mentioned is the category of motives related to strengthening the market or bargaining position. The fact that this category was mentioned

Table 3. Main categories of motives for merger (multiple response question)

	# and % of healthcare executives	
	#	%
Main categories of motives for merger		
Healthcare provision	107	69
Market/bargaining position	97	63
Efficiency	71	46
Financial reasons	43	28
Pressure from internal and/or external stakeholders	19	12

by more than 60 per cent of all executives supports the expectation that policy changes aimed at increasing competition are important drivers for mergers in the Netherlands. Furthermore, although efficiency and financial reasons are less frequently mentioned, these considerations were still important in almost 50 and 30 per cent of executives' decisions to merge. This is consistent with policy changes aimed at improving efficiency of healthcare provision and increasing financial risk for providers. Pressure from internal or external stakeholders did not play an important role in executives' merger decisions. Less than 10 per cent of the executives indicated this reason. This suggests that healthcare executives have a large degree of autonomy in making merger decisions.

The majority of healthcare executives (72 per cent) mentioned more than one category of merger motives. Table 4 distinguishes between executives who mentioned a single category (panel A) and those who reported multiple categories (panel B). Among those who mentioned a single category, the vast majority (84 per cent) mentioned healthcare provision or bargaining position as motive for merger. For those who mentioned multiple motives, the same two categories were the most important. In total, healthcare executives reported 22 combinations of categories, of which 20 include the category 'healthcare provision', the category 'market/bargaining position' or both.

Table 4. Single (panel A) or multiple (panel B) categories of motives for merger

	# and % of healthcare executives (n=155)	
	#	%
Panel A. Single categories of motives for merger	**43**	**100**
Healthcare provision	19	44
Market/bargaining position	17	40
Efficiency	2	5
Financial reasons	2	5
Pressure from internal and/or external stakeholders	3	7
Panel B. Multiple categories of motives for merger	**112**	**100**
Healthcare provision and market/bargaining position	24	21
Healthcare provision, market/bargaining position and efficiency	18	16
Healthcare provision and efficiency	11	10
Market/bargaining position and efficiency	9	8
Healthcare provision and financial reasons	8	7
Healthcare provision, financial reasons and efficiency	7	6
Healthcare provision, market/bargaining position, financial reasons and efficiency	7	6
Other combinations of motives to merge	28	25

Merger motives across sectors

Within each of the categories of merger motives, a number of more specific motives were distinguished. Table 5 reports the relative importance of these motives within the five main categories. We first focus on the importance of merger motives across sectors (panel A).

Within the category 'efficiency', the three motives – more efficient use of capacity, more efficient deployment of personnel and a reduction of overhead – are almost equally important. However, although the number of observations is low, more efficient use of production capacity seems to be more important for mergers involving nursing homes and healthcare conglomerates (93 and 96 per cent of the executives respectively) than in hospitals (50 per cent of executives). This is in line with the observed trends of de-institutionalisation and downscaling and the resulting pressure on inpatient LTC providers to reduce overcapacity.

Within the category 'market/bargaining position', almost all executives mention improving the market/bargaining position vis-à-vis health insurers. This is not surprising since the financing of providers depends on a contract (hospitals, mental health and home care providers) or a budget (nursing homes and disability care providers) to be negotiated with either competing health insurers or

Table 5. Motives for merger per category per healthcare sector (Panel A) and per period (Panel B)[1]

	Panel A. Healthcare executives per sector (before merger) (n=155)						Panel B. Healthcare executives per period (n=155)	
	Mental healthcare (n=23)	Disability care (n=12)	Nursing homes (n=29)	Hospitals (n=21)	Healthcare conglomerates (n=44)	Other (n=24)	2005 – 2008 (n=64)	2009 – 2012 (n=91)
1. Efficiency	**53% (n=12)**	**17% (n=2)**	**45% (n=13)**	**38% (n=8)**	**48% (n=21)**	**63% (n=15)**	**42% (n=27)**	**49% (n=44)**
			% of efficiency				**% of efficiency**	
More efficient use of real estate and/or (bed)capacity	84	50	93	50	96	47	85	71
More efficient deployment of personnel	92	50	70	50	96	67	81	75
Reduction of overhead	100	100	93	88	96	100	96	96
Other	17	50	8	13	43	40	19	34
2. Market/bargaining position	**66% (n=15)**	**50% (n=6)**	**76% (n=22)**	**43% (n=9)**	**69% (n=30)**	**63% (n=15)**	**61% (n=39)**	**64% (n=58)**
			% of market/bargaining position				**% of market/bargaining position**	
Improving or maintaining bargaining position vis-à-vis health insurers	93	84	96	89	84	94	95	87
Improving or maintaining bargaining position vis-à-vis suppliers	67	50	59	78	64	80	72	62
Improving or maintaining bargaining position vis-à-vis municipalities	60	67	73	23	77	60	59*	69*
Improving or maintaining market position vis-à-vis other healthcare providers	80	100	82	89	94	94	95	85

Table 5. Motives for merger per category per healthcare sector (Panel A) and per period (Panel B)[1] Continued

	Panel A. Healthcare executives per sector (before merger) (n=155)						Panel B. Healthcare executives per period (n=155)	
	Mental healthcare (n=23)	**Disability care (n=12)**	**Nursing homes (n=29)**	**Hospitals (n=21)**	**Healthcare conglomerates (n=44)**	**Other (n=24)**	**2005 – 2008 (n=64)**	**2009 – 2012 (n=91)**
Improving or maintaining political influence	80	84	50	45	77	74	69	68
If the organization would not merge, it would be vulnerable to a takeover by a third party	34	50	32	12	27	27	33	26
Other	0	17	11	12	17	14	5	18
3. Pressure from stakeholders	**5% (n=1)**	**9% (n=1)**	**14% (n=4)**	**19% (n=4)**	**9% (n=4)**	**21% (n=5)**	**7% (n=5)**	**5% (n=14)**
	% of pressure from stakeholders						**% of pressure from stakeholders**	
Pressure from government	0	0	25	0	89	80	60	43
Pressure from health insurers	0	0	50	75	89	40	60	50
Pressure from physicians	0	0	0	75	81	0	40	15
Pressure from management	0	100	25	50	70	40	80	43
Pressure from supervisory board	0	100	25	75	59	40	80	43
Other	100	100	25	0	68	0	40	15
4. Healthcare provision	**74% (n=17)**	**100% (n=12)**	**56% (n=16)**	**86% (n=18)**	**69% (n=30)**	**59% (n=14)**	**72% (n=46)**	**67% (n=61)**
	% of healthcare provision						**% of healthcare provision**	
Consolidating healthcare services	89	84	82	89	90	79	85	80

Table 5. Motives for merger per category per healthcare sector (Panel A) and per period (Panel B)[1] Continued

	Panel A. Healthcare executives per sector (before merger) (n=155)						Panel B. Healthcare executives per period (n=155)	
	Mental healthcare (n=23)	Disability care (n=12)	Nursing homes (n=29)	Hospitals (n=21)	Healthcare conglomerates (n=44)	Other (n=24)	2005 – 2008 (n=64)	2009 – 2012 (n=91)
Realising a broader/ more specialised range of healthcare services	100	100	63	84	100	86	89	82
Providing healthcare services to new groups of patients	65	59	69	50	64	79	67	56
Providing healthcare services in other geographical areas	18	50	38	12	30	50	20*	36*
Reducing waiting lists	30	9	25	34	40	22	35	23
Increasing possibilities for small-scale care	53	42	50	28	64	50	63	41
Being able to meet volume criteria	71	50	69	78	37	72	43*	62*
Other	24	59	38	17	30	22	33	26
5. Financial reasons	**18% (n=4)**	**17% (n=2)**	**31% (n=9)**	**34% (n=7)**	**32% (n=14)**	**30% (n=7)**	**22% (n=14)**	**32% (n=29)**
			% of financial reasons				**% of financial reasons**	
Strengthening or consolidating solvency	50	100	100	100	86	100	86	94
Improving access to external capital	50	50	56	86	58	43	64	56
Other	0	0	23	15	58	43	29	35

[1] These were all multiple response questions. On the multiple response sets, we performed chi-square tests of independence and pairwise comparison within each of the five categories of proportions with Bonferroni-adjusted p-values for multiple comparisons. Null hypothesis: no significant difference between time periods or healthcare sectors (α = 0.05 and 0.10).

* Significant difference between time periods (between 2005-2007 and 2008-2012 in the case of 'Improving or maintaining bargaining position vis-à-vis municipalities').

regional insurance carriers. Also, the rapid consolidation of the health insurance market (the four largest insurers currently have a combined market share of approximately 90 per cent (NZa 2014b)), might have urged providers to develop countervailing power by merging. For LTC providers, strengthening their market/bargaining position vis-à-vis municipalities is also found to be important. This is in line with the growing importance of municipalities as purchaser of home care.

Furthermore, almost all executives mention fortifying or maintaining a strong position versus competitors, thereby illustrating the increasingly competitive environment in which healthcare providers operate. Despite the increasing marketization however, executives still seem to perceive the government as an important player: about two-thirds of the executives within this category reports that improving or maintaining political influence was a motive to merge.

Within the category 'healthcare provision', mergers are particularly motivated by consolidation and specialization of healthcare services. Expanding services to new patient groups and new areas is also frequently mentioned, though more often in case of mergers between LTC providers than in case of hospital mergers. Increasing possibilities for small-scale care is a motive in almost half of the LTC and mental healthcare mergers. This is consistent with the trend of downscaling.

Within the category 'financial reasons', clearly the most important motive for merger is strengthening or consolidating solvency. This motive is dominant across all types of healthcare providers. This likely reflects the increasing financial pressure, which urges providers to find partners with a better solvency rate to achieve more financial stability. For the partner with the better solvency rate, the merger might be valuable for other reasons, for example because of the portfolio of the other organization (despite its worse financial situation). Acquiring or safeguarding access to external capital is also important, perhaps because of the stricter requirements of banks – in response to the increasing financial risk of providers – as primary source of external capital.

Changing merger motives

We now turn to the changes in merger motives over time and the relation with health policy. Since the number of observations is too low to investigate changes per year and per healthcare sector, we split our study period in two equal time periods – 2005-2008 and 2009-2012 – and aggregated merger motives of the executives of the various healthcare sectors. The results are shown in Panel B of

Table 5. Using a chi-square test we find no significant dependence between merger period and main categories of merger motives. Nevertheless, it is interesting to note that especially 'financial reasons' and 'efficiency' seem to be mentioned more frequently in the second period (albeit not significantly), pointing to the increasing financial pressure on healthcare providers. A reason for the absence of differences in the main categories between the two time periods could be an anticipation effect: providers foresee changes in health policies and decide to merge before the changes are effectuated.

Within categories we find that executives that were involved in mergers in the second period (2009-2012) significantly more often report 'providing healthcare services in other geographical areas' and 'being able to meet volume criteria' as a motivation to merge ($p < 0.05$) than in the first period (2005-2008). The first change possibly points to the ambition of healthcare providers to expand their market share in reaction to incentives for competition. The second change is consistent with the growing importance of volume criteria in selective contracting by health insurers. Although selective contracting of healthcare services is limited, the threat of the use of volume criteria for selective contracting may have had influenced mergers already. When we split the study period in 2005-2007 and 2008-2012 we find that in the second period significantly more executives indicate 'improving or maintaining market/bargaining position vis-à-vis municipalities' as an important motive for merger ($p < 0.05$). This is consistent with the decentralisation of household services from public LTC insurance towards municipalities in 2007.

Conclusion and discussion

This study is the first to systematically analyse motives for mergers over a period of time and across different healthcare sectors, using a rich and unique dataset from a survey among Dutch healthcare executives. We analysed why healthcare providers merge and how these merger motives relate to (sector-specific) policy changes.

Our study shows that healthcare mergers are motivated by a variety of reasons. We find that the dominant motives for mergers were improving healthcare provision and strengthening market/bargaining power. Also efficiency and financial reasons are important drivers of merger activity in healthcare. Our study thereby

confirms findings from earlier studies that emphasize the importance of market power and, to a lesser extent, efficiency and financial considerations as motive for healthcare mergers (e.g. Bogue et al. 1995; Barro and Cutler 1997; Gaynor and Haas-Wilson 1999; Bazzoli et al. 2002). Pressure from external or internal stakeholders is rarely a reason for Dutch healthcare providers to merge. This result does not support earlier studies that indicate that pressure from third parties is an important motive for merger (e.g. Fulop et al. 2002; Gaynor, Moreno-Serra and Propper 2013).

The importance of motives related to the provision of healthcare also confirms findings from earlier studies (Bogue et al. 1995; Bazzoli et al. 2002). In most studies on healthcare mergers however, motives regarding the provision of healthcare are not identified as a separate category. Although it might be argued that these motives are related to market power and/or efficiency considerations, the fact that the majority of healthcare executives indicate these reasons as relevant, strengthens the idea that executives perceive this category as different from market power and efficiency. We therefore argue for incorporating reasons regarding healthcare provision as a separate category in theories on healthcare mergers.

Merger motives across sectors seem to be partly related to changes in specific health policies. Particularly de-institutionalisation, downscaling and decentralisation are reflected in motives for mergers in long-term care. Higher financial risks and increasing pressure from competitors and insurers seem to be important for all types of providers. As regards changes over time, we find that between 2005 and 2012 healthcare providers increasingly merge because of motives related to their market position ('providing healthcare services in other geographical areas'), selective contracting of hospital care by health insurers ('being able to meet volume criteria') and decentralisation of long-term care ('improvement or maintenance of market/bargaining position vis-à-vis municipalities') as the pressure from competitors, health insurers and municipalities is increasing. We also find that providers tend to merge with providers from the same healthcare sector (i.e. integration), which likely creates more opportunities for specialization and strengthening their market position. These findings indicate that changes in health policy have an impact on merger motives, although further research is required to understand how this relation exactly works.

This study contributes to the literature by empirically showing what motives for mergers executives in Dutch healthcare have and how these relate to health

policies. However, although we tried to minimise the risk of social desirability bias by processing the survey anonymously, we cannot rule out the possibility that in some cases the answers of executives to our survey questions are ex post justifications to hide other types of motives. These could for example be 'mimicking', uncritically copying business practices (such as merger) from the private sector (Bigelow and Arndt 2000; Kitchener 2002; Comtois, Denis and Langley 2004) or the personal ambition of management or executives (Angwin 2007). We recommend future studies, for example ethnographic research, to investigate in detail whether, and if so how, these other types of motives play a role.

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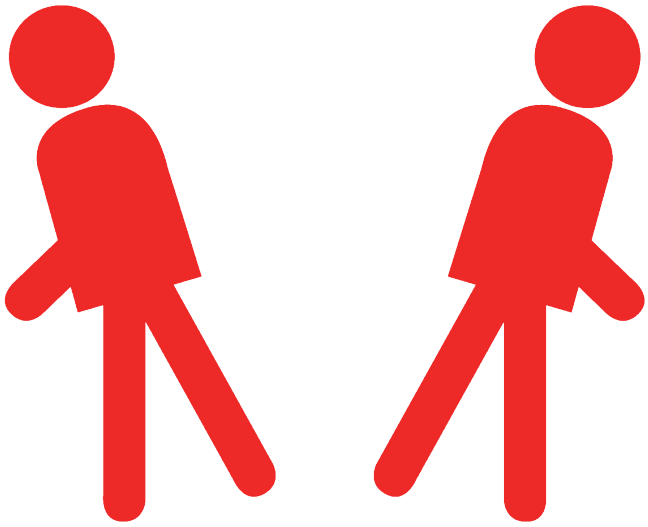
CHAPTER 3

Getting cold feet?
Why healthcare mergers are abandoned



Chapter based on:
Roos, A.-F. and Postma, J. (2015). Getting cold feet? Why health care mergers are abandoned. *Health Care Management Review,* doi: 10.1097/HMR.0000000000000060.

Abstract

Background. Despite the frequent occurrence and sizeable consequences of merger abandonment in other sectors, there is no thorough understanding of merger abandonment in healthcare.
Purpose. The purpose of this study is to improve the understanding of determinants of healthcare merger abandonment.
Approach. Based on the literature on merger abandonment we formulated a framework on potential determinants of healthcare merger abandonment. We then designed a survey that was sent to 70 per cent of all executives of Dutch healthcare organizations (response rate: 35 per cent; n=291). We provide descriptive overviews of open, multiple response and multiple choice questions on merger abandonment and use chi-square tests and Fisher's exact tests to test whether abandoned and completed merger processes differ.
Findings. About 62 per cent of the respondents were involved in at least one merger process during the period 2005-2012. 38 per cent of these respondents reported that their last merger case ended prematurely (n=53). The most frequently mentioned determinants of merger abandonment are changing insights on the desirability and feasibility during merger processes, incompatibilities between executives and insufficient support for the merger from internal stakeholders. We did not find significant relationships between merger abandonment and executives' previous merger experience, organizational diversification, healthcare sector, size differences or other differences between the merging organizations.
Discussion. Our findings partially confirm results from previous studies, especially with regard to the importance of changing insights and incompatibilities between the involved executives in merger abandonment. In addition, we find that pressure from internal stakeholders, particularly non-executive directors, and distrust, fear and animosity play an important role in merger abandonment.
Practice implications. To minimise the organizational and societal costs of abandoned mergers, we advise executives who engage in mergers to design back-up plans with alternative strategies in case the merger is abandoned, to conduct a thorough analysis of pros and cons prior to the merger and to invest in the relations with non-executives and other stakeholders.

Introduction

In many countries, increased merger activity in healthcare has fuelled a political and scientific debate about the consequences of mergers and the desirability of further concentration of healthcare markets (Gaynor and Town 2012). Much less attention is paid to situations where organizations intend to merge but eventually decide to abandon the merger, even though studies estimate that between 11 per cent and 28 per cent of all merger cases across industries are abandoned (Pickering 1978; Madura and Ngo, 2012). From a societal viewpoint, merger abandonment may have positive or negative consequences (Akhigbe, Borde and Whyte 2000; Song and Walkling 2000; Wong and O'Sullivan 2001; Pett, Francis and Van Ness 2003; Neuhauser, Davidson III and Glascock 2011; Liu 2012). On the one hand, merger abandonment may prevent potentially harmful mergers that are likely to be inefficient or aimed at gaining anticompetitive advantage. On the other hand, the resources from internal and external stakeholders that are devoted to merger preparation are largely lost when a deal is off. Although it is difficult to quantify the consequences of merger abandonment, abandoning a merger can be costly and undesirable, especially if the merger would have been successful when consummated.

Despite the frequent occurrence and sizeable consequences of merger abandonment in other sectors, there is no thorough understanding of merger abandonment in healthcare. To fill this gap we conducted a survey study among Dutch healthcare executives (i.e. end-responsible managers) to examine the determinants of healthcare merger abandonment. Our study provides valuable insights into potential deal-breakers of healthcare mergers, so that organizations are better able to decide whether or not to engage in a merger and improve the process once they are involved in one.

Literature on merger abandonment

In this section we provide an overview of the available literature on merger abandonment for several industries. We limit our overview to findings or determinants that are relevant to healthcare and distinguish three main categories: (1) external pressure, (2) resistance by internal stakeholders and (3) organization / sector characteristics. Based on this literature, we develop 11 expectations about

the determinants of merger abandonments in healthcare. We use the expectations as a framework for our survey and analysis.

External pressure

In competitive markets, antitrust laws are found to play an important role in the abandonment of mergers (Wong and O'Sullivan 2001). Antitrust policy may prevent mergers in two ways: (1) by direct prohibition if an antitrust authority finds that the proposed consolidation will lead to anticompetitive behaviour in the relevant market and (2) by anticipatory action of the organizations that have the intention to merge. Anticipatory action means that organizations modify their behaviour and plans – without direct intervention of the agencies – to remain within the bounds of the antitrust law. In the context of this study, that means that organizations abandon a merger because they anticipate that the antitrust agency will block the merger. Both Baarsma et al. (2012) and Gordon and Squires (2008) found that about 10 per cent of the intended mergers are abandoned because of (anticipated) objections to the consolidation by antitrust authorities. For competitive healthcare markets that are subject to antitrust laws, such as the Netherlands, we therefore expect that:

> (1) Enforcement by antitrust agencies plays a role in the abandonment of healthcare mergers, either by prohibition of the merger by antitrust agencies or by anticipatory action of merging organizations.

Also, pressure from external stakeholders other than antitrust agencies, for example media and other healthcare organizations, is found to influence the likelihood of merger completion (Pickering 1983; Lamberg et al. 2008; Dikova, Sahib and Van Witteloostuijn 2010; Muehlfeld, Weitzel and Van Witteloostuijn 2011; McCann 2013). The studies in this field indicate that external uncertainty and unpredictability, caused by stakeholders in the environment of the organizations, increases the probability of merger abandonment. Furthermore, Aguilera, Dencker and Escandell (2007) and Muehlfeld, Sahib and Van Witteloostuijn (2007) found that merger cases that gather close societal attention are more likely to be abandoned than other cases. Since healthcare is a sector with high public interest, attracting a lot of attention from various actors, we expect that:

(2) Pressure from external stakeholders other than antitrust agencies is a reason for the abandonment of healthcare merger cases.

Resistance by internal stakeholders

Several studies indicate that a positive attitude of executives towards a merger is the most important factor for completion (Walkling 1985; Branch and Yang 2003; Muehlfeld, Sahib and Van Witteloostuijn 2007; Meyer and Altenborg 2008; McCann 2013). Holl and Kyriazis (1997) found that the probability that an intended merger actually results in a merger is lowered substantially when executives of one of the involved parties do not want to cooperate. Executives may resist a merger when they foresee a loss in compensation, prestige, job satisfaction and security following post-merger displacement (Aguilera, Dencker and Escandell 2007). Also personality clashes, a lack of trust between executives, inability to work towards common goals, a managerial preference for remaining independent and doubts on the (intended) effects of the proposed merger can lead to merger abandonment (Pickering 1983; Sudarsanam 1991; Brennan, Daly and Harrington, 2010). Therefore, we expect that:

(3) Resistance by executives is a determinant for the abandonment of healthcare merger cases.

According to Wong and O'Sullivan (2001), little is known about the role of non-executive directors in the abandonment of mergers. Henry (2004) found that the corporate governance structure (e.g. board composition and the number of non-executive directors) has no correlation with merger abandonment. This is not to say that non-executive directors are unimportant in merger decisions. Irrespective of whether an organization features a one-tier or a two-tier executive board, non-executive directors have an obligation to (dis)approve major organizational decisions like mergers. If non-executive directors reject the merger, the deal is off. Works Councils and Client Advisory Councils usually have a legal right to advice the boards of executives in important strategic decisions, which means that they have a say in merger decisions as well. Finally, stakeholders like middle management and professionals are found to be important players in the governance of healthcare organizations (Oldenhof, Postma and Putters 2014; Witman et al. 2011). Therefore, we expect that:

(4) Non-executive directors, Works Councils, Client Advisory Councils, middle management and professionals play a role in the abandonment of healthcare merger cases.

Organization / sector characteristics

A range of studies shows that organization or sector characteristics play a role in the abandonment of mergers.

First, Pickering (1983) and Ingham and Wong (1994) found that problems in financial performance or other performance problems of one of the organizations that are discovered during a merger process could lead to merger abandonment. Therefore, we expect that:

(5) The discovery of performance problems of one of the organizations during healthcare merger cases is a reason for abandonment.

Second, several studies showed that if organizations have prior experience with mergers, the likelihood of merger abandonment decreases. However, there is little evidence on how merger experience exactly influences abandonment or completion (Dikova, Sahib and Van Witteloostuijn 2010; Muehlfeld, Weitzel and Van Witteloostuijn 2011). It is likely that the impact of an organization's merger experience (partly) depends on the merger experience of its executives, being the key decision makers. We therefore expect that:

(6) In comparison to executives that complete merger processes, executives that abandon mergers have less merger experience.

Third, Aguilera, Dencker and Escandell (2007) and Aguilera and Dencker (2010) found that the more diversified merging organizations are (i.e. the broader the range of different products or services they provide), the lower the probability that they abandon the merger. They argue that diversified organizations develop capabilities and routines to facilitate the integration of new activities, which is helpful in merger cases. Therefore, we expect that:

(7) Executives involved in abandoned mergers more often work in less diversified organizations than executives involved in completed mergers.

Fourth, D'Aveni and Kesner (1993), Aguilera and Dencker (2010) and Madura and Ngo (2012) found that mergers between organizations from different sectors have a lower propensity to be abandoned than mergers between organizations from the same sector. These authors argue that, although the involved organizations have a common understanding of the sector, merger cases in the same sector are abandoned more often because competition in the past may have led to informal collisions and personal disputes between management of both organizations. Cross-sector mergers that involve distinct markets do not have to deal with these issues and are therefore likely to experience fewer conflicts during merger process, resulting in a higher probability of merger completion. Therefore, we expect that:

(8) In comparison to executives involved in completed mergers, executives involved in abandoned mergers are more likely to operate in the same healthcare sector as their merger partner.

Fifth, several studies indicate that organizational size is an important factor in merger abandonment. Holl and Pickering (1988), Akhigbe, Borde and Whyte (2000), Branch and Yang (2003), Maheswaran and Pinder (2005) and Aguilera, Dencker and Escandell (2007) found that mergers between organizations with comparable sizes are less likely to be completed than mergers between organizations with a different size. Perhaps small organizations do not try to resist the wishes of the larger organizations, especially in the case of a hostile takeover, while equally sized organizations collide over merger conditions. Furthermore, Pickering (1978) found that merger abandonment is more likely if both organizations are large. Therefore, we expect that:

(9) Size differences between organizations involving executives that complete merger processes are larger than size differences between organizations involving executives that abandon mergers.

And that:

(10) Executives are more likely to experience merger abandonment if the healthcare organizations that are involved in the merger are both large.

Case studies on healthcare merger abandonment

Research on merger abandonment in healthcare is limited and mainly consists of case studies of abandoned hospital mergers in the US and Canada. The determinants of merger abandonment that are found in these case studies are consistent with our expectations based on the general literature. Appelbaum and Morrison (2000), for example, show that also in healthcare antitrust policy prevents anticompetitive mergers (expectation 1). Furthermore, Neufeld, Hold and Deber (1993) find that a wide variety of variables played a role in the abandonment of the hospital merger that they studied, including insufficient insight in the financial viability of the merger (expectation 5) and a lacking stakeholder management strategy (expectations 2 – 4).

However, in the case studies, we also identified a reason for abandonment that had not been reported in research in other sectors. Several case studies have shown that ideological and religious differences can be important determinants of the abandonment of healthcare mergers, especially in mergers between religiously-affiliated and secular hospitals (Appelbaum and Morrison 2000; Palley and Kohler 2003; Gelb and Shogan 2005). We therefore formulate one additional expectation:

(11) Ideological/religious differences are determinants for merger abandonment in healthcare.

Data and method

The case studies provide insight in why specific healthcare mergers have been abandoned, but a more general, sector-wide insight in the phenomenon is lacking. We fill this gap in the literature by investigating the determinants of healthcare merger abandonment in the Netherlands between 2005 and 2012. We designed a survey that was sent to 70 percent of all Dutch healthcare executives.

Study period

The year 2005 served as a starting point because of major healthcare reforms that were enacted in the Netherlands since that year. New regulations in the Netherlands between 2005 and 2012 include the Health Insurance Act (ZVW) and the Healthcare Market Regulation Act (WMG). The first introduced a new

health insurance scheme that strengthened competition between health insurance companies; the second was created to expand the room for competition among healthcare providers. As a consequence, Dutch healthcare organizations that operated in a strictly regulated environment until 2006 are now increasingly exposed to competition and financial risks.

The survey

To our knowledge, there are no validated surveys on merger abandonment. We therefore designed a survey on the basis of the expectations and piloted by former healthcare executives and colleagues. The survey contained open, multiple choice and multiple response questions on the background of executives, the characteristics of the organizations involved in a merger and reasons for merger abandonment.

To date, research on merger abandonment uses the organization as the unit of analysis. These studies mostly use publicly available information, which is arguable incomplete. First, there is no registry of (abandoned) mergers, so abandoned mergers that are not publicly announced, are not included in these studies. Second, even if it is publicly known that the merger was abandoned, the reasons are often not made public. We therefore concluded that we had to survey as many executives as possible to get a complete picture of the phenomenon. We focus on executives as they are key players in merger processes and have inside knowledge of why mergers are abandoned.

An e-mail with a link to the online survey was sent out in April 2012 to all 740 members of the Dutch Association of Healthcare Executives (NVZD) and another 108 executives whose contact details were received from a Dutch consultancy firm (BMC). Based on undisclosed documents of the NVZD we estimated that we have sent the survey to about 70 per cent of Dutch healthcare executives. Hence, we sent the survey to the majority of healthcare executives nationally, which provided us with a comprehensive and unique dataset. We excluded 17 persons from the sample as they never received the e-mail (i.e. error message 'e-mail undeliverable'). In total 291 respondents out of 831 contacts have filled out the survey (response rate: 35 per cent). We excluded the respondents who did not work in healthcare organizations at time of the merger or on who we had no full information, so the study sample eventually included 223 respondents. Of these, 62 per cent (n=139) had been involved in at least one merger case between January 2005 and April 2012. We asked the executives that participated in more

than one merger (38 per cent of all executives that participated in mergers) to focus on the most recent merger case. Of the executives that had been involved in merger cases, 62 per cent (n=86) indicated that their last merger case was completed, while 38 per cent (n=53) indicated that their last merger case was abandoned. Hence, more than one third of the respondents reported that the last merger in which they participated, was abandoned.

Measurement

According to the definition used in the survey, a merger case starts when parties decide that they want to merge and ends either in a legal consolidation of the organizations (completed merger) or in a decision to terminate the process (abandoned merger). We analyse (1) the answers that the executives provided to an open question ('What was/were the main reason(s) for merger abandonment?') and (2) the answers to two multiple response questions that focused on the role of stakeholders in abandoned mergers ('Which external / internal stakeholders have influenced the merger abandonment?'). To analyse the answers to the open question on reasons for merger abandonment, we used the main concepts from our theoretical framework in combination with open coding. We also compare the answers on questions about the organization and the sector of 53 executives that were involved in abandoned mergers with the answers of 86 executives that were involved in completed mergers. For the comparisons, we used chi-square tests of independence and the Fisher's exact test with small sample sizes. Table 1 summarises the distribution of the executives' characteristics.

As a sensitivity check, we used different operationalizations. For example, we used different definitions of small / large organizations and we used the overall experience of the healthcare executive as a proxy for the organization's merger experience instead of the respondent's experience with mergers. Also, in testing expectations 9 and 10 we assumed a merger between two healthcare organizations, while in practice healthcare mergers between more than two healthcare organizations also occur (23 per cent of the executives that we surveyed were involved in mergers with more than two partners). Because we collected information on the largest merger partner, we only have information on two organizations (the executive's organization and the largest partner's organization). As a sensitivity check we also tested expectations 9 and 10 limiting the dataset to the respondents that indicated that their merger only included two organizations. The sensitivity checks did not lead to different results.

Table 1. Measurement and operationalization of key variables in expectations 6 to 10

#	Variable	Operationalization	Answer categories	Executives that were involved in completed mergers (n=86)		Executives that were involved in abandoned mergers (n=53)	
6	Organization's merger experience	Executive's merger experience	No experience (1st merger case)	50	58%	36	68%
			Experience (> 1 merger cases)	36	42%	17	32%
7	Organizational diversification	Number of healthcare sectors in which the healthcare organization is active	No organizational diversification (single sector before merger)	49	57%	32	60%
			Organizational diversification (multiple sectors before merger)	37	43%	21	40%
8	Sectoral differences between the merging organizations	Merger between organizations that are (partly) active within the same healthcare sector or not	Merger (partly) within the same sector	80	93%	47	89%
			Merger across sectors	6	7%	6	11%
9	Size differences between the merging organizations	Size of the merging organizations in terms of yearly turnover (small organization < € 50 mln, large organization > € 50 mln.)	Small difference (a merger between 2 small or 2 large organizations)	63	73%	44	83%
			Large difference (a merger between a small and a large organization)	23	27%	9	17%
10	Combined size of the merging organizations	Size of the merging organization based on the combined yearly turnover (small organization < € 50 mln, large organization > € 50 mln.)	Small merger (a merger between 2 small organizations)	36	42%	21	40%
			Medium merger (a merger between a small and a large organization)	23	27%	9	17%
			Large merger (a merger between 2 large organizations)	27	31%	23	43%

Findings

The executives that are included in our study work throughout the field of healthcare in private not-for-profit organizations that provide (a combination of) mental care, disability care, nursing home care, hospital care and other forms of care (including home care and primary care). 73 per cent (n=163) of the respondents is male and the mean age is 55.6 years (std.dev.: 5.44). The executives' length of career varies strongly in the sample (mean: 13 years; std.dev.: 8.89). Our findings on the executives' age and gender are similar to those in a previous study among Dutch healthcare executives (Van der Scheer 2007).

Reasons for merger abandonment

Most respondents gave multiple reasons for merger abandonment. In table 2, the most important reasons that were given in response to the open question are categorised.

Table 2. Main reasons for merger abandonment (open question)[1]

Reason for merger abandonment	Total: 53 respondents	
Changing insights on the desirability/feasibility of the merger	17	32%
Executives' stance towards the merger, relationship between executives and changes therein	16	30%
Pressure from non-executive board	8	15%
Pressure from internal stakeholders (middle management and healthcare professionals)	8	15%
Distrust, lack of synergy, fear, animosity	7	13%
Pressure from the antitrust authority/antitrust law	7	13%
Ideological/religious reasons	6	11%
Pressure from other healthcare organizations	4	8%
Chose an alternative for merger (e.g. a joint venture)	2	4%

[1] Notice that respondents were able to give more than one answer.

Table 3 summarises the main findings of the two multiple response questions that focused on the influence of internal and external stakeholders. In the following, we analyse to what degree the expectations that we formulated in the theoretical framework, are correct. Hereto, we use the answers that the respondents gave to the open and two multiple response questions (tables 2 and 3).

Table 3. Influence of internal and external stakeholders on merger abandonment (multiple response questions)[1]

Internal or external	Answer categories		Total: 53 respondents	
Internal stakeholders	Non-executive board		35	66%
	Middle management		16	30%
	Works Council		14	26%
	No internal stakeholders		13	25%
	Client Advisory Council		9	17%
	Healthcare professionals		8	15%
	Other		1	2%
External stakeholders	No external stakeholders		34	64%
	Antitrust authority		8	15%
	Another healthcare organization (besides the merger partner(s))		6	11%
	Media		1	2%
	Government		1	2%
	Politicians		1	2%
	Other:	Consultants	2	4%
		Patient and Consumer Federation	1	2%
	Banks		0	0%
	Health insurance companies		0	0%

[1] Notice that respondents were able to tick more than one category.

External pressure

Executives report that internal stakeholders are much more influential in healthcare merger abandonment than external stakeholders. The most frequently mentioned external stakeholder is the antitrust authority. Seven respondents (13 per cent) indicated that antitrust law and/or direct involvement of the antitrust authority were the main reasons for merger abandonment (table 2). The same executives plus one other (15 per cent) mentioned the antitrust authority as an influential actor in the abandonment of mergers (table 3). Of these, five respondents indicated that they modified their merger plans because they anticipated that the antitrust authority would otherwise intervene (anticipatory action). The remaining three respondents indicated that the antitrust authority blocked the merger. These findings mean that we find support for the first expectation that follows from the literature: according to over 10 per cent of the respondents, antitrust law plays a role in merger abandonment.

Other external stakeholders had a negligible influence on merger abandonment. The majority of executives (64 per cent, n=34) indicated that no external

stakeholders influenced the decision to abandon the merger (table 3). Furthermore, only four respondents claimed that pressure from external stakeholders (other than the antitrust authority) was a main reason for merger abandonment (table 2). We therefore find limited support for our second expectation: the majority of respondents indicate that pressure from external stakeholders did not influence healthcare merger abandonment in the Netherlands.

Resistance by internal stakeholders

From the literature it followed that resistance by executives is one of the most important determinants for healthcare abandonment (expectation 3). We find support for this expectation. The second most frequently mentioned reason for merger abandonment is the executives' stance towards the merger, the relationship between executives and changes therein (30 per cent, n=16). These issues were mostly related to collaboration difficulties between executives or to changes in the composition of boards. For example, one executive stated: "*Despite all rationalisations, the root cause of the abandonment was the lack of positive energy among the executives involved*" and two executives mentioned "*frictions between executives*" and "[a lack of] *cooperation between the members of the executive board*" as the most important reason for abandonment. In addition, seven respondents indicated that feelings of distrust, a lack of synergy, fear and animosity between key players (likely executives) were among the main reasons for merger abandonment. Answers include: "*On paper it worked out well, but after a number of incidents during the merger process, we lost trust in each other*" and "[personal] *conflicts of interest*".

We also expected that non-executive boards, Works Councils, Client Advisory Councils, middle management and professionals play a role in the abandonment of healthcare mergers. We find support for this expectation. Non-executive directors (66 per cent, n=35) are by far the most often mentioned internal stakeholders in merger abandonment (table 3) and, as depicted in table 2, pressure from non-executive directors is the third most important reason for merger abandonment (15 per cent, n=8). Deviating opinions on strategic choices (for example "*insufficient support to the merger as the non-executive directors preferred another merger partner*") force executives to abandon a merger. Also the interaction between executives and non-executive directors matters: "*there was no chemistry between the designated chairman of the non-executive board and the designated chairman of the executive board*".

Works Councils (26 per cent, n=14) and Client Advisory Councils (17 per cent, n=9) are important actors (table 3), but these seem to be less important than non-executive directors in the abandonment of healthcare mergers. None of the respondents indicated that pressure from either the Works Council or Client Advisory Council was decisive in abandoning the merger (table 2). Also middle management is found to influence the decision to abandon the merger. Although attitudes and behaviour of middle management is rarely mentioned as a main reason for merger abandonment in response to the open question, 30 per cent of the executives (n=16) ticked the middle management option in the multiple response question on internal stakeholders (table 3). Pressure from healthcare professionals seems to be less important (15 per cent, n=8).

Organization / sector characteristics

It follows from table 2 that changing insights into the desirability and feasibility of the merger during the merger process is the most frequently cited reason for abandonment (32 per cent, n=17). One executive, for example, stated that there was a "*lack of agreement on the organizational structure and positions*". Another executive mentioned that the merging organizations were not able to "*come to terms on the organization of medical care*". If we look more specifically at the issues over which disagreements arose, we find that financial issues are mentioned most often (n=6 or 35 per cent of those that indicated disagreement as the main reason for abandonment – not in table 2). For example, two executives stated that "*insufficient value and the bad financial position of the merger partner*" and "*sudden financial deficits at one of the merger partners*" resulted in abandonment of the merger. These findings provide support for the fifth expectation.

To find out whether organizational differences matter (expectations 6 – 10), we compared the answers of executives involved in completed healthcare mergers to answers of those involved in abandoned ones. We find that none of the expectations that follow from the literature are supported by our survey data as the *p*-values of all relationships exceed .10. Our analysis shows that the association between the executive's merger experience and merger abandonment is not significant ($\chi^2(1) = 1.331$, $p > .10$). We therefore find no support for the sixth expectation. Likewise, we find no support for expectation 7 as diversification is not found to be related to executives' involvement in merger abandonment ($\chi^2(1) = 0.156$, $p > .10$). Also, the relationships that were predicted under expectations 8, 9 and 10 are not found to be significantly related (Fisher's exact test, $p > .10$; $\chi^2(1)$

= 1.764, $p > .10$ and $\chi^2(2) = 2.711$, $p > .10$ respectively). Hence, organizational differences do not seem to play a role in explaining why mergers are abandoned or not. Finally, we find some support for the expectation that ideological/religious differences play a role in merger abandonment as six executives (11 per cent) indicated that religious reasons were among the most decisive reasons for abandonment (table 2).

Discussion

Based on a survey among the majority of Dutch healthcare executives, this study is the first to present nationwide evidence on merger abandonment in healthcare. Our findings partially confirm results from previous studies, especially with regard to the importance of changing insights on the desirability and feasibility of the merger in merger abandonment. Also, we find that many healthcare executives are getting cold feet because of incompatibilities with the other executive(s). Unlike previous studies, we do not find that pressure from external stakeholders, other than antitrust agencies, is a major determinant of merger abandonment. We do find that pressure from internal stakeholders, particularly non-executive directors, and notions like distrust, fear and animosity play an important role in merger abandonment. These latter elements have received limited attention in studies on abandoned mergers so far.

We were not able to find support for the expectations on organizational characteristics that we found in the literature, except for ideological/religious differences. This may mean that these relationships are not (or no longer) valid in healthcare, that there is not enough variance between healthcare organizations in our sample or that, despite the fact that we sent the survey to the majority of Dutch healthcare executives, the number of observations on merger abandonments is rather small.

Our study shows that a large portion of healthcare executives has to deal with merger abandonment: 38 per cent of the respondents reported that they have been involved in at least one abandoned merger between January 2005 and April 2012. This percentage exceeds the number of abandoned mergers that has been found in other sectors (i.e. 11 per cent to 28 per cent). This does not necessarily mean, however, that merger abandonment occurs more frequently in healthcare, because studies from other sectors are likely to underreport the actual number

of abandonments as they predominantly use data from publicly announced mergers. We, instead, asked executives directly whether they were involved in abandoned mergers. However, the disadvantage of this approach is that we have probably counted some mergers multiple times, because different executives may have been involved in the same merger. This may also explain the rather large number of abandoned mergers that we find.

Despite the differences between the Dutch healthcare system and other healthcare systems, our findings likely bear external validity to other countries and healthcare systems. Changing insights and executives' attitudes, which are the most important determinants of merger abandonment found in our study, are likely to be relevant in any system. The same holds for the pressure from internal stakeholders. However, the exact influence of each stakeholder will depend on the institutional context. It would be interesting to replicate our survey to other countries and to find out whether those and other institutional differences matter in healthcare merger abandonment.

Practice implications

Our study shows that merger abandonment is not a rare phenomenon. We derive three recommendations for executives from our study. Our first recommendation is that executives who engage in a merger should construct back-up plans with alternative strategies in case a merger is abandoned. This helps the executive to stay in control of the organization's strategy and avoids unnecessary negative effects of merger abandonment on the organization.

As changing insights on the desirability and feasibility of the merger during the merger process seem to be the most important reason for abandonment, we also recommend that executives conduct a thorough analysis of pros and cons before engaging in a merger and monitor the progress of the merger closely. This will not prevent all unpleasant surprises during merger processes, but at least some of the changing insights can be spotted earlier on, preferably before the final decision to merge is made.

Third, we emphasize the importance of relations between executives, non-executives and other stakeholders. Both strategic (e.g. different goals) and interpersonal considerations (e.g. bad personal relations) seem to play a role in merger abandonment. Dealing with non-executive directors and other stake-

holders requires a delicate balancing act of executives. On the one hand, they have to keep the formal and legal relationships between actors in mind, which sometimes call for distance and discretion; while, on the other hand, they have to invest in informal ties with stakeholders to prevent feelings of distrust, a lack of synergy, fear and animosity. As such, a merger is a process that calls upon the social competences of executives. Executives should be prepared for that.

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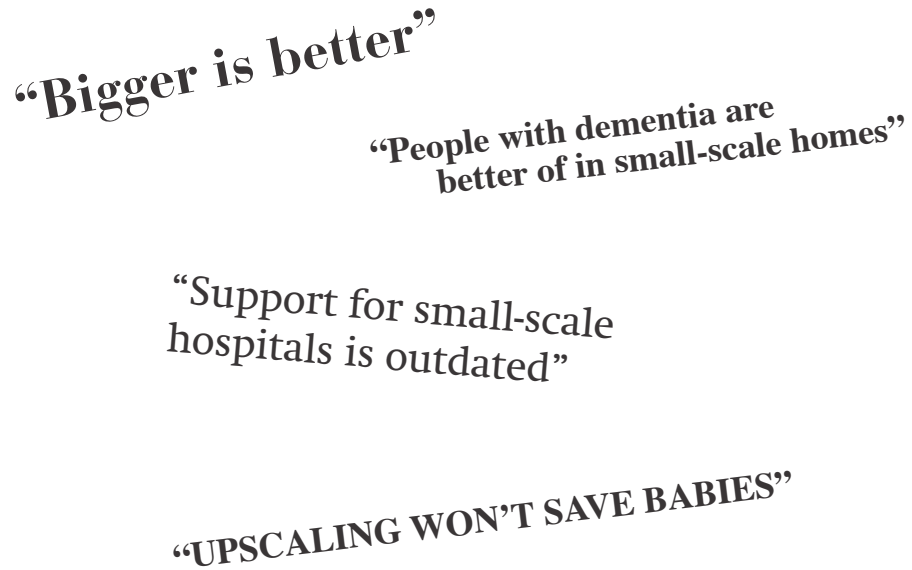
CHAPTER 4

The social construction of organizational scale



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Abstract

In organization literature, scale is often (implicitly) equated with size and taken for granted as a neutral organizational characteristic. Building on the work of Henri Lefebvre, the spatial turn in organizational studies and insights from the field of human geography, we develop a new way of thinking about scale. We conceptualise scale as a social construction and distinguish three aspects: scalar practice, representations of scale and scalar representation. We empirically study the social construction of scale in Dutch healthcare. By conducting a critical discourse analysis of newspaper texts published between 1990 and June 2014, we identify four discourses that construct organizational scale: human scale, professional scale, business scale and system scale. Each discourse emphasizes certain physical and non-physical spaces and comprises an ideal-typical notion of what scale means and should look like. This study shows how multiple discursive constructions of scale are contested in the public debate and how they define healthcare organizations as 'multiscalar' entities. This is not a smooth process as conflicting values lead to heated discussions about scale, legitimising some and supressing other activities, strategies and policies.

Introduction

> "We should stimulate small-scale care (…) because small-scale organizations listen better to personnel and clients and therefore provide better care."
> (Dutch Secretary of Health, 7 November 2007)

> "By forming health centres and shared practices for general practitioners, we can guarantee continuity of care. The large-scale structures provide a broad range of services. Tasks can be divided, thereby limiting the workload of general practitioners."
> (General Practitioner, 25 October 2003)

These quotes are taken from Dutch newspaper articles. The quotes exemplify the public discussion on scale of healthcare organizations in the Netherlands, including debates about mergers, small-scale care for the elderly and people with a disability, neighbourhood care and concentration of hospital care. Although scale is a much debated topic, what is meant by 'scale' is often left implicit. Here, both the then Secretary of Health and the General Practitioner relate scale to size ('small' and 'large'), but neither states how small 'small-scale' or how large 'large-scale' is. In addition, it is not clear whether small-scale and large-scale have the same meaning in long-term care (the first quote) and primary care (the second). In this chapter, we critically examine the way organizational scale is debated in newspaper texts and contribute to a better understanding of scale in organization literature.

The Aston Studies in the 1960s and 1970s were among the first in organization literature to systematically study scale. These studies focused on the relationship between scale and other organizational characteristics, like structure, behaviour and performance (Pugh et al. 1963; 1968). After that, scale of organizations has been subject of many studies. Already in 1976, however, Kimberley noted on the basis of a review of studies that *scale* and *size* are used interchangeably and often studied without taking the specifics of organizations into account. Kimberly (1976: 577) argues that this can be problematic: "might not using the absolute value of size be misleading, as a butcher shop of 100 employees might be considered large, while an automobile plant with the same number might be considered small?"

Still, subsequent studies in organization sciences continue to equate scale with size and take both concepts for granted. For example, Chandler, in his seminal

work Scale and Scope defines economies of scale as "those that result when the increased *size* of a single operating unit (...) reduces the unit cost" (1994: 17, our emphasis). Ginzberg and Vojta, also, introduce their book Beyond Human Scale with "this book is about the large corporation" (1985: 3). They look at the relationship between scale, structure and human behaviour, but do not define scale in terms other than large or small. Furthermore, Kuemmerle (1998: 111) studied the 'optimal scale' of R&D laboratories, in what he calls "an investigation into size and performance." Again, the scale of a laboratory is measured in terms of the number of employees. Finally, in one of the few studies that use the term 'organizational scale', Guthrie (1979) takes the number of students in school districts, schools and classrooms as a measure for scale. He too makes no analytical distinction between scale and size.

In this chapter, we take a closer look at organizational scale. We question some of the traditional assumptions about scale; especially that scale equates size and that scale is unproblematic and can be measured and analysed objectively. We do so by combining Henri Lefebvre's theory on space and studies that are part of the 'spatial turn in organizational studies' with insights on the social construction of scale from the field of human geography. Our empirical study comprises a critical discourse analysis of Dutch newspaper texts about scale of healthcare organizations. Critical discourse analysis studies the relation between reality and our perceptions of reality (Fairclough 2005; Alvesson and Kärreman 2011). It starts from the assumption that language is social (it represents and constructs social realities), it is political (it expresses viewpoints that are not neutral) and it has power (it shapes our understanding of events, ideas and people) (Richardson 2007). This research method allows us to openly investigate how actors define and attribute meaning to the notion of scale in an under researched setting in organizational research, namely media accounts. The study addresses the following research question: *How is scale of Dutch healthcare organizations constructed in newspaper texts and what are the consequences?* Our research aim is to provide a conceptualization of scale that contributes to a better understanding of scale in organization literature and practice.

The spatial turn in organization studies

Our point of departure is the 'spatial turn in organizational studies' (Beyes and Steyaert 2012). This term denotes an increasing number of studies that take the notion of space in organizational practices as a central analytical theme (e.g. Dobers and Strannegård 2004; Hernes 2004; Kornberger and Clegg 2004; Taylor and Spicer 2007; Zhang, Spicer and Hancock 2008; Tyler and Cohen 2010; Beyes and Steyaert 2012). The attention to space in organization studies has been accelerated by such trends as teleworking, 'virtual organizations' and the relocation of work from organizational spaces to domestic and other spaces (e.g. trains, hotels, restaurants) (Hernes 2004; Halford 2005). Kivinen (2006: 165) argues that in the past, space "has often been seen as a naturalised, fixed place, a 'real' site in which social and historic actions are played, thus merely a setting for change and revolution." Increasingly, organizational scholars recognize the importance of space not merely as 'context' or a 'setting' but as a constitutive force in how we think about and engage with organizations (Soja 1989; Kornberger and Clegg 2004; Zhang, Spicer and Hancock 2008). For example, Dale (2005) shows how organizational control of workers is enacted through the (re)arrangement of spaces, including the design of offices, meeting rooms and open spaces in an office building.

One of the pioneers of this approach to space is French philosopher and sociologist Henri Lefebvre. According to Lefebvre (1991: 8), we are "confronted by an indefinite multitude of spaces, each one piled upon, or perhaps contained within, the next: geographical, economic, demographic, sociological, ecological, political, commercial, national, continental, global. Not to mention nature's (physical) space, the space of (energy) flows, and so on." In this myriad of spaces, he distinguishes between three aspects: spatial practice, representations of space and spatial representation.

Spatial practice involves everyday actions of people as they interact with and attach meaning to the physical spaces (e.g. offices, streets, forests) they are in. The idea of spatial practice emphasizes that "it is our perception and experiences of a space that give it life, animation, and make it occupied" (Taylor and Spicer 2007: 333). Consequently, spaces are perceived in different ways. For example, the way a patient experiences a hospital is quite different from the experience of a medical doctor.

Representations of space stand for the space of planners, architects, designers and urbanists. According to Low (2008: 28), "it is the ideological, cognitive aspect of space, its representation, mathematical and physical models and plans, which enable space to be read." Representations of space involve maps, images and models, aimed at the application of knowledge and rationality in the distribution of materials in a physical space (Zhang, Spicer and Hancock 2008). Lefebvre (1991) calls those spaces 'planned' or 'conceived', in the sense that they pervade and prestructure spatial practice.

Spatial representation entails the discursive work through which new spaces are envisioned and expressed. It is often the space that is created by artists and scientists who question taken for granted societal conditions and structures (Low 2008). Images and symbols are important elements of spatial representations. Spatial representations "dominate, they overlay physical space, using it symbolically rather than physically" (Dobers and Strannegård, 2004: 830). An example of a spatial representation is the Utopia that Thomas More describes in his 16th century book.

Based on the spatial triad, Lefebvre (1991) argues that space is *produced*. In his words, space is "a social reality – that is to say, a set of relations and forms" (Lefebvre 1991: 116). Organizational spaces are not 'out there' as a given, but are the result of human action. According to Taylor and Spicer (2007), each aspect of space entails a different range of activities which produce space: (1) practices such as working, walking, sitting and meeting (spatial practice), (2) designing, planning and mapping (representations of space) and (3) imagining, painting and writing (spatial representation).

Soja (1989) calls produced space 'spatiality' to emphasize the importance of both physical forms (concrete spatialities) and the social activities that people engage in while producing space. Space is concrete in our bodies and in material objects. It is also something interstitial between materialities, including the space of thought, theory, sense-making, interactions and relations (Lefebvre 1991). In any social activity, the two sides of space, the 'physicality' of objects and bodies and the 'imaginary' of the human mind are intertwined (Soja 1989; Dobers and Strannegård 2004; Dale 2005; Taylor and Spicer 2007).

The relation between the physical and the imaginary encourages us "to conceive space not as a static reality but as active, generative, to experience space as created by interaction, as something that our bodies reactivate, and that through this reactivation, in turn modifies and transforms us" (Ross 1988: 35, cited in

Beyes and Steyaert 2012). People form organizational spaces through social action and give them meaning, but are at the same time influenced by spaces that enable and restrict certain actions (Lefebvre 1991; Clegg and Kornberger 2006). Space is produced by, and at the same time produces, social relations: it is both medium and outcome (Soja 1989; Beyes and Michels 2011).

Towards a social construction of organizational scale

Despite the increasing attention for space in organization studies, the related concept of *scale* is under researched and under conceptualised. According to Brenner (1998: 2), scales are generally seen as "relatively stable, nested geographical arenas inside of which the production of space occurred rather than as constitutive elements of this process." Taylor and Spicer (2007: 325, 336) define scale as 'spatial levels' (2) "at which social activity takes place." In most studies on organizations, scales are (implicitly) defined as 'context' in the form of a fixed hierarchy of spaces, for example micro (e.g. social practices within organizations), meso (e.g. inter-organizational relations) and macro (e.g. external economic environment), or local, regional, national and global (Taylor and Spicer 2007).

While scale is under developed in organization studies, it plays a central role in the field of human geography. Scale has been studied in a variety of contexts, including labour unions (Herod 1997), cities (Kaiser and Nikiforova 2008), political parties (Agnew 1997) and the state (De Cillia, Reisigl and Wodak 1999). The focus of this stream of research is to understand how scale comes to be seen and acted on as real and what the consequences are (Smith 1992; Howitt 1998; Kaiser and Nikiforova 2008). In particular, scholars of human geography have conceptualised scale as a *social construction* (Marston 2000; Brenner 2001). This means that scale is not an external fact awaiting discovery but is "produced, contested, and transformed through an immense range of sociopolitical and discursive processes, strategies, and struggles that cannot be derived from any single encompassing dynamic" (Brenner 1998: 3).

The social construction of scale is not neutral but "heterogeneous, conflictual and contested" (Swyngedouw 1997: 140). In processes of constructing scales, actors set hierarchical boundaries between spaces as means of constraint, expansion, exclusion and inclusion (Smith 1992; Delaney and Leitner 1997). They try to scale spaces such that it allows them to persuade others in order to gain or

exercise power (Herod and Wright 2002; Howitt 2003). For example, the scale of the 'national' is not a natural element of the world. People construct the scale of the national by using certain language and by organizing social, legal, economic and political processes in a way that gives the concept content and meaning. It would not exist without passports, border controls, ministries and legal systems. And the consequences are real: due to the construction of 'the national', the state is able to yield power over its citizens (Smith 1992; De Cillia, Reisigl and Wodak 1999).

As an empirical example of the social construction of scale as a contested process, Masson (2006) shows how the Quebec women's movement responded to a state project that delegated policy making to the region. By organizing, mobilizing and making claims regionally instead of nationally as they used to, the women's movement was able to construct the region as relevant and legitimate for feminist politics. Johnson (2008) offers another example, where he argues that European Union economic policy aims to reorganize scale by creating new regions, thereby transcending national borders. He shows how governments and organizations from Germany, the Czech Republic and Poland struggle to engage in trans-boundary arrangements, thereby constructing a '3-CIP' (3 Countries Innovation Push) as a new scale. The examples show that scale is constructed in processes wherein people attach meaning to scale and engage in social action aimed at contesting or legitimising a certain scale.

In sum, scales can be defined as *socially constructed hierarchically nested spaces*. In other words: a scale is a space that is demarcated by social action, hierarchically related to other spaces (e.g. small versus large, micro versus macro, global versus local) and endowed with meaning (e.g. the community, the nation state, the European Union). This distinguishes scale from size: size is an absolute measure of a phenomenon, while scale denotes the relation between different phenomena. In daily practices, people explicitly and implicitly act and talk in a 'scalar' way, thereby making scale real, important and seemingly inevitable (Kelly 1997; Jones 1998; Kaiser and Nikiforova 2008). The interesting question for organization scholars, that is central in the empirical part of our chapter, is how *scale of organizations* is constructed. Inspired by Lefebvre (1991), we explore this territory by studying the way three aspects of scale are used rhetorically in newspaper texts. First, we look at how 'scalar practices', everyday actions of people as they implicitly and explicitly construct scale, are used in newspapers. Second, we study 'representations of scale', i.e. the way actors talk and write about planning,

structuring and organizing scales. Third, we look at 'scalar representations' of organizations, which includes the discursive work through which actors 'imagine' scales in newspaper texts.

A critical discourse analysis of newspaper texts on organizational scale in Dutch healthcare

In this section, we introduce critical discourse analysis of newspaper texts as our research method and Dutch healthcare as our field of research.

Critical discourse analysis

Organizational discourse can be defined as texts that are embodied in talking, writing, visual representations and cultural artefacts within organizations (Grant 2004). As these texts are used, they provide meaning to organizational objects and spaces. Discourse both says something about a space and emits from a space. Lefebvre provides a nice example of the importance of discourse (1991: 110): "Let us consider a primary aspect, the simplest perhaps, of the history of space as it proceeds from nature to abstraction. Imagine a time when each people that had managed to measure space had its own units of measurement, usually borrowed from the parts of the body: thumb's breadths, cubits, feet, palms, and so on. The space of one group, like their measures of duration, must have been unfathomable to all others. A mutual interference occurs here between natural peculiarities of space and the peculiar nature of a given human group."

This 'mutual interference' also goes for the relation between scale and discourse. Through "scalar narratives" (Swyngedouw 1997: 140), people endow scales with meaning and frame them as real and legitimate sites of social action and the execution of power (Sneddon 2003). To study the social construction of organizational scale, we performed a critical discourse analysis (Fairclough 1995) of newspaper texts. With critical discourse analysis, one interprets the meaning of texts, analyses what is missing, situates what is written in the context in which it occurs and acknowledges that meaning is constructed in interaction between producer, text and audience (Richardson 2007). This method goes beyond describing the use of language, as most textual content analyses do, to analysing how and why language is used and what ideological goals it serves (Blommaert and Bulcaen 2000; Richardson 2007; Machin and Mayr 2012). Critical discourse

analysis does not accept readily defined notions in texts, but explores the underlying assumptions and the mechanisms through which actors try to naturalise particular views of the world. (Blommaert and Bulcaen 2000; Richardson 2007; Machin and Mayr 2012). Furthermore, it emphasizes that meanings in texts and the social practices outside these texts always have a constituting effect on each other (Blommaert and Bulcaen 2000). The social construction of scale in texts is therefore not merely rhetoric; it both shapes and is shaped by elements in the physical and social world (Van Dijk 1997; Fairclough and Wodak 1997; Fairclough 2005).

Newspaper texts

Despite increasing attention for discourse in organization sciences (Alvesson and Kärreman 2011), *media* are still a neglected location for studying organizational practices (for some exceptions, see Kuronen, Tienari and Vaara 2005; Vaara, Tienari and Laurila 2006; Halsall 2008; Hartz and Steger 2010; Siltaoja and Vehkapera 2010; Grandy and Mavin 2012). We argue that discourse in media deserves more attention because organizational phenomena increasingly transcend the boundaries of organizations. In a 'mediated' society (Luhmann 2000), newspaper texts are both an important forum and a reflection of collective sensemaking of organizational phenomena through discourse (Vaara and Tienari 2002; Kuronen, Tienari and Vaara 2005; Richardson 2007; Grandy and Mavin 2012). In newspaper texts, organizational actors (e.g. managers and professionals) engage in public discussions with actors outside the organization (e.g. politicians and experts), via interviews, essays and letters for publication. The public discussion has been shown to influence the behaviour of individuals in organizations, for example in the construction of organizational identity, (de-) legitimisation of organizational change and attitudes towards mergers and acquisitions (Hellgren et al. 2002; Vaara and Tienari 2002; Hartz and Steger 2010; Grandy and Mavin 2012).

It should be noted that media not only reflect discourse, but also produce it (Hellgren et al. 2002; Richardson 2007). Journalists and editors influence meaning making of their audiences by framing issues in a certain way and selectively representing certain topics and actors for interviews or essays (Richardson 2007; Scheufele and Tewksbury 2007). It is therefore important to critically study whose voice is dominant in newspaper texts (and what it is saying) and whose

voice is marginalized or not heard at all (Hellgren et al. 2002; Vaara and Tienari 2002; Machin and Mayr 2012).

Dutch healthcare

In the last decades, scale of organizations has become an important topic in the public debate on Dutch healthcare. Developments that lead to changes in organizational scale, for instance mergers (Postma and Roos forthcoming), the proliferation of small-scale care in communities (Oldenhof, Postma and Putters 2014), the rise of neighbourhood care (Postma, Oldenhof and Putters 2014) and concentration of hospital care (Zuiderent-Jerak et al. 2012), have sparked a heated discussion. The discussion is taking place during a transition of the healthcare system in which business-like incentives and market elements are increasingly being introduced to Dutch healthcare, aimed at improving quality and lowering costs (Bal and Zuiderent-Jerak 2011). The various forms of new legislation and policy measures demarcate a change from supply-side state regulation towards 'regulated competition' and decentralisation to municipalities (Bal and Zuiderent-Jerak 2011). Government regulates the system to fulfil its constitutional responsibility for the quality, affordability and accessibility of healthcare, but depends on private, competing health insurance companies and healthcare providers to finance and deliver healthcare. Healthcare organizations therefore operate in a hybrid context including public, private and professional elements (Meurs and Van de Grinten 2005; Putters 2009). Discussions about organizational scale in the changing and hybrid setting of Dutch healthcare provide an interesting case for the study of socially constructed organizational scale.

Data analysis and coding

To gain a good overview of the public discussion, we searched the website http://academic.lexisnexis.nl for Dutch newspaper texts in all (14) major daily national newspapers in the period January 1990-June 2014. The Dutch newspapers had a combined circulation (including internet subscriptions) of approximately 2.2 million (in a population of 16.5 million) in 2014. We used the search terms 'scale' *(schaalgrootte),* 'small-scale' *(kleinschalig and kleinschaligheid),* 'large-scale' *(grootschalig* and *grootschaligheid)*, 'downscaling' *(schaalverkleining)* and 'upscaling' *(schaalvergroting)* in combination with 'healthcare' *(zorg)*. Our search resulted in a total of 867 relevant newspaper texts, including columns, editorials, letters, interviews and news articles, containing 1,235 extracts.

We analysed the texts, using ATLAS.ti, in two steps. The *first step* was textual analysis, when we searched for the most prevalent words in the texts. We inductively distinguished four coherent groups of approximately twenty keywords each. A group of words is coherent in its references to organizational scale, its emphasis on certain values and its relation to practice. For example, one of the groups we constructed contains words like 'market', 'marketization', 'merger', 'money', 'competition' and 'efficiency'. The extracts in which these words were used mostly dealt with the marketization of Dutch healthcare and the consequences for organizational scale. We also looked at 'internal intertextuality'; the way the newspaper texts relate to other spoken or written language (Richardson 2007). We inductively identified the following forms of internal intertextuality: direct quotation (extracts from reported speech, for instance an interview), indirect quotation (a summary of what was said or written elsewhere without using the exact same words), third-person writer (an article or letter written by a non-journalist or non-editor) and statements by journalists, editors or columnists.

In the *second step*, we conducted an interpretative analysis of the four groups of words found in the first step. In each group of words, we studied the meaning that actors attributed to scale. For example, we found that the extracts about the marketization of healthcare contained a distinct perspective on the advantages and disadvantages of small- and large-scale organizations, based on different values (including efficiency and competition). Our analysis enabled us to identify and describe four coherent discourses that construct organizational scale. We studied which actors use the discourses, what healthcare sectors are involved and how the discourses change over time. We also studied how ideologies and political viewpoints are reflected in the discourses.

Four discourses on organizational scale in the public debate

We inductively distinguished four discourses in the public debate on organizational scale in Dutch healthcare: the human scale, the professional scale, the business scale and the system scale. Each discourse tells coherent, distinctive 'stories' and entails a different construction of organizational scale.

An overview of the public discussion

Before we go into the discourses in detail, we discuss the overall occurrence of the topic of organizational scale in newspaper texts, the developments in the discourses over time and the actors and healthcare sectors that are prominent in the public discussion.

Figure 1 provides an overview of the occurrence of the topic of organizational scale and the four discourses in newspaper texts from 1990 to June 2014 (the Y-axis represents the number of extracts that use the discourse; the X-axis represents the year of publication).

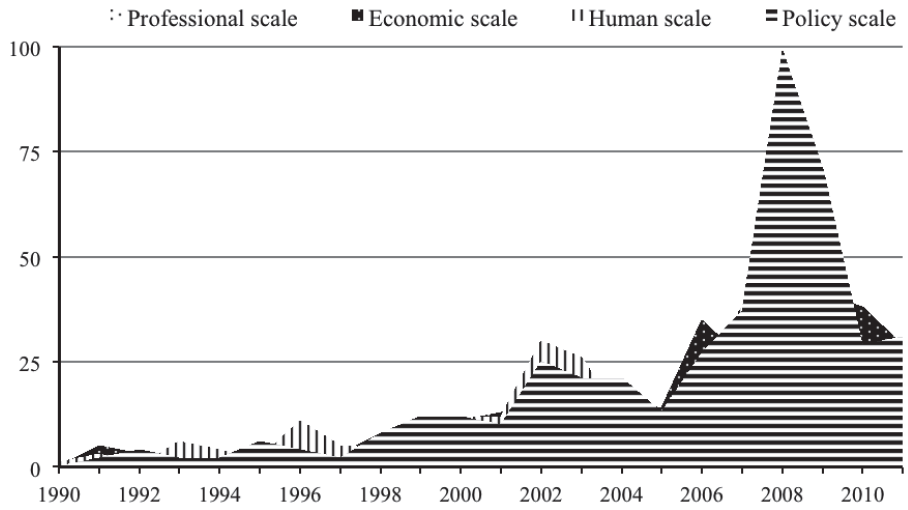

Figure 1. Four discourses on scale in newspaper texts (1990-June 2014)

Organizational scale in newspaper texts

The figure shows that the topic of organizational scale gained increasing attention in the late 1990s and early 2000s. One of the most important reasons for this was the growing public unrest with upscaling (mostly through mergers) of healthcare organizations, especially healthcare insurers and hospitals. During this period, there was a lot of media attention for a populist political party that argued for organizing public services on a smaller and 'more human' scale. After this, the attention for organizational scale lessened a bit until 2005. It rose again in the years after that, to peak in 2008. The main reason for the peak was financial problems and worries about the quality of care of some well-known

large-scale healthcare organizations. These problems were extensively reported in newspapers, leading to negative sentiments about large-scale organizations. In the same year, a government advisory council presented the Scale and Healthcare Report (RVZ 2008), which also was subject of extensive debate. Although the advisory council painted a nuanced picture about the pros and cons of small- and large-scale care, most reactions to the report were negative towards large-scale organizations. These reactions were combined with a call for a bigger role of government in the healthcare system to prevent further upscaling of healthcare organizations. In 2012 and 2013 another peak appeared in the public debate on scale, predominantly caused by widely discussed mergers between hospitals and discussions about the desirability of decentralisation of care to municipalities.

Developments in the discourses

From 1990 to June 2014, the content of the discourses was remarkably stable. However, one important development can be distinguished. Over time and throughout the different discourses, actors increasingly *favour small organizational scale* and *oppose large organizational scale*. More and more, large-scale was associated with distance, inefficiency, bureaucracy and overpaid management. On the other hand, small-scale was associated with values like proximity, affordability, recognition, professional freedom and humanity. Exceptions were executives of healthcare organizations, who over time favour large organizational scale. They argued that large-scale care is needed to achieve a good market position, provide efficient and integrated care and stimulate professional development. We go into these arguments and associations in detail in our analysis of the four discourses.

Actors and sectors

In terms of the number of extracts in which they are represented, politicians and healthcare executives have the dominant voice in newspaper texts, followed by journalists, columnists and professionals (particularly medical doctors). Although care for patients is one of the major topics in the public debate, patients themselves have almost no voice in the newspaper texts (six of the 1,235 extracts can be ascribed to patients). Middle managers are also seldom heard in the public debate on organizational scale in Dutch healthcare.

With regard to internal intertextuality and the role of the media in the public debate about scale, our data show that almost 35 per cent of the extracts comprise

direct quotations from reported speech, while a third-person writer (e.g. an op-ed contribution) features in more than 25 per cent of the extracts. Indirect quotation (a summary of what was said or written elsewhere without using the actual words) counts for almost 20 per cent of the extracts, while more than 25 per cent of the extracts can be ascribed to the opinion of a journalist, editor or columnist. The results imply that media have an important, active role in the social construction of organizational scale in newspaper texts. Not only do they select and modify the texts that appear in articles, they also express their own voice directly.

When we look at the different sectors in healthcare, we see that over a quarter of the extracts discuss scale of healthcare organizations with no reference to a specific sector. The other extracts pay the most attention to nursing home care and hospital care. There is little attention for organizational scale in sectors such as psychiatric care and primary care.

Four discourses

In this section, we outline the four discourses. Each discourse entails a different construction of scale in terms of its emphasis on certain organizational spaces (that are both physical and imaginary) and the hierarchical relation of these spaces to other spaces. Each discourse also contains 'scalar practices', 'representations of scale' and 'scalar representations' of healthcare organizations. In the analysis, we provide extracts from newspaper texts that are typical for each of the discourses.

Discourse 1: The human scale

The human scale discourse entails such words as 'home', 'neighbourhood', 'human', 'care' and 'community'. The discourse demarcates the space that patients, clients and citizens inhibit as the scale that is most relevant. Actors use the discourse to express that it is important that healthcare organizations provide care that fits the scale of patients. The discourse focuses on the mental, social and physical needs of individual patients, their relatives and the professionals that are involved, and the homes and neighbourhoods patients live in:

> "First of all, it is essential to return to the human scale. People should receive care where they live, in their own home. If for whatever reason this becomes impossible, they should be able to go to a small-scale service facility that includes nursing home

> care; a healthcare centre with a fixed team of professionals that is part of a district or a neighbourhood. A neighbourhood is more than a postal code. It is the place where people in some way derive their identity."
> (Executive of an organization for long-term care, 9 March 2007)

In the human scale discourse, predominantly used by journalists and columnists, the human scale is defined as the smallest and most important scale of organizational action. Scalar practices, 'lived experiences' in everyday lives of patients, are central in this discourse. Actors emphasize that values like 'caring', 'empathy' and 'compassion' are essential in the provision of care and require a small scale:

> "The human scale that you find in small-scale facilities facilitates personal attention for people, for empathizing with people. That ensures quality."
> (Healthcare inspector, 27 December 2008)

The quote not only exemplifies the importance of scalar practices of patients, but also how these practices are used in scalar representations of organizations. Actors rhetorically use scalar practices to paint an idealistic picture of a small-scale 'utopia' where patients are cared for in the best possible way. To emphasize the importance of the human scale, small-scale organizations are depicted positively in comparison to large-scale organizations:

> "In healthcare, everyone is busy with mergers and acquisitions. Everyone? No, a small healthcare organization in Drenthe [Dutch province] keeps on resisting the 'monster of upscaling.'"
> (Journalist, 18 February 2013, in an article about an organization for elderly care)

Discourse 2: The professional scale

The discourse of the professional scale comprises such words as 'professional', 'work floor', 'quality', 'specialization' and 'autonomy'. The professional scale discourse focuses on the organizational spaces healthcare professionals, especially nurses and medical doctors, inhibit. Those spaces of work include examination and treatment rooms, wards and the geographical area professionals work in (e.g. home care in the neighbourhood). The professional scale is hierarchically distinguished from (layers of) management. The discourse emphasizes the distance

between management and professionals (the 'top of the organization' versus the 'work floor'):

> "Employers are deaf and blind to signals from the work floor (…) As a result of upscaling, management in his hospital are 'miles away' from the work floor. 'Nurses have become puppets randomly assigned to wards. They lose all connection with a specific ward. That goes at the expense of quality of care."
> (Nurse and Union Representative, 2 February 2009)

Like in the human scale discourse, scalar practice is central in the professional scale discourse. The discourse emphasizes the daily work that professionals perform, including providing care, organizing their work and talking to patients and colleagues. An important value in this discourse is 'autonomy'. Actors (especially politicians, professionals and experts) argue that on a small scale, professionals can organize, prioritise and execute their work without being hindered by managers that run the show in large-scale organizations (as the above extract exemplifies).

Notably, also in this discourse, scalar representations of organizations are important. Often, the work spaces of the (ideal-typical) nurse or doctor are envisioned as the most important scales in the provision and organization of care:

> "Those were good times when I started as a General Practitioner in 1970. A small sickness fund in my region, sickness fund Almelo [a Dutch city] and surroundings, with a pale bookkeeper as its director. The Green Cross [home care cooperation] worked autonomously. All General Practitioners and neighbourhood nurses were present at meetings. We all knew each other and we could do business right on the spot. A cup of coffee, a slice of home-made pie, a drink and a cigar were the overhead costs. On a regional scale we could quickly bring in specialized care if necessary, for example a nurse who was specialized in lung diseases. Also the hospital was not large (350 beds). But then the curse of upscaling struck."
> (General Practitioner, 18 October 2004)

Discourse 3: The business scale

The business scale discourse entails such words as 'market', 'competition', 'money', 'efficiency' and 'production'. Actors argue that a large scale provides organiza-

tions with economies of scale in development of technology, use of medical equipment, innovation of services and deployment of personnel:

> "The past years, healthcare organizations have taken several measures to organize the care provision process more efficiently. Home care cooperatives and family care organizations merged. Clients can report at a central location. This "registration point" works efficiently and is easily accessible to clients. An added gain in merged organizations with integrated teams is that it is easier to have "the right person at the right place". Communication, cooperation and transfer of clients runs smoother. Less time is being spent on meetings and productivity can be monitored better."
> (Research institute on healthcare, 27 March 1997)

Besides the value of efficiency, the discourse emphasizes that a large scale is important for the market position of a healthcare organization versus other actors, such as suppliers, competitors and purchasers. Without a strong market position, the continuity of an organization is said to be in danger:

> "A large-scale organization is necessary for strategic reasons and to survive as an organization. If you are too small, you will be eaten."
> (Executive of an organization for long-term care of the elderly, 26 November 2004)

In the human scale and professional scale discourses, scalar practices, especially the concrete spaces in which human interactions take place, play a central role. The business scale discourse is about abstract spaces and emphasizes representations of scale. That is, the most important actors are healthcare executives; the most important activities are planning, drawing up strategies and initiating mergers between organizations. These activities are in line with 'marketization' and 'business-like behaviour' in the healthcare sector. According to actors that use the business scale discourse, this leads to outcomes that are beneficial to patients:

> "Especially the large enterprise can integrate a variety of needs. The large healthcare organization can offer a broad portfolio of decentralised services; it can introduce the 'one-stop shopping' system for aid and care. (…) Small-scale care that we look at with such nostalgia seldom has an answer to these aspects."
> (Consultant, 19 April 2008)

The above abstract exemplifies an important scalar representation of healthcare organizations in this discourse: a large-scale organization is being defined as efficient, modern and customer-friendly, while small-scale care is 'nostalgic' and out-dated.

Discourse 4: The system scale

The system scale discourse comprises such words as 'policy', 'law', 'government', 'governance' and 'system'. The healthcare system as a whole is central in the discourse. The discourse emphasizes that organizations, executives, professionals and patients are part of a wider system. It discusses the way policies, rules and regulations influence the degree of integration, specialization and alignment of different healthcare services within and between organizations.

Moreover, the discourse is about the nature of the healthcare sector and involves a struggle between politicians on the one hand and healthcare executives on the other. Politicians claim that they try to reconcile different and sometimes conflicting values, such as freedom of choice for patients and accessibility, quality and affordability of care, in their policies on scale. Healthcare executives are seen as the most important actors in reconciling those conflicting values and policies in practice. They often see upscaling through mergers as unavoidable to reconcile different values and policies. However, others worry that upscaling conflicts with the public goals of healthcare organizations:

> "The upscaling of healthcare organizations is a questionable development. Despite all the governance codes and oversight councils, the organizations can get out of reach in the no man's land between government and market, while they represent important social capital." (Columnist, 11 July 2007)

As a result, politicians use the system scale discourse to argue for stronger government regulations to fight healthcare mergers and stimulate small-scale care:

> "[T]he line between private and public is less clear than we thought. For home care there is another essential argument for direct government engagement. Without interference there is a chance of new mergers and upscaling. That is undesirable. Furthermore, financial support to home care offers an unprecedented opportunity to steer policy towards small-scale organizing in the community: the return of the

neighbourhood nurse."
(Member of the Social Democratic Party (PvdA), 12 January 2009)

Scalar practices have a symbolic function in the system scale discourse. They are being used rhetorically to argue for an active role of government in regulating and planning the healthcare sector (representations of scale), especially by preventing healthcare mergers, and by emphasizing the importance of government as 'guardian of small-scale care' (scalar representation).

Summary of the discourses
The four discourses are summarized in table 1.

Table 1. Summary of the four discourses

Discourse	Key words	Dominant actors	The construction of scale
1. Human scale	Home, neighbourhood, human, care, community	Journalists and columnists	Scale is constructed through accounts of scalar practices in which small-scale care for patients, attention for their needs, the physical spaces in which they live and the everyday interactions they have with relatives and professionals, is central. This results in scalar representations that paint idealistic pictures of small-scale care.
2. Professional scale	Professional, work floor, quality, specialization, autonomy	Politicians, professionals and experts	Scale is constructed through accounts of scalar practices that focus on organizational spaces that professionals occupy (e.g. treatment rooms and wards), free from managerial interference. Scalar representations comprise ideal-typical, benevolent and autonomous, nurses and doctors.
3. Economic scale	Market, competition, money, efficiency, production	Healthcare executives	Scale is constructed through representations of scale, including organizational plans and strategies (e.g. for mergers). This leads to scalar representations in which large-scale organizations are superior to small-scale organizations in terms of efficiency, market position and customer orientation.

Table 1. Summary of the four discourses Continued

Discourse	Key words	Dominant actors	The construction of scale
4. Policy scale	Policy, law, government, governance, system	Politicians	Scale is constructed through representations of scale that stress the importance of government regulation in healthcare. Scalar representations emphasize the importance of laws and regulations that integrate different types of care, prevent upscaling (particularly through mergers) and protect small-scale care.

Conclusion and discussion

This study shows that scale is not something that should be taken for granted as a neutral organizational characteristic. Based on an analysis of newspaper texts, we argue that scale is constructed by discourse that informs and is informed by social and political processes. In the analysis, we distinguish four discourses that people use to construct organizational scale: the human scale, the professional scale, the business scale and the system scale. In each discourse, different physical and non-physical spaces are demarcated and constructed as scales that are important. In the human scale and professional scale discourses, physical spaces, including homes, neighbourhoods, wards and treatment rooms play an important role. In the business scale and system scale discourses, spaces that are largely non-physical are more important (the market, the policy arena).

The emphasis on a certain space is not innocent. By putting the physical spaces of patients and professionals central in the first two discourses, and by contrasting those with the spaces of managers and executives that are 'miles away, at the top of the organization', actors (especially journalists, columnists and professionals) try to legitimise and naturalise a greater role for patients and professionals in healthcare. This strategy involves the rhetorical use of scalar practices: everyday stories of interactions between the patients and the professionals that inhibit organizational spaces. These stories are reflected in scalar representations of organizations that comprise idealistic notions of personal attention, warmth, empathy and benevolent professionals.

The use of non-physical, abstract notions of space in discourse three and four, and the importance of representations of scale, denotes attempts by actors to

construct scale as something that should be planned, organized and structured from 'above'. The most important activities related to these discourses include merging of organizations and introducing new policies and laws. By making healthcare abstract, it becomes subject to structural, systemic change, specifically by 'marketization' or 'economization', granting executives and politicians power over professionals and patients. At the same time, executives and politicians engage in a struggle over power by contrasting (idealistic) scalar representations of large-scale, efficient organizations (the business scale discourse) with scalar representations of small-scale care in communities, protected and regulated by the government (the system scale discourse).

In our analysis of newspaper texts, we find that some voices, especially those of healthcare executives and politicians, are heard louder than others. Executives and politicians seem to be more skilled than others actors in using media to serve their agendas, thereby enforcing and legitimising their position. Although middle managers are key players in daily dilemmas of scale involving values like efficiency, professionalism, patient centeredness and integrated care (Oldenhof, Postma and Putters 2014), their voice is seldom heard in the public discussion. The voice of patients is the least heard. Even in the human scale discourse, which revolves around the position of the patient, there is much talk *about* patients (predominantly by journalists and columnists) but almost no talk *by* patients. Lefebvre (1991: 181) suggests that such domination is possible because in Western societies, abstract space is seen as more important than concrete space: "the space of habiting, of gestures, bodies and symbols is being suppressed by vision and geometry". Executives and politicians move within a space of paper and ink (representing scale) that dominates everyday realities (scalar practices). By prioritising the views of executives and politicians over those of professionals and patients in newspapers, lived experience becomes subordinate to strategies and policies. These findings illustrate that language in media accounts is not neutral and rational but political and embedded in values, naturalising some and supressing other perspectives (Fairclough 1995; Blommaert and Bulcaen 2000; Richardson 2007; Machin and Mayr 2012).

This study provides a new perspective on the concept of scale in organization studies. Our findings renounce the ideas that scale equates size and that scale is unproblematic and can be measured and analysed objectively. Combining insights from the work of Lefebvre and the 'spatial turn in organization studies' with studies on scale in human geography, we show how multiple discursive

constructions of scale are contested in the public debate and how they define healthcare organizations as 'multiscalar' entities. By hierarchically contrasting certain demarcated physical and non-physical spaces with other spaces, for example 'large-scale' versus 'small-scale', 'the workfloor' versus 'the top of the organization', 'the nearby' versus 'the distant' and 'micro-level practices' versus 'macro-level decisions', actors try to make some spaces, and the accompanying social processes, more important than others. Building on the work of Lefebvre, we also show how organizational scale is constructed in newspaper texts as a combination of scalar practices, representations of scale and scalar representations.

We consider our findings relevant to more than debates on organizational scale. The four discourses entail broader notions of the roles of patients, professionals, healthcare executives and policy makers, the organization of healthcare and the perception of 'good care' in the Netherlands. In particular, this study shows how actors prioritise and legitimise views on healthcare by using discourses that comprise accounts of everyday life (scalar practice), rational attempts to structure and organize (representations of scale) and ideal-typical notions of what the world should look like (scalar representations). Our findings likely also have relevancy outside the Dutch context. Public sector reforms, especially in healthcare, often lead to changes in organizational scale through mergers, new physician-organization arrangements and health networks (e.g. Bazolli et al. 2004). Our analysis helps to better understand how actors construct and contest these changes in the public debate.

The analysis presents several directions for further research. A promising direction is research on how the four discourses are linked to and situated in the daily provision of healthcare, specifically focusing on the way the language of important 'scalar themes', such as mergers, small-scale care, neighbourhood care and concentration of medical care, relates to lived experiences in real-world practices. A study of the underlying processes of legitimisation and justification and the behaviour of the actors involved can contribute to a better understanding of organizational scale.

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CHAPTER 5

On justification work: How compromising enables public managers to deal with conflicting values in small-scale care

Chapter based on:
Oldenhof, L., Postma, J. and Putters, K. (2014). On Justification Work: How Compromising Enables Public Managers to Deal with Conflicting Values. *Public Administration Review*, 74(1): 52–63.

Abstract

In the public administration literature, a variety of responses to value conflicts have been described, such as trade-offs, decoupling values and incrementalism. Yet little attention has been paid to the possibility of constructive compromises that enable public managers to deal with conflicting values simultaneously rather than separately. The authors use Luc Boltanski and Laurent Thévenot's theory of justification to extend current conceptualizations of management of conflicting values. On the basis of a qualitative study of daily practices of Dutch healthcare managers (executives and middle managers) in small-scale care, they show how compromises are constructed and justified to significant others. Because compromises are fragile and open to criticism, managers have to perform continuous "justification work" that entails not only the use of rhetoric but also the adaption of behaviour and material objects. By inscribing compromises into objects and behaviour, managers are able to solidify compromises, thereby creating temporary stability in times of public sector change.

Introduction

Policy issues in the public domain are often characterized by multiple and conflicting values (Bozeman 2007; Koppenjan, Charles and Ryan 2008; Loyens 2009; Spicer 2009; Steenhuisen, Dicke and De Bruijn 2009; Van der Wal, De Graaf and Lawton 2011). Recurring examples of value conflict include dilemmas between efficiency and equity (Le Grand 1990), efficiency and democratic legitimacy (Weihe 2008) and equity and liberty (Stone 2002). Public managers face these value conflicts in their daily work and have to find ways to manage the tensions between contradictory values.

Scholars have described various responses to value conflicts, ranging from trade-offs and decoupling values from one another, to incrementalism and case-by-case assessments of value conflicts (Thacher and Rein 2004; Steenhuisen 2009; Stewart 2009). Despite these valuable contributions, to date researchers have paid little attention to the possibility of producing constructive *compromises* that incorporate multiple, conflicting values. In day-to-day decision making, public managers frequently make compromises, as they have to deal with conflicting values simultaneously, rather than separately or sequentially (Brandsen, Van de Donk and Putters 2005; Boltanski and Thévenot 2006; Dunn and Jones 2010; Karré 2011; Oldenhof and Putters 2011). Yet these organizational actors are often portrayed as constrained agents that either have "to conform with or deviate from abstract institutional logics" (Patriotta, Gond and Schulz 2011: 1808). Patriotta, Gond and Schulz therefore call for studies that investigate the active role of organizational actors in constructing legitimate compromises, especially in environments where "the harmonious arrangements of things and persons is always 'up for grabs'" (2011: 1806).

Another gap in the literature concerns the question of how public managers *justify* compromises to themselves and the outer world (Jagd 2011; Patriotta, Gond and Schulz 2011). Jagd recently observed that "relatively few empirical studies explicitly focus on the complex processes involved in justification, critique, and attempts to produce compromises in organizations" (2011: 355). He asserts that "empirical studies of 'justification work' may be a potentially very promising focus for future empirical studies" (Jagd 2011: 343).

In this chapter, we begin to fill in the gaps in public management research on conflicting values by focusing on compromises and justification work. We use Boltanski and Thévenot's theory of justification (Boltanski and Thévenot 1991;

1999; 2000; 2006) to analyse how managers reconcile justifications in order to deal with conflicting values. In line with Boltanski and Thévenot (2006), we define a justification as a logical and harmonious order of objects and people that entails a higher principle of justice. According to Boltanski and Thévenot, social order is fragile because people often use different justifications to legitimise their action. Especially in organizations with multiple imperatives, disagreements arise when people, knowingly or unknowingly, refer to different justifications. In those situations, competent actors need to solve conflicts by establishing compromises through justification work.

The empirical analysis is situated in the Dutch healthcare sector. This is an especially interesting setting for applying the justification framework due to recent public controversies on how to secure conflicting values of healthcare, such as accessibility, affordability and quality (Van Egmond and Bal 2010). In the Netherlands, healthcare is provided by private non-profit organizations serving public goals: the provision of good, affordable and accessible healthcare. The government regulates the system by law, incentives and inspection. Given the state regulation of healthcare and the public nature of the goals and value conflicts, the study of Dutch healthcare managers provides valuable insights into how *public managers* deal with value conflicts. By focusing on middle managers and executives, this chapter analyses the justification work involved in dealing with conflicting values and making compromises. In particular, the delivery of small-scale care for people with dementia or a disability in the Netherlands is studied in-depth. The research question is as follows*: How do middle managers and executives in the Dutch long-term care sector perform justification work in order to deal with conflicting values in the provision of small-scale care?*

This chapter is organized into five sections. The first section discusses research on conflicting values and presents the justification framework developed by Boltanski and Thévenot. Section two introduces small-scale care in the Netherlands. Section three describes the qualitative research methods. The fourth section presents the empirical analysis of the justification work managers perform when dealing with conflicting values in the provision of small-scale care. The final section discusses the results and conclusions.

Management of conflicting values

According to Kernaghan, value conflict "is a pervasive feature of public administration" (2003: 712). Value conflicts can make decision making exceedingly hard. As Van Wart notes, public decision makers "want to do the right thing, but it is not always clear what that right thing is" (Van Wart 1998: 18). It is thus necessary to provide better insights into the way responses to value conflicts are constructed.

In public administration literature, responses to value conflicts are often portrayed as trade-offs between values (Bozeman 2008; Charles, Ryan and Paredes 2008). An important underlying assumption of trade-offs is that public actors can "balance the gains of one value against the costs of others," resulting in "less" of one value compared to "more" of the other (Thacher and Rein 2004: 462). In this rational cost-benefit view, values are in essence commensurable and can be balanced according to a single overarching norm.

However, several authors have argued that the trade-off approach has limitations. Lukes (1989) and Spicer (2001; 2009) formulate a theoretical critique on trade-offs. Building on Berlin's (1982) ideas of incommensurability of values, they argue that it is impossible to calculate the costs and benefits of values because "there is no single currency or scale on which conflicting values can be measured" (Lukes 1989: 135; Spicer 2009). Consequently, the incommensurability of values limits the role that rational cost-benefit analysis can play in making moral choices (Spicer 2001). Additionally, Steenhuisen's study of infrastructure companies empirically shows that value decisions seldom take the form of explicit trade-offs. Instead, value conflicts are addressed implicitly by operational staff and middle management through one sided priorities and single value protocols (Steenhuisen 2009).

Despite the difficulties of systematic balancing and the lack of an overarching norm, it is believed that practitioners can still deal rationally with conflicting values (Thacher and Rein 2004; Steenhuisen 2009; Stewart 2009). Thacher and Rein (2004) describe three strategies practitioners use to manage value conflicts: (1) 'cycling': giving attention to each value sequentially, (2) 'firewalls': establishing multiple institutions dedicated to different values and (3) 'casuistry': a case-by-case judgment on how to respond to particular value conflicts. Building on Thacher and Rein (2004), Stewart (2006; 2009) recently extended this framework with additional strategies, namely (4) 'bias': excluding alternative

values through the development of a dominant single value discourse, (5) 'hybridization': layering new policy on top of existing policy with a different value base and (6) 'incrementalism': stepped change that avoids the further arousal of value conflicts, while signalling intentions to solve conflicts in the long run. Of the six, cycling, firewalls and bias can be considered examples of 'decoupled' responses, which separate conflicting values. This allows practitioners to circumvent conflicting values. In contrast, hybridization, incrementalism and casuistry allow for the possibility of multi-value responses: conflicting values can be addressed simultaneously.

Although the above strategies are frequently used in practice, it remains to be seen whether they are sustainable, long-term solutions to value conflicts (Steenhuisen 2009). Studies of policy change demonstrate that *decoupling mechanisms* can be corrosive to organizational morale (Sandholtz 2012), may inhibit policy learning (Stewart 2009) and are often undone in the long run by *re*coupling (Stewart 2009; Tilczik 2010). Consequently, Haack, Schoeneborn and Wickert (2012) argue that decoupling is not a permanent solution, but merely a transitory phenomenon.

Given the transitory nature of decoupling strategies and their potential negative side effects, it is necessary to investigate strategies that incorporate rather than separate and bypass conflicting values. Although *multi-value responses* describe the coexistence of conflicting values, they do not sufficiently explain the dynamics of friction and productive (re) combinations of conflicting values. In other words, they do not provide insights into *how* competent actors actually deal with conflicting values. Work by economic sociologist Stark (2009) on heterarchies – that is, organizations with multiple evaluative principles – provides important insights into these dynamics. According to Stark, heterarchical organizations do not have to succumb to 'value cacophony,' but in fact can organize productive dissonance: disagreement over rivalling principles. This dissonance is said to enable opportunities for action and innovation. For example, in an ethnographic account of a Wall Street trading room, Stark shows how innovation in quantitative finance can occur thanks to rivalry between specialized trading functions (i.e. arbitrage traders, momentum traders and value investors) and the use of different evaluative principles, metrics and instruments. Each trading function has its own desk in the trading room that is organized around one distinctive evaluative principle, thereby building dissonance into the organizational struc-

ture. Through close contact on the trading floor, traders can recognize conflicting evaluative principles and generate new innovative forms of arbitrage.

In Stark's perspective on heterarchy, disagreement is deemed more important than agreement and harmony. In fact, he pays little attention to how actors might incorporate multiple, conflicting values by means of compromises. In contrast, Boltanski and Thévenot (2006) show that compromises are at heart of the functioning of heterarchical organizations as they allow actors to deal with conflicting values in daily practice (Boltanski and Thévenot 2000; Lamont 2012). Boltanski and Thévenot describe modern organizations as "composite assemblages that include arrangements deriving from different worlds" (2006: 18) and "encompass resources that are heterogeneous in terms of their mode of coherence and the underlying principle of justice on which that coherence is based" (2006: 151). Because of the existence of multiple principles of justice, everyday clashes arise that can be suspended or remedied by constructing compromises. As an illustration of a compromise, Boltanski and Thévenot describe France's Economic and Social Council: a composite institution that merges civic and industrial values into mundane compromises such as the slogan "we're all in this together: increased productivity is good for us all" (Boltanski and Thévenot 2006: 279). Despite Boltanski and Thévenot's contribution, the construction of legitimate compromises is still an under researched topic in public administration (Patriotta, Gond and Schulz 2011; Cloutier and Langley 2013). As Cloutier and Langley recently argued, the production of compromises remains "largely invisible" in the institutional analysis of multiple logics (2013: 11). To remedy this blind spot, they recommend ethnographic research *in situ* that investigates micro-processes whereby various logics interact and merge into compromises. Boltanski and Thévenot's framework is especially suitable to study these micro-processes and the active role of competent actors in establishing compromises. For this reason, the framework of justification is applied to managerial practices in Dutch small-scale care.

On Justification

According to Boltanski and Thévenot (2006), a neglected dimension of social interaction is the way people justify their actions in every day disputes. They consider the act of justification not as a cover up, but as an integral part of hu-

man interaction: "Justifiable acts are our focus: we shall draw out all the possible consequences from the fact that people need to justify their actions. In other words, people do not ordinarily seek to invent false pretexts after the fact so as to cover up some secret motive, the way one comes up with an alibi; rather, they seek to carry out their actions in such a way that these can withstand the test of justification" (Boltanski and Thévenot 2006: 37).

Boltanski and Thévenot (2006) have developed six justifications[7], also called worlds, orders, repertoires or generalities of worth: (1) market, (2) industry, (3) civic, (4) domestic, (5) inspired and (6) fame. These justifications are based on three bodies of data: empirical data gathered by asking people to create classification systems by sorting occupations into categories, a study of organization handbooks and an analysis of political philosophical works by Rousseau (civic), Adam Smith (market), Saint-Simon (industrial), Bossuet (domestic), Augustine (inspiration) and Hobbes (fame). In their 2006 book 'On Justification' they extensively describe the six justifications summarized in Table 1. Each justification entails certain values[8], states of worthiness (shared ideas of what is good and just) and specific forms of evaluation (how the good and just is measured).

Boltanski and Thévenot (2006) argue that people explicitly or implicitly refer to one or more justifications when deciding what is just in *ordinary situated disputes*. In these situations, people realize that something is wrong and has to change. This realization has a dual meaning and refers to "an inward reflexive move and to a performance in the outward world" (Boltanski and Thévenot 1999: 359). Therefore, people not only try to answer for their own interpretation of what is just but also to others with whom they interact.

7 Boltanski and Thévenot argue that the six justifications are historical and social constructions "and some of them are less and less able to ground people's justifications whereas other ones are emerging" (1999: 369). They identify a number of emerging justifications, including projective (Boltanski and Chiapello 2005), information, communicative and green (Thévenot et al. 2000). In this chapter, we use the six original justifications since they have a more solid empirical and theoretical foundation than the others (Boltanski and Thévenot 2006). Including other justifications would not provide additional insights into the study of conflicting values in small-scale care.

8 Please note that when broadly conceptualised, values can belong to different justifications. For example, the encompassing value of 'choice' can belong to both market (consumer choice) and civic (electing representatives in elections by casting a vote). For categorizations of values to be meaningful, it is necessary to operationalize values more specifically, as we do in Table 1.

Table 1. Justifications and values

Justification	Values	State of worth	Evaluation
1. Market	Competition, profit, consumer choice	Desirable, valuable, winner	Price
2. Industrial	Production efficiency, planning	Effective, functional, dependable	Functionality
3. Civic	Equality, welfare, social participation	Representative, free official, statutory	Votes, civic rights, law
4. Domestic	Household duties, tradition, trust, family honour	Benevolent, well-bred, wise, sensible	Responsibilities
5. Inspired	Inspiration, creativity, grace	Bizarre, different, original, spontaneous	Singularity, uniqueness
6. Fame	Public opinion	Celebrity, prestige	PR, public recognition

Based on: Boltanski and Thévenot (2006)

As Table 1 makes clear, there is a plurality of justness. This means that justifications represent different types of common good (Boltanski and Thévenot 2000), or 'varieties of goodness' (Wright 1972), and carry equal weight (Patriotta, Gond and Schulz 2011). There is no overarching norm to balance different justifications. Each justification is a logical, harmonious order of objects and people that provides a general sense of justice. When justifying, people "extract themselves from the immediate situation and *rise to a level of generality*" (Boltanski and Thévenot 2000: 213, emphasis in original). In this process, people attach worth to persons and objects. For example, an object like a house can be endowed a different worth in each justification. The justification of the market sees a house as a good that can be traded for money, whereas the domestic justification sees it as a place where family life takes place. Similarly, people can be endowed with different values, such as consumers, citizens, or producers.

A distinguishing feature of the theory of justification is that it is based on the notion of equivalence. The theory therefore only applies to disputes in which people are equal and strive for agreement without exercising power. Acts of love, domination, force, routine, deceit, delusion and self-deception fall outside the regime of justification (Boltanski and Thévenot 1999; 2000; 2006).

Conflicts, fragile compromises and justification work

According to Boltanski and Thévenot (2006), people are subjected to an imperative of justification when they experience different forms of disputes in everyday life, ranging from modest disagreements to full-blown clashes. Disagreements can arise in one justification over the distribution of worth, for example over the appropriate price of a certain good. In these situations, the judgment measure itself is not contested. However, disagreements can also extend to clashes (Boltanski and Thévenot 1999). This is the case when different justifications conflict and people disagree on the judgment measure, for example, whether it is appropriate to make a cost-benefit analysis of certain medical treatments. Then a "clash between worlds" arises and people exchange criticism, blame and grievances based on differing justifications (Boltanski and Thévenot 1999; 2006: 223, 237). As Boltanski and Thévenot put it, "The one who criticizes other persons must produce justifications in order to support their criticism just as the person who is the target of the criticisms must justify his or her actions in order to defend his or her own cause" (Boltanski and Thévenot 1999: 360).

Despite the plurality of justness and the lack of an overarching norm, Boltanski and Thévenot (2006) claim that compromises between justifications are possible. In fact, compromises are an integral part of social interaction. In the face of criticism, people try to make daily situations involving conflicting values workable by constructing a compromise between justifications (Lamont 2012). An important part of compromising consists of finding a formulation that is acceptable to the people involved: the compromise needs to be justifiable to others. However, Boltanski and Thévenot (2000: 212) note that "the competence to make an agreement is not a uniquely linguistic competence." People also make compromises with the construction and arrangement of objects. Objects are important as "every principle of justice is associated with a universe of objects that constitute a coherent world" (Boltanski and Thévenot 2000: 213). They have the potential to tie ill-suited elements together and solidify compromises. For example, Thévenot shows that compromises between market, civic and domestic justifications can be incorporated in the design and construction of a new road (Thévenot 2002).

Compromises entail considerable work as they have to be created, solidified and justified. In line with Jagd (2011), this is called *justification work*, which is not only about establishing compromises, but also about maintaining and re-crafting

compromises. This is necessary because even when a compromise is solidified, it remains fragile, temporary and open to critique (Boltanski and Thévenot 2006; Patriotta, Gond and Schulz 2011) because people make compromises between justifications "without trying to clarify the principle upon which their agreement is founded" (Boltanski and Thévenot 1999: 347). Thus, the entities or beings combined in a compromise continue to belong to their justification of origin. People can reactivate the clash by bringing up one of the justifications again. A more complex situation then arises, as people cannot simply withstand the criticism and justify the compromise by referring to a higher common principle or overarching justification (Boltanski and Thévenot 2006). In these cases, actors must perform justification work by re-crafting existing compromises or creating new ones.

Conceptually, justification work aligns closely with the notion of discursive practices. A discursive practice not only entails language, but also action, objects and settings that have a constituting effect on each other (Van Dijk 1997; Fairclough and Wodak 1997; Potter 2004). In other words, language shapes and is shaped by situations, institutions, people, objects and social structures. Furthermore, Potter (2004) emphasizes that discursive practices are action-oriented, situated and constructed. This study further builds on this tradition by empirically showing how justification work is constituted in practice through objects, behaviour and rhetoric.

Small-scale care

Traditionally, western countries modelled long-term care and housing for people with severe dementia and for people with a mental or physical disability on hospital care (Finnema et al. 2000). People deemed unable to care for themselves used to live in large-scale institutions, isolated from society and restricted in opportunities and lifestyle (Ericsson 2002). In recent decades, care and housing have become de-institutionalised and community-based (Emerson 2004). The goal of de-institutionalisation has been "the complete replacement of institutions by services in the community" (Mansell 2006: 65). People with dementia or a disability increasingly live in small-scale domestic dwellings in residential neighbourhoods (Braddock et al. 2001). Consequently, the number of people

that live in large-scale institutions has steadily declined in Europe and the US (Beadle-Brown, Mansell and Kozma 2007).

Te Boekhorst et al. (2007: 18) define small-scale group living homes for people with dementia by seven characteristics, including "residents are allowed to stay until death," "residents, family and staff together decide the daily course of events," and "care planning resembles a household routine." The number of residents in small-scale homes typically ranges from five to nine (Verbeek et al. 2009). Van Hoof, Kort and Van Waarde (2009: 387) define a small-scale home as "a 'normal' household" combined with "24-hr care and surveillance offered by one or two staff members." Furthermore, "there is room for one's own furniture and goods in a private living/bedroom. The kitchen unit, living room, and in most cases the sanitary units are shared." In the shift to community care, the following values play an important role: self-determination, social integration, social relationships with relatives and friends, meaningful activity, health, engagement in domestic and personal activities and general quality of life (Emerson 2004; Beadle-Brown, Mansell and Kozma 2007; Kozma, Mansell and Beadle-Brown 2009).

The case of small-scale care in the Netherlands is interesting for several reasons. De-institutionalisation and tightening of budgets in long-term care could potentially lead to new value conflicts for managers. Previous research has already shown that small-scale living facilities can put a strain on the affordability of care (Oldenhof and Putters 2011). Furthermore, the scale of healthcare organizations and facilities is a heavily debated issue in the Netherlands, comprising multiple discourses of what 'good scale' is (Postma, Van de Bovenkamp and Putters forthcoming).

Methods

We used a qualitative research design to openly investigate how healthcare managers experience value conflicts and perform justification work. The qualitative analysis is based on (1) semi-structured interviews with middle managers and executives working in different organizations in long-term care and (2) ethnographic observations of middle managers in one care organization. Appendix A contains details of the data sources.

In the period between November 2009 and June 2010 we conducted semi-structured interviews with healthcare middle managers and executives, includ-

ing 16 interviews with middle managers in the long-term care sector who were responsible for managing healthcare professionals and the financial performance of residential facilities. The goal of the interviews was to investigate the daily dilemmas of middle managers. Middle managers were asked to describe a typical working day, their experiences with enjoyable/difficult aspects of their work and day-to-day decisions in the organization of care. Furthermore, 13 interviews were conducted with executives from 13 organizations for elderly care. The goal of these semi-structured interviews was to gain an overview of the different dilemmas executives face when dealing with scale in their healthcare organizations. All interviews were fully transcribed.

Additionally, ethnographic observations were conducted in an organization that provides small-scale care for people with a disability. In the period between February 2011 and December 2011, seven middle managers were shadowed for three days each, during the course of their regular working day. Field notes were taken during all the activities of middle managers, including team meetings, telephoning, coaching of professionals and meetings with client councils and clients' relatives. These notes provided rich information about the daily management of small-scale homes.

The analysis of justification work not only focuses on how managers justify decisions regarding small-scale care to themselves and the researchers (particularly in interviews), but also on how managers justify their decisions vis-à-vis 'significant others' such as professionals, other managers, clients and their relatives (hence the observations). The analysis is based on an initial phase of inductive exploration and a sequential phase of deductive coding based on Boltanski and Thévenot's framework of justification. The combination of inductive and deductive analysis on the one hand enabled an open exploration of value conflicts in managerial practices and on the other hand created opportunities to develop existing theory of justification (e.g. the importance of rhetorics, behaviour and objects).

First, by a process of inductive coding (Kvale and Brinkman 2009), we identified three main value conflicts in the provision of small-scale care. Signifiers of value conflicts were words like 'dilemma,' 'tension,' 'struggle,' 'difficulty,' and emotional utterances about 'what should be or should not be.' After identifying the three value conflicts, we linked them deductively to the six justifications. For example, with the help of Table 1, the value conflict between *freedom of choice* and *efficient organizing* of small-scale care was deductively coded as a conflict

between market and industry justifications. Please note that the coding evolved during the analytical process. The researchers' initial assumption was that value conflicts could only occur *between* different justifications, but this proved to be incorrect. The data showed that also *within* one justification value conflicts could arise, such as the wish to *integrate clients into society* and *receive legitimacy* from local neighbourhoods (both relating to the civic justification). Other than this civic value conflict, we found no value conflicts within one justification in the data.

A second step in the analysis was to identify language, affiliated behaviour and objects that managers use when dealing with value conflicts. We then used Table 1 to deductively ascribe these to the different justifications. For example, in the case of the third value conflict (integration of clients into society versus legitimacy from local neighbourhoods), concrete objects like PR flyers were used to improve the 'public image' of clients with a disability in the neighbourhood, which aligned with the fame justification (source: interviews). Additionally, baby phones and cameras were coded as objects stemming from the industry justification because these objects were used by managers to 'efficiently plan' and 'organize' 24-hour care in different locations (source: observations and interviews). Similarly, we linked managerial language and behaviour to the justifications. For example, rhetoric on consumerism and client choice concerning spending client-linked budgets was linked to the market justification (source: observations and interviews).

Thirdly, we analysed deductively the recurring combinations between justifications in order to identify compromises. This resulted in two central compromises concerning small-scale living facilities: civic/domestic and industry/market. These compromises were not only created rhetorically, but also were solidified over time in work schedules, behaviour of care workers and buildings (i.e. the civic/domestic compromise materialized in domestic, family-sized houses, whereas the industry/market compromise was created in practice by individual apartments in communal buildings). The results section includes quotes that exemplify the identified value conflicts, the justifications that are used and the two main compromises.

Results

This section shows how public middle managers and executives (called 'managers' from now on) deal with value conflicts in the provision of small-scale care for people with dementia or a disability. Firstly, we describe the current practice of small-scale care as a compromise between the domestic and the civic justification. Secondly, we define three emerging value conflicts, showing the fragility of the current compromise. Thirdly, we show how managerial justification work is performed by means of rhetoric, behaviour and material objects. Managers perform justification work to keep the current compromise together and create a new compromise between the industry and the market justification. Finally, we describe the cyclical nature of justification work.

Small-scale care as a compromise between the civic and domestic justification

As stated above, de-institutionalisation in Dutch healthcare brought different values to the fore. This resulted in small-scale care that can be typified as a compromise between the civic and domestic justification. In their daily practices, managers justify this compromise in various ways. They argue that small-scale homes function like a regular (domestic) household, while simultaneously providing opportunities to integrate clients into society (civic). Clients are stimulated to engage in both household activities (domestic) and social activities in the neighbourhood (civic). Managers encourage clients to have social relationships with relatives and friends (domestic) and be a good citizen and neighbour (civic). Elements from both justifications are reflected in the managers' language:

> "These types of organizations belong to society; they (…) belong to local communities." (Executive)

> "(…) that people can live with pleasure in their home and are able to continue living there and be themselves." (Middle manager)

The civic/domestic compromise is not just rhetorically justified: it is also solidified in materials and behaviour. The most obvious material solidification of the compromise is that small-scale buildings are situated in regular neighbourhoods. They have mostly replaced the large-scale institutions situated on secluded ter-

rains. The compromise is further solidified in the behaviour of managers as they work together with professionals and relatives to help clients live their lives as "normally" as possible. Managers coach professionals to accept certain risks that come with treating clients as "normal citizens" and "family members." When clients perform daily activities – like going to the supermarket independently, participating in neighbourhood activities, or cooking for themselves – most of the attached risks are deemed acceptable because they are part of a "normal life." In addition, managers try to further solidify the compromise by involving relatives in the provision of small-scale care, for example by asking them to paint or decorate a client's room.

Critique on the fragile compromise: Three value conflicts

While the current practice of small-scale care is a solidified compromise, it remains fragile and open to critique. Managers have to deal with two types of criticism. The civic/domestic compromise is first open to external critique from other justifications and corresponding values (outside the current compromise). It emanates from market and industry justifications, as some actors feel that these justifications are not sufficiently reflected in the current practice of small-scale care. Secondly, because the civic-domestic compromise is a composite assemblage, it is open to internal critique from the 'pure' forms of the two justifications.

In managerial practices, critique manifests itself in value conflicts, which are expressions of the fragility of the current civic/domestic compromise. Although the value conflicts are not manifest in all practices and sometimes look differently in different contexts, there is a remarkable consensus in the conflicts that the managers in the study experienced. Interestingly, middle managers appear to experience value conflicts more intensely and more concretely than executives do. During interviews, they provided more detailed examples of value conflicts in the provision of small-scale care than executives did. The three value conflicts that managers experience are described in the remainder of this section. The first two value conflicts are examples of external critique; the third value conflict is representative of internal critique.

Firstly, managers experience external critique as a value conflict between keeping small-scale homes *affordable* (market justification) and *planning 24-hour care* for clients (industry justification). Clients receive 24-hour care and supervision according to their client-linked budget (a legally defined individual budget that defines the amount and type of care a client is entitled to). However,

managers struggle to realize 24-hour care in small-scale homes for a few clients with limited budgets. It is difficult to provide all the care clients are entitled to *and* stay within budget:

> "We used to have six clients in one small-scale home (…). We just can't afford that any more. When you have clients that live in a small-scale home, and you have to arrange for supervision during the night, then it [the budget] is just too small." (Middle manager)

> "With the new funding system, you cannot provide 24-hour care for a cluster of less than thirty clients." (Executive)

Secondly, managers experience external critique as a value conflict between guaranteeing *freedom of choice* for clients (market) and organizing small-scale care *efficiently* (industry). Managers stress the importance of clients with dementia or a disability having the freedom to choose how they want spend their client-linked budget. However, this freedom of choice is often at odds with the interest of the organization to provide care efficiently. For example, when some clients choose to go on holiday during the summer and other clients choose to stay at home, managers find it difficult to organize supervision for a small number of clients. The clients' daily choices, whether they would like to stay at home during the day or prefer to go out to activities, create conflicts:

> "Can I say to a client that they are obliged to go to a social activity outside the home because I don't have the money to arrange for supervision of clients who want to stay at home? Can I do that?" (Middle manager)

Thirdly, managers experience internal critique as a conflict between the wish to *integrate* clients into society and receive *legitimacy* from local neighbourhoods (both civic). This value conflict manifests itself almost exclusively in small-scale care for people with a disability. Managers stress that people with a disability should live a normal life in the community; gaining acceptance and legitimacy from neighbours is central to this. However, they find it hard to realize this ideal in practice. Managers have to deal with conflicts between the wishes of neighbours (for peace and quiet) and the needs of clients to be who they are (often more noisy and expressive than quiet):

> "Well, we've experienced lots of trouble with the neighbours in the past two years. (...) People who don't want it, don't like it, are bothered by the noise that clients make. People who get annoyed when a client undresses on the street. People who get upset because their children are scared of clients. Yes, things like that. Noise nuisance at night. They complain a lot about that. Houses have dropped in value." (Middle manager)

> "You've got lots of neighbours who think, 'Go live in a cabin in the woods with your handicapped people." (Middle manager)

Dealing with value conflicts requires justification work

As the above has shown, the current practice of small-scale care is a fragile compromise between the civic and domestic justifications. This fragility manifests itself in three value conflicts. To deal with value conflicts, managers perform justification work. The analysis identified two types of justification work: (1) maintaining the current compromise and (2) creating a new compromise. The analysis inductively shows that both types of justification work consist of rhetoric, human behaviour and material objects. Rhetoric comprises the use of language; behaviour largely manifests itself in the routines of professionals, clients and managers; and material objects include things like cameras and buildings. In the practice of justification work, these dimensions are often interwoven.

Justification work type 1: Keeping the fragile compromise together

The first type of justification work is keeping the fragile civic/domestic compromise together. Managers include elements from different justifications into the current compromise in order to deal with conflicting values. However, they and other actors (like colleagues, clients and relatives of clients) sometimes perceive it as unjust as the current compromise becomes less 'pure'. Dealing with this injustice requires a lot of justification work to make language, behaviour and objects compatible.

Managers deal with the conflict between affordability and 24-hour care (*the first value conflict*) using civic, market and industry justifications. With regard to civic justification, managers emphasize that 24-hour care is not just the healthcare organization's professional responsibility. In the civic view, clients are portrayed as citizens with both the right and responsibility to participate in the provision of small-scale care, together with relatives and other actors from the community:

> "The small-scale homes need to be connected to civil initiatives as far as possible. Citizens need to take far more responsibility. (…). So what we are going to do is arrange, together with social housing organizations to connect with citizens' initiatives. We want a community of professionals and citizens forming a small-scale home together." (Executive)

With regard to market justification, managers emphasize that clients are consumers too. As consumers, they are expected to use their client-linked budgets to make their own choices in the provision of 24-hour care. For example, people with a disability are asked what type of care they want most: assistance in the morning when getting up or supervision of social activities in the evening. Also, relatives are asked to assist in the choice of how to spend the client-linked budget, as demonstrated by these statements from a middle manager to parents of a client with a disability:

> "Do we want all-night supervision? (…) It means that instead of three professionals in the evening, you only have two. Then you'd miss out on individual care in the evening. We always have to choose. Are you going to walk or ride the bike? Do you want to help clients prepare food or during the meal? It's a dilemma: how do you deal with it?" (Middle manager)

> "There is money, but you have to decide how to spend it." (Middle manager)

Aside from rhetorically emphasizing civic duties and consumer choice, managers work on material solutions that stem from the industry justification. Many small-scale residential homes use ICT devices to allow clients to be supervised from a distance. For example, baby phones and cameras are used to oversee clients at night. These devices alert professionals when clients need help. It permits one professional to be in attendance in one location who can supervise several homes.

Managers deal with conflicts between freedom of choice and efficient planning (*the second value conflict*) using the civic justification and stressing the importance of solidarity among clients. For example, they encourage clients to undertake the same activities or to go on holiday at the same time as other clients in their group. By calling on solidarity, managers try to achieve efficient care planning without restricting clients in their freedom of choice:

> "In a group you have to agree on when, for example people can take a day off. Clients have to do more together, at the same moment. And clients sometimes fight about it because they cannot agree. As a manager you then have to take a step back." (Middle manager)

The conflict between the wish to integrate clients into society and receiving legitimacy from local neighbourhoods (*the third value conflict*) is interesting as this is not a conflict between different justifications, but between interpretations of the civic justification. Neighbours define civic as a peaceful neighbourhood where their children can play outside without noisy people next door and without being confronted by people acting strange. Managers define civic as the integration of clients into a pluralistic neighbourhood where many kinds of people, both with and without disabilities, live and work together.

Managers use the justifications of fame and industry to deal with this value conflict. With regard to fame, managers try to improve the image of small-scale homes by investing in good will and PR. Through rhetoric (regular talks and meetings with neighbours), material objects (flyers) and behaviour (recycling bottles), managers try to build local relationships:

> "You try to work together with the neighbourhood (…) We distribute flyers: we would like to collect your empty bottles for you. You want to show people that you are there for them. Be visible." (Middle manager)

With regard to industry, managers emphasize to neighbours that they have their safety in mind and have control over clients. Especially when complaints about clients seem hard to resolve, such as complaints about misconduct, managers stress the importance of rules:

> "When neighbours address a client about his misconduct, for example, he [a client] (…) for example says 'what the f***'.We have made it very clear to this client that he lives in a home that is part of our organization and he has to respect certain rules." (Middle manager)

Justification work type 2: Creating a new compromise

The second type of justification work is creating a new compromise between market and industry justifications. In creating a new compromise, managers try

to resolve persistent criticism stemming from market and industry justifications (the first and second value conflicts). Managers take this rather radical step when they think that these value conflicts are unsolvable in the current civic/domestic compromise. Creating the new compromise requires more justification work than simply holding on to the current one. Managers not only have to rhetorically justify their decisions to actors that want to stick to the current practice of small-scale care, they have to change their own and others' behaviour and make fundamental rearrangements in objects (like buildings).

The first step of creating the new compromise involves critiquing the current one. Managers stress the undesirability of the civic/domestic compromise from the perspective of other justifications. For example, small-scale homes are criticized for limiting the clients' choice (market justification):

> "Not every client benefits from a group of six people. They didn't choose this so-called family, but nonetheless they are locked up with six other people." (Executive)

Furthermore, the current compromise is attacked as a financial burden for society (civic) and an inefficient scale for planning (industry):

> "You can only provide 24-hour care on a reasonable scale, (…) a unit of 20 clients. That's plain logic. You're just fooling people when you say that you can provide it in smaller units. That's irresponsible; you're bringing higher costs upon society." (Executive)

Next, managers create the new compromise that tries to resolve the value conflicts. In creating it, managers argue for upscaling small-scale homes. Upscaling is done by building homes consisting of multiple individual apartments (at least 20, with some 40–60 square meters per apartment) and shared communal living rooms. The scale of individual apartments is relatively small, whereas the size of the building is large compared to the archetypical house. The combination of private and communal rooms is regarded as a new way of providing small-scale care.

This new way can be seen as a compromise between the market and industry justifications. Managers justify the market/industry compromise by stressing the importance of affordable care (market) and more efficient planning in a larger building (industry). With regard to the market, they also argue that clients no

longer have to share their lives with other clients in an artificial family household, but can choose whether they want to participate in daily activities in communal rooms or enjoy the privacy of their own apartment. Managers indicate that upscaling enables them to provide a broader range of services, thereby enhancing client choice:

> "Matching is very important because we develop the support and care for clients from the group perspective. Shopping together, eating together, spending free time together, clients do everything together. On a larger scale I can make more combinations." (Middle manager)

With regard to the industry justification, managers claim that the new compromise enables more efficient planning. Expensive types of care, like night shift supervision, can be shared more easily over a larger number of clients in a larger building. Additionally, managers claim that they can organize the control over professionals better in larger buildings (industry):

> "You've got some sort of social control over what happens. (…) A professional could make a mistake by intervening too physically. Or, well, you don't know what could happen. When it happens on the same team, you run the risk of professionals helping each other. Or keeping something like that quiet. That alone is reason enough to cluster more, because then we'd have more control over each other." (Middle manager)

Like the current civic/domestic compromise, the new market/industry compromise is solidified in a number of ways. The most visible aspect of the justification work of managers is material solidification in the stone of new buildings. With regard to rhetorical work, managers regularly talk to professionals, clients and relatives to justify the new compromise. Particularly, managers stress the advantages of the new compromise for both clients and healthcare organizations. The market/industry compromise is also solidified in behaviour. For example, managers make sure that professional work schedules permit efficient planning and keep the preferences and needs of clients in mind as far as possible. As a result, professionals are no longer responsible for providing care to one fixed group of clients in a single small-scale home. Instead, they often have to work at different sites in a larger building. Furthermore, managers and professionals try to change

clients' behaviour, enhancing their independence and encouraging them to use their freedom of choice to live the life they prefer.

The cyclical nature of justification work

Justification work is highly cyclical, not a linear process leading to final outcomes. Even when compromises are solidified in objects and behaviour, they remain subject to adaptation. Managers and care workers are constantly re-crafting individual compromises when their effect turns out to be undesirable in the critical eyes of relevant others. As the following quotes make clear, a good alignment between the provision of small-scale care and the needs of clients is not a given:

> "Sometimes clients like to spend their time in a group [in a small-scale home] and want lots of support and other people around them. Then they really have to move against the current. We say (…) 'It's good that clients have lots of individual space, right? You need it, you'll get used to it'. But sometimes a client really doesn't want that." (Middle manager)

> "Some clients didn't become happier [in individual apartments] (…). In a small-scale home, everything was arranged for them. Now they have to do it for themselves. Making a cup of coffee, turning on the lights in the evening, when it gets dark. We had a client who sat in the dark at night if you didn't help him. He didn't take any initiative." (Middle manager)

Mitigating undesired effects of compromises by means of redrafting is part of the ongoing justification work. For example, in the case of loneliness in individual apartments, managers encourage clients to visit the communal rooms and participate in social activities, such as cooking together. Or managers prepare fixed daily schedules for clients to make sure they do not stay in their apartments all day. By doing so, managers try to guarantee that compromises do not become ends in themselves and contribute to a good alignment between different needs. This alignment does not only take client's wishes into account, but also the broader interests of the organization and society with regards to affordability and accessibility of care.

Conclusion and discussion

Using the justification framework of Boltanski and Thévenot (1991; 1999; 2000; 2006), we studied how Dutch healthcare managers used compromises to deal with conflicting values in the practice of small-scale care. The results demonstrate that public managers play a crucial role in establishing, maintaining and re-crafting justifiable compromises when faced with value conflicts. This study describes two compromises that represent different ideals of small-scale care: a civic/domestic compromise (clients living in a domestic household in the neighbourhood) and a market/industry compromise (clients living in a private apartment in a collective building). Because compromises are based on different justifications (civic, domestic, industry, market), they remain fragile and open to critique by clients, their relatives, professionals and neighbours. To deal with criticism and the emerging value conflicts, public managers have to perform continuous justification work, which includes rebuilding existing compromises, creating new compromises and justifying these to significant others.

Although several scholars recently acknowledged the importance of justification processes and compromises (Jagd 2011; Patriotta et al. 2011; Cloutier and Langley 2013), this study provides a more detailed conceptualization of justification work *in situ*. The analysis demonstrates that justification work is not only *rhetorical* (justifying compromises to others), but also involves the use and adaptation of *material* objects (buildings) and the remodelling of professional *behaviour* (working methods and schedules). Compromises can be solidified by inscribing them in material objects and behaviour, thereby achieving temporary stability in times of public sector change. As Ramirez' (2013) analysis of the accountancy sector demonstrates, when institutional change disrupts the underlying value systems of a professional sector "compromising and legitimising are all the more necessary" to realign conflicting values and restore a sense of worth in the professional community (Ramirez 2013: 846). In the healthcare sector, compromising may in fact become more of a necessity due to New Public Management reforms that apply business models and market logics to public service provision (Grit and Dolfsma 2002; Simonet 2008), thereby challenging professional and public values. Although previous research has shown that value conflicts can be avoided by creating separations or 'firewalls' (Jacobs 1994; Thacher and Rein 2004; Stewart 2006), it is questionable whether decoupling mechanisms are sustainable in the long run (Steenhuisen 2009; Haack, Schoeneborn and Wickert

2012; Sandholtz 2012). The empirical analysis suggests that public managers can use compromises as a more durable strategy to cope with value conflicts, which broadens the scope of the strategies described so far in the literature, such as cycling, firewalls and bias (Thacher and Rein 2004; Stewart 2006).

This study furthermore demonstrates that public managers are not cognitively bound to a cluster of like-minded, traditional management values, such as efficiency and effectiveness, but can engage with a plurality of values and justifications simultaneously (see also Patriotta et al. 2011). By incorporating multiple values into justifiable compromises, managers do not merely cope with value conflicts, but actively try to contribute to 'good' public service delivery. As the justification framework suggests, there is not just one good, but varieties of goodness that public managers need to take into account (Von Wright 1972; Boltanski and Thévenot 1999). Yet, managerial compromises do not have to lead to relativism ('anything goes'), as managerial actions are supported by justifiable arguments, materials and behaviour. This research contributes to previous studies that show that public and private values often share a common core (Van der Wal, De Graaf and Lasthuizen 2008) and need to be mixed in (semi-) public sectors, such as healthcare, social housing and waste management to provide good services (Brandsen, Van de Donk and Putters 2005; Helderman 2007; Putters 2009; Karré 2011).

Compromising as a managerial and political strategy (Padgett and Ansell 1993) can enable productive solutions to value conflicts and provide temporary stability, but it does have important limitations. A 'justifiable' compromise does not *necessarily* contribute to 'good' public service delivery. Particularly when rhetorically skilled managers and politicians can advantageously 'sell' compromises to audiences with different worth, there is a risk of continuous legitimacy struggles once compromises are criticized. These legitimacy struggles could lead to a gradual erosion or even complete lack of support for existing compromises. In that case, never-ending justification processes may do more harm than good, diverting attention away from the actual delivery of public services. Moreover, when public managers are unable to make compromises durable via solidification, the act of compromising is likely to yield only a temporal agreement to disagree (Cloutier and Langley 2013). While this loose agreement can permit necessary breathing space when actors are in conflict, it does not provide a structural basis for public service delivery and policy making.

The empirical analysis also shows an interesting distinction between the way public middle managers and executives deal with value conflicts. Compared to executives, middle managers seem to experience a broader range of value conflicts in the provision of small- scale care. They also seem to experience value conflicts more concretely. Without going into all possible explanations for this variation, these findings suggest that middle managers experience value conflicts in a very direct, relational sense vis-à-vis significant others. Their close ties to clients, client's relatives, professionals and neighbours constitute a web of morally "thick relations" (O'Kelly and Dubnick 2006; De Graaf 2011). Due to these thick relations, middle managers can easily be torn between their individual allegiances and the attainment of public goals. Yet, despite being torn, they have to decide and act. They do not have the option to avoid or postpone morally difficult choices, as opposed to actors with thinner relations. Consequently, the justification work required from middle managers may be more challenging than that of executives in the case of small-scale care.

A limitation of this study is that the analysis is primarily based on *managerial* justification work by middle managers and executives. Future studies could pay more attention to interactions between a wider variety of actors, including policy makers, inspectorates, professionals and clients. A multi-stakeholder approach could shed light on the reciprocal nature of justification work and the inner workings of legitimacy struggles that cut across different professional groups and organizational contexts (commercial businesses and public sector organizations). Such studies could also focus on justification work in other settings, such as large-scale hospitals.

While this study shows that justification work and managerial decision making are closely connected (managers generally do what they say), it is conceivable that in more political or hierarchical environments, justification work can turn into a cover up. Therefore, an in-depth investigation of justification work is necessary to explore the underlying reasons why actors choose to justify compromises in decision making processes as opposed to using other strategies (e.g. decoupling conflicting values). A related topic for future research could be the connection between compromises and 'good governance'. Relevant questions are for example: under what conditions do compromises lead to 'good' governance and when does it lead to 'bad' governance, (e.g. monstrous hybrids, Jacobs 1994)? Are these conditions different in public and private sectors? And how do deductive definitions of good governance (e.g. in guidelines and codes, see Aguilera

and Cuervo-Cazurra 2004) reconcile with the inductive interpretations of good governance that are developed bottom-up in daily practices? A last fruitful direction for future research lies in the combined use of theories on justification and institutions. As Cloutier and Langley (2013) point out, institutional theory has several blind spots, such as a lack of attention for micro-processes and the active role of agents in establishing agreements, which could be remedied by applying a justification framework. The conceptualization of justification work on the basis of rhetoric, behaviour and objects, as developed in this chapter, can be used to gain an in-depth understanding of shifting institutional logics and the way micro-level compromises contribute to macro-level shifts.

Finally, there are some practical implications and recommendations for future studies. Justification work is 'emerging work' *in situ*, that is, based on discretionary decision making in managerial practices and a "situated sense of the just" (Boltanski and Thévenot 2000: 216). Given its emerging nature, top-down standardization and one-dimensional performance formats may inhibit the establishment of productive compromises. For that reason, policy makers should allow public managers sufficient discretionary space to negotiate, establish and re-craft compromises in daily practices. When performing justification work, it is important that public managers not only look for vertical legitimisation from their superiors and inspectorates, but also seek horizontal legitimisation from clients, professionals and other service organization in their environment.

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Appendix: Details of interviews and observations

Interviews with middle managers			Interviews with executives	
Gender	**Interview length**	**Organization**	**Gender**	**Interview length**
Female	1h 16m	A	Male	1h 22m
Female	1h 59m	A	Male	53m
Female	1h 1m	A	Male	56m
Female	1h 4m	A	Male	1h 16m
Female	1h 39m	A	Male	1h 13m
Female	1h 10m	A	Male	1h 35m
Male	1h 28m	B	Female	1h 9m
Female	1h 24m	B	Male	1h 2m
Female	1h 43m	C	Female	36m
Female	1h 24m	C	Male	52m
Female	1h 48m	C	Male	1h 1m
Female	2h 9m	C	Male	1h 17m
Male	51m	D	Male	1h 1m
Female	52m	D		
Male	1h 8m	E		
Female	2h 4m	F		

Location of observations	Activities
Small-scale homes and organizational offices	Observations of team meetings with care workers, client meetings; meetings with clients' relatives
Small-scale homes	Participation in daily activities of clients (e.g. drinking coffee and having dinner)
Headquarters of the organization	Observations of meetings with fellow middle managers; meetings with architects (to develop new living facilities)
Offices of middle managers	Observations of telephone calls and informal talks with colleagues and care workers
Cars of middle managers	Traveling to clients' homes

CHAPTER 6

Organized professionalism in healthcare: Articulation work of nurses on the neighbourhood scale

Chapter based on:

Postma, J., Oldenhof, L. and Putters, K. (2015). Organized Professionalism in Healthcare: Articulation Work by Neighbourhood Nurses. *Journal of Professions and Organization,* 2(1): 61-77.

Abstract

Organizational and professional logics are often viewed as intrinsically conflicting. Organizational influences either encroach on professional work or professionals resist change and evade organizational rules. Increasingly however, this dualistic view is supplemented with the perspective of organized professionalism, which focuses on the negotiated and reciprocal relationship between organizational and professional logics. In this perspective, professionals increasingly engage in new organizational issues and incorporate those into their professional work. We build on these insights, but take the debate on organized professionalism one step further. Using the sociological concept of articulation work, we show that organizational tasks are not always 'new', but can be inherent to professionalism. In a study of Dutch neighbourhood nurses (NNs), we find three types of articulation work: intraprofessional, interprofessional and lay articulation work. NNs perform articulation work to provide and organize care at the same time. On the scale of the neighbourhood, they integrate taylorized home care services, coordinate the work of different professionals and stimulate informal care. We conclude that articulation work traditionally lies at the heart of professionalism, but is not static and acquires new meaning because of changing organizational conditions and policy reforms.

Introduction

> "Home care has become an impersonal, ice-cold form of service delivery. If you need care, you should not be surprised to see three different care workers at your bedside on a single morning: a health assistant washes you, a nurse administers an injection and a home help prepares your breakfast. Home care is provided with a stopwatch in hand: one minute for putting on compression stockings, two minutes for applying a bandage." (Editor of Dutch newspaper Telegraaf, 14 February 2004)

The above quote exemplifies unease in society about the organization of home care. Not only newspaper editors, but also professionals, managers and politicians argue that division of labour, treatment of healthcare professionals as 'production workers' and the rise of a powerful management caste has led to fragmentation and deprofessionalization of care (Tonkens 2003; De Blok and Pool 2010; Van Dalen 2012). In this chapter, we however show the possibility of reprofessionalization and integration of fragmented public services. We do so by studying a case of organized professionalism in which neighbourhood nurses (NNs) perform articulation work. By performing articulation work, they undo 'tayloristic' notions of labour division and managerial control that were introduced in public service provision in the last decades (Pollitt 1990; Bolton 2004). These notions originate from the work of engineer Frederick Winslow Taylor more than 100 years ago. Taylorization entails the replacement of professional judgment and personal experience by science-like rules, managerial planning and division of labour:

> "The development of a science (…) involves the establishment of many rules, laws, formulae which replace the judgement of the individual workman and which can be effectively used only after having been systematically recorded, indexed etc. (…). Thus all the planning which under the old system was done by the workman, as a result of his personal experience, must of necessity under the new system be done by the management in accordance with the laws of science (…). The man in the planning room, whose speciality under scientific management is planning ahead, invariably finds that the work can be done better and more economically by a subdivision of labour." (Taylor 1911, reprint 1997: 16)

Unrest about managerial dominance and taylorization of professional work is not merely a Dutch phenomenon (Pollitt 1990; Bolton 2004), but mirrors an international debate about professional and organizational logics. In this debate, the two logics are depicted as intrinsically conflicting (Muzio and Kirkpatrick 2011; Noordegraaf 2011). On the one hand, increased organizational control is said to infringe on the professional domain. Under pressure of production targets, quality indicators and increased regulation and standardization, professionals reluctantly give in to managerial power, supposedly leading to 'deprofessionalization' and 'proletarization' (Gleeson and Knights 2006; Noordegraaf 2007; Evetts 2011; Muzio and Kirkpatrick 2011). On the other hand, autonomous professions are frequently depicted as resistant to change and difficult to control, both by markets and organizations. Professionals fight back organizational pressure by means of specialization, protection of jurisdictions and conservation of occupational values (Evetts 2011; Muzio and Kirkpatrick 2011). Hence, organizations and professions are framed in this literature as opposing logics. The interplay of these logics is seen as a zero-sum game: an increase in the one, leads to a decrease in the other.

A recent stream of research on 'organized professionalism' (Evetts 2009; Muzio and Kirkpatrick 2011; Noordegraaf 2011) challenges this dualism. This research shows that organizational and professional logics are increasingly intertwining in work practices where professionals have to respond to new expectations of public service delivery from clients, organizations and the state (e.g. Cohen et al. 2002; Gleeson and Knights 2006; Noordegraaf 2007; 2011; Evetts 2009; 2011 ,Waring and Currie 2009). As Noordegraaf (2011: 1358) argues, "increasingly, organizing and managing must be seen as professional issues". Tasks such as quality management, cross-sector coordination and risk evaluation are not only managerial or organizational, but also part and parcel of professional work (Noordegraaf 2011). In this view, professional and organizational logics coexist in practice (Faulconbridge and Muzio 2008) and in fact should be mixed in order to deliver high-quality public services (Noordegraaf 2011). Despite increasing attention for the entanglement of logics, our knowledge of the changing relationship between organizations and professions still remains rather limited (Muzio and Kirkpatrick 2011). Especially, the question how and to what extent professional work is getting more or less organizational remains unaddressed.

In this chapter, we contribute to the literature on organized professionalism by showing that 'organizational' tasks, like coordinating and planning, do not

necessarily come on top of professional work but can be an intrinsic part of professionalism. We do so by using the concept of articulation work, developed by Strauss and colleagues (1985, reprint 1997). Articulation work can be described as a 'supra type of work' that connects and integrates tasks, responsibilities and types of work, thereby establishing a 'total arc of work' (Strauss et al. 1985; Eschenfelder 2003; Hampson and Junor 2005). Importantly, articulation work questions the dichotomy between organizational and professional logics that is still (implicitly) present in organized professionalism literature and provides an alternative perspective on how the organization and the delivery of public services are intertwined in daily practices.

We use the concept of articulation work to study a new initiative in Dutch home care, called the 'Visible link' (in Dutch: 'Zichtbare schakel'), that reintroduces NNs after they were gradually organized out of home care during the last decades. The initiative aims to stimulate both professional autonomy of NNs and to enhance the integration of different services (e.g. care, welfare and housing) on the neighbourhood scale. NNs are viewed as an alternative to the current taylorized organization of home care: they are responsible for providing a broad range of services themselves as well as organizing and coordinating services that are delivered by other professionals. Our research addresses the following question: *How do Dutch NNs engage in articulation work and what are the consequences for the delivery and organization of home care?* The empirical analysis is based on semi-structured interviews with 35 NNs, resulting in 84 detailed client reports. By studying the articulation work of NNs in the setting of Dutch home care, we aim to offer new insights into 'organizational work' that is inherent to professionalism and thereby contribute to the academic debate about professions and organizations.

Organized professionalism

Theories that portray organizational and professional logics as separate and conflicting forces are increasingly criticized (e.g. Cohen et al. 2002; Gleeson and Knights 2006; Noordegraaf 2007; 2011; Evetts 2009; 2011; Waring and Currie 2009). A first critique is that these theories overstate the analytical distinction between pure 'professional' and 'organizational' logics, thereby foregrounding differences and conflicts and backgrounding common ground, interaction and

hybridization processes. As Noordegraaf (2007) points out, professional groups, market actors and the state have historically influenced each other; professionals have never been 'free' from outside logics. A second criticism relates to the claim that professional and organizational logics are intrinsically conflicting. Authors have recently countered this assumption by empirically showing that the way professional and organizational logics coexist in practice is the result of daily negotiations and interactions between managers, professionals and clients as well as organizational procedures and macro policies. The outcome of these negotiations can differ from conflicts and clashes to hybridization and compromises (Wallenburg et al. 2012; Oldenhof, Postma and Putters 2014).

Building on these criticisms, less dualistic views on professional and organizational logics have been developed, which are grouped under the overarching term of 'organized professionalism' (Evetts 2009; Muzio and Kirkpatrick 2011; Noordegraaf 2011). Broadly defined, organized professionalism denotes the mediation and hybridization between organizational and professional logics in daily work practices. Organized professionalism assumes that the relationship between organizations and professions is dynamic, negotiated and reciprocal in nature rather than pre-determined and fixed (Cohen et al. 2002; Noordegraaf 2011). Although authors in this body of literature still assume that professional and organizational logics are analytically distinct, they no longer expect logics to exist in their pure form and a priori lead to conflict. To underline the interdependency of professional and organizational logics, authors describe forms of 'entanglement' and 'hybridization' (e.g. Noordegraaf 2011; Wallenburg et al. 2012). However, the debate on organized professionalism sometimes becomes fuzzy because authors (implicitly) use different interpretations of the term. Before discussing our contribution to this literature, we therefore provide a short overview of the current debate. On the basis of existing studies, we identify three main interpretations of organized professionalism: (1) organizations as sites for professional development, (2) organizational influences on professional work and (3) new organizational roles for professionals.

First, several authors interpret organized professionalism in terms of organizational sites that facilitate professionalization (Muzio and Kirkpatrick 2011). Professionals increasingly work in large-scale, global organizations that play an important role in the professionalization of workers, for example by providing educational courses and infrastructure that aid further specialization (Faulconbridge and Muzio 2008; Evetts 2011; Muzio and Kirkpatrick 2011; Oldenhof,

Stoopendaal and Putters 2013). As a result, employing organizations (Evetts 2011) and managers (Oldenhof, Stoopendaal and Putters 2013) have become key actors in the development of professions in addition to states and universities.

Second, organized professionalism can refer to organizational influences that change the nature of professional work. Societal trends such as increasing specialization and work division, technological advancement, changing working conditions and the rise of multi-problem cases, call for new forms of organization, coordination and integration of professional services (Noordegraaf 2007; 2011; Evetts 2011). Moreover, trends like outsourcing, privatization and commercialization urge professionals to rethink their work and develop 'organizational' responses to deal with more competitive environments (Gleeson and Knights 2006; Waring and Currie 2009; Evetts 2011; Waring and Bishop 2013). For example, Waring and Bishop's (2013) study of private providers of public healthcare in the UK, illustrates how global bureaucratic reforms and market logics transform the organization of medical work, leading to more rationalized and standardized medical practices, which they dub as 'McMedicine'. Medical expertise is still important, but is increasingly aligned with organizational and commercial needs (Waring and Bishop 2013). Doctors can adopt different strategies to cope with organizational influences. They can acquiesce or resist organizational changes, but also mediate, co-opt and co-create organizational reforms (Waring and Currie 2009). Gleeson and Knights (2006) call the latter strategies 'creative mediation', which can be viewed as an alternative to top-down compliance or bottom-up resistance to organizational reforms (Waring and Currie 2009).

Third, organized professionalism can be understood in terms of new organizational roles that professionals adopt to deal with societal and organizational influences such as outlined above. This stream of literature does not focus on the mediation of outside pressures in professional work, but on the tasks and responsibilities that come 'on top' of their work. For example in healthcare, doctors are increasingly becoming 'organized professionals' who combine their medical work with new organizational responsibilities such as the implementation of management appraisal instruments and information systems (Waring and Currie 2009; Witman et al. 2011).

The above forms of organized professionalism all describe the changing relation between organizations and professions. What conclusions can be drawn from this? First, studies on organized professionalism show that organizations can no

longer be ignored in the study of professionals "if we accept the fundamentally dialectic and negotiated nature of this relationship [between organizations and professions] at the micro-level" (Cohen et al. 2002: 8). Second, professionals are not necessarily victims of managerial pressure or rebels against organizational control, but actively reconfigure their professional work and reshape organizational policies. As a result, professional and organizational logics coexist in work floor practices. Third, despite the identification of creative mediation strategies, studies on organized professionalism still assume that organizational and professional logics do not necessarily merge or integrate but remain analytically distinct. Both logics encompass different worlds, values and repertoires. As a result, in the current debate on organized professionalism, much emphasis is put on 'new' organizational roles and organizational work that comes 'on top of' professional work. The possibility that professionals may not perceive 'organizational tasks', such as coordinating and planning, as a separate organizational logic but as an inherent part of their work, is left relatively unexplored.

By introducing the concept of 'articulation work' (Strauss et al. 1985) in the following section, we aim to take the debate on organized professionalism one step forward by going one step backward: what organizing work is an intrinsic part of professional work? We use articulation work to provide a better understanding of 'classic' organizing work that is performed by professionals. At the same time, we investigate how classic organizing acquires new meaning in response to changes in policies, organizational strategies and societal trends. We show how certain elements of professional articulation work stay the same, while other elements change in reaction to outside pressures. We thereby contribute to the second stream of literature on organized professionalism that we identified before.

Articulation work

The concept of articulation work was originally developed by sociologists Strauss, Fagerhausen, Suczek and Wiener, who were interested in the organization of medical work. They conducted extensive observations in American hospitals to study the work involved in treating dying patients (Strauss et al. 1985). An important finding of their ethnographic study was that there are different types of work that actors combine to provide good patient care: machine work (the

use of technical equipment), comfort work (relieving patients from physical discomforts), sentimental work (supporting patients in coping with anxiety and depression), safety work (reducing medical risks that endanger patients' health) and articulation work (coordination and integration). In this chapter, we focus on articulation work to investigate how professionals engage in coordination and integration as part of their professional work.

Over the course of a disease, or the so-called 'illness trajectory' (Strauss et al. 1985), healthcare professionals not only have to deal with the physiological unfolding of the disease itself, but also with the organization of work. Strauss et al. (1985) coined the term articulation work to refer to this 'supra-type of work'. Articulation work occurs in any situation where labour is divided and in some way needs to be integrated or coordinated. It involves "the meshing of (1) numerous tasks and, clusters of tasks and segments of the total arc, (2) the meshing of efforts of various unit-workers (individuals, departments, etc.), (3) the meshing of actors with their various types of work and implicated tasks" (Strauss 1985: 8). As a result of articulation work, the 'total arc of work' can be maintained. The arc of work constitutes all the work that is necessary to deliver and organize professional services. Articulation work reduces fragmentation and contributes to a proper flow of work (Strauss 1988). An example of articulation work can be found in the daily work of hospital nurses. When a patient refuses treatment or wants to go home despite deteriorating conditions, nurses have to make articulations to avoid that the medical trajectory gets fragmented, or in other words, gets 'disarticulated'. They alert doctors and other nurses or organize a multidisciplinary team meeting about the patient's new situation, thereby making articulations between medical disciplines. At the same time, they make articulations between tasks by reassuring and convincing the patient to stay in the hospital (emotion work), while performing other types of care work, e.g. machine and safety work.

The example of hospital nursing shows that activities like planning, organizing and coordinating are not necessarily extra organizational tasks on top of professional work or stem from a separate organizational logic, but can be at the heart of professional work. The concept of articulation work therefore allows us to go beyond the dichotomy between organizational and professional logics that is still — implicitly — assumed in studies about organized professionalism. Furthermore, Straus et al. (1985) show the possibility of professionals operating on a continuum from articulation to disarticulation. Depending on their work

environment, they may be enabled or inhibited in making articulations. For example, disarticulation can occur in taylorized and standardized work settings in which specialized professionals are assigned separate tasks and need to make production on tight time schedules. In these organizational settings, professionals may not have the opportunity to articulate and integrate different types of work (Hampson and Junor 2005).

Several authors stress that articulation work is more than "mere coordination" (Hampson and Junor 2005: 167) or "cooperative work" (Schmidt and Simone 1996: 158). Articulation work reduces the distributed and specialized nature of work by integrating and meshing different types of professional work (e.g. emotion, safety, machine and comfort work), professional disciplines (medical or otherwise), resources (e.g. finances, personnel, time) and work arrangements (e.g. multidisciplinary team meetings or interdepartmental projects) (Strauss 1988; Schmidt and Simone 1996). Integration and meshing can be attained via formal planning and scheduling, but also requires implicit and intangible efforts, such as the bringing together of social worlds (Gerson and Star 1986; Hampson and Junor 2005). The latter is necessary as increasing professionalization and specialization lead to a multitude of occupational communities and specialties, resulting in different ideas about what constitutes good work. When different social worlds intersect, they can either mix harmoniously or create tensions (Strauss 1985). Managing these tensions is an important part of articulation work (Strauss 1985; Hampson and Junor 2005).

The concept of articulation work is not just applicable to work in hospitals. Several authors have investigated articulation work in other settings, like informal care giving at home (Corbin and Strauss 1993; Timmermans and Freidin 2007), social care (Allen, Griffiths and Lyne 2004), customer service work in call centres (Hampson and Junor 2005), traffic control at airports (Suchman 1996) and computer system design and maintenance (Grinter 1996; Schmidt and Simone 1996; Berg 1999; Schmidt 1999; Star and Strauss 1999; Ferreira, Sharp and Robinson 2011). These studies show that articulation work often remains in the background and is seldom part of standard job descriptions (Suchman 1996). Timmermans and Freidin (2007: 1351) remark that articulation work usually is done by "invisible armies of nameless secretaries, support staff, technicians, administrative and other help, editors, and other backstage workers". In a similar vein, Hampson and Junor (2005: 178) note that articulation work involves "invisible skills". Although it is generally thought that call centre agents perform com-

pletely standardized work, they frequently have to depart from standard scripts and need to skilfully deal with competing values of customer responsiveness and business efficiency. This work is not expressed in job descriptions and invisible to managers and others in the outside world. Articulation work is thus more likely than other types of work to be made invisible, even though it is crucially important for the smooth operation of organizations.

To our knowledge, the concept of articulation work has not been used in the current debate on organized professionalism. Yet, we feel that the theoretical implications of articulation work, combined with an empirical investigation of articulation work on the neighbourhood scale, could contribute to this debate. The concept allows us to explore how professionals engage in organizing as an intrinsic part of their work. By empirically investigating articulation work of NNs in Dutch home care, we examine both articulations and disarticulations in public service delivery. Our study contributes to the literature on articulation work by investigating articulation work in an interorganizational neighbourhood setting where service providers in care, welfare and housing collaborate. Articulation work on this scale may have its own dynamics compared to articulation work that so far has been researched within the boundaries of one organization (e.g. one hospital, call centre, or airport).

Home care in the Netherlands: Articulation and disarticulation

This study about articulation work is situated on the neighbourhood scale. We focus on the work of NNs who participate in a project called 'the Visible link'. In this project, NNs have a large degree of autonomy to perform activities they deem necessary to achieve the goals of the project: improving the coherence ('the link') between housing, healthcare and social services on the neighbourhood scale; increasing accessibility of services for citizens; matching supply of services with demand; and increasing the autonomy and quality of life of vulnerable citizens (ZonMw 2009). Moreover, NNs are free to find and select citizens that need their support the most, thereby determining who are eligible for the project. Local project leaders were appointed to facilitate the NNs in their work, like providing office spaces and organizing meetings. In the following, we provide a short overview of the history of Dutch home care, including the introduction of

the Visible link project. We illustrate how the work of NNs provides a suitable case to study articulation and disarticulation of professional work.

Until the 1970s, home care in the Netherlands was provided by local, private non-profit associations with different denominations: Roman Catholic, protestant and general. During the 1970s, these organizations merged into the National Cross Association, resulting in one organization providing home care (Van der Zee et al. 1994). NNs were employed by the National Cross Association and together with general practitioners (GPs) were responsible for organizing public healthcare within a municipality or a neighbourhood. Nursing work included a variety of activities: health education (e.g. in schools), preventive health home visits to citizens with potential problems, supporting informal care and stimulating self-care, domestic activities in clients' homes (e.g. preparing food and drinks), providing psychosocial care, hygienic care and technical nursing care (e.g. dressing wounds, preventing decubitus, applying catheters and administering injections), coordinating care and administrative activities (Van der Zee et al. 1994). Due to task variety and a large degree of autonomy, nurses were able to make articulations between types of work (e.g. medical, education, self-care) and actors (e.g. GPs, schools, client's family). The work of the Dutch NN in this period resembles the work of the 'community nurse' (e.g. Chalmers and Bramadat 1996) or the 'district nurse' (e.g. McGarry 2003) in other Western countries.

Between the 1980s and 2000s, home care was reformed in response to various developments: an ageing population, technological changes that enabled the provision of complex care at home, the need for cost-effective use of resources, the urgency to reduce waiting lists and a call for better quality of care and more freedom of choice for clients (Jansen et al. 1996a; Meurs and Van der Grinten 2005). Policy reforms introduced business-like incentives and competition in home care (Dekker 2004; Helderman et al. 2005). The reimbursement system changed from budget- and input-financing to product- and output-financing (Jansen et al. 1996a), introducing incentives for home care organizations to increase production in order to collect more revenues. Furthermore, legislative changes allowed for new home care organizations to enter 'the market'. In most neighbourhoods, patients could now choose between several home care organizations. In order to achieve economies of scale and strengthen their market position, local home care organizations started to merge with other home care

organizations (Noordegraaf, Meurs and Stoopendaal 2005; De Blok and Pool 2010).

Building on these market-oriented reforms, home care organizations restructured the work of NNs along tayloristic principles of work division and specialization in order to increase efficiency and quality (Jansen et al. 1996a, b, 1997; De Blok and Pool 2010). It was believed that the different elements of nursing work had to be "carried out by the most appropriate nurse in the most appropriate way" (Jansen et al. 1997: 220). Consequently, nursing work was being 'disarticulated' by subdividing tasks, the so-called 'products'. These products were to be executed by different care workers, depending on required professional capabilities. NNs became involved in assessment, diagnostics and care in unstructured situations, including the arrangement of care prior to hospital admission and after discharge. They also increasingly specialized in certain types of care (e.g. in diabetes, dementia, or incontinence). Second-level auxiliary nurses concerned themselves with personal hygiene of clients and well-defined, uncomplicated technical nursing activities. Health assistants focused on problems in housekeeping and supported clients in case informal caregivers could no longer provide necessary care. Finally, home helps were introduced to deliver domestic services, especially cleaning (Jansen et al. 1997; De Blok and Pool 2010).

During the 2000s, public discontent arose about the tayloristic organization and provision of home care. Patients, especially those with multiple conditions, complained about the fragmentation of care: for every task, a new care worker was assigned, resulting in a multitude of professionals going in and out of clients' homes. Coordination was lacking as professionals were primarily responsible for their own work. Furthermore, professionals complained that new layers of management introduced undesirable commercialization of home care, restricted their autonomy and continued to narrow the scope of their work to specific medical–technical interventions and coaching of other care workers (Tonkens 2003; De Blok and Pool 2010; Van Dalen 2012). Tasks such as brokerage, contracting, budget-holding, service development, assessment and care planning now belonged exclusively to the domain of care managers. As such, almost all articulation work was organized out of the work of the NN and transferred to managers and central planning departments.

In response to increasing societal concerns about home care, Dutch parliament accepted a motion in 2008 that called for more integrated home care and reinforcement of the position of the NN on the neighbourhood scale, i.e. more

autonomy and a broader range of responsibilities. The motion adopted by the Dutch Ministers of Health and Internal Affairs. They asked the Netherlands Organization for Health Research and Development (ZonMw) to set up the Visible link project. After two years, there were 95 projects in 50 municipalities nationwide, especially in the so-called 'vulnerable neighbourhoods', comprising between 300 and 350 NNs (ZonMw 2011).

The work of NNs in the Visible link project provides an interesting case to study articulation work. Until the 1980s, articulation work was an integral part of neighbourhood nursing. During the 1980s and 1990s, a major part of articulation work was organized out of the work of NNs. In the Visible link project, NNs are given new opportunities to perform articulation work against the backdrop of a taylorized home care system. This fragmented public service environment, combined with increasing budget cuts and the need for informal care, differs notably from the environment in previous decades and provides new organizing challenges. It is still unknown how articulation work in this changed context takes shape and what the consequences are for clients, other professionals and organizations in neighbourhoods.

Methodology: Interviews with neighbourhood nurses

On the basis of interviews with NNs, we analyse how they perform articulation work and thereby enact organized professionalism. The NNs were part of the Visible link project. In September 2011, the Netherlands Organization for Health Research and Development (ZonMw) requested BMC — a Dutch research and consultancy firm — to perform a 'social cost-benefit analysis' of the Visible link project (for the report, see Van der Meer and Postma 2012). The researchers from BMC had no prior involvement in the project. In this chapter, we use data that were initially gathered for the cost-benefit analysis, in which one of the authors was involved, for an analysis of articulation work. At the start of the analysis, the researchers selected projects in 13 municipalities. The selection was based on the size of the projects in terms of budget and the geographical dispersion of the projects over the Netherlands, making the sample representative for the Visible link project (Van der Meer and Postma 2012). The sample included the four largest projects in major Dutch cities (Rotterdam, Amsterdam, Utrecht and The Hague), five medium-sized projects and five small projects. The researchers then

randomly selected NNs from each project, leading to a total of 35 respondents. A team of two researchers conducted semi-structured interviews with the nurses about clients in the project. The researchers selected clients randomly from digital registration systems in which NNs register their clients. In the large projects, 5-17 clients were discussed; in the small- and medium-sized projects five clients were discussed. A discussion about a client lasted approximately 45 min. In total, the researchers included 84 clients in the study.

The aim of the interviews was to gain insight in the daily work of NNs. During the interviews, each client was discussed along four main questions: (1) Could you describe the (problems of the) client and his or her social, economic and health status?; (2) What activities did you undertake in this situation?; (3) What do you see as the result of these actions?; and (4) What do you think would have happened to the client if there would not have been an intervention by you? With regard to the fourth question, the NNs were asked to describe the hypothetical situation in which there would not have been a Visible link project and the client would have received care from regular service providers or would not have received care at all. Notably, the majority of NNs in the Visible link project also work part time as a nurse in regular home care organizations, so they were expected to come up with reliable judgements about the hypothetical situation.

During the interviews, the two researchers took notes separately. After the interviews, they also wrote reports separately and subsequently discussed and combined the reports. They then sent the reports to the NNs themselves, other professionals that were involved in the case(s) and an independent group of experts that did not know the NNs and clients, including a GP, a social worker and two geriatricians. The other involved professionals provided first-hand feedback on the clients and the outcomes of the actions of the NNs. Based on their experience with similar clients, the group of experts assessed whether the judgements of the NNs with regard to the hypothetical situation (what would have happened without an intervention from the NN?) was reliable. The peer checks improved the validity of the reports, which was necessary because NNs may have been inclined to emphasize their own accomplishments and paint a negative picture of the hypothetical situation (i.e. services from regular providers or no aid at all). The peer checks resulted in some minor corrections in the reports, sometimes leading to more positive and other times to more negative outcomes. These minor corrections indicate that the NNs were fairly accurate in their assessment of cases. Table 1 shows a typical report.

Table 1. Typical report of a client of a neighbourhood nurse

Client description		83 year old woman; lives alone; has two sons and a daughter. The client's daughter takes care of the paper work and performs minor household tasks. The general practitioner (GP) and the daughter notice memory loss of the client: the client often forgets to take her medication and gets lost when she goes somewhere by car. The GP and the daughter sign the client up for a dementia test at a mental care organization. The client does not want to be 'nurtured' and cancels the test. The GP and the daughter are worried and do not know what to do next. Especially the daughter has difficulties in dealing with the situation.
First contact	**Real**	The GP calls the neighbourhood nurse (NN).
	Hypothetical	The GP would have called a regular home care organization.
Activities	**Real**	NN wants to bring in a health assistant to support the client in taking her medication, but the client refuses. NN also tries to convince the client to go to the mental care organization for the test, but she refuses this as well. After a meeting between the GP, the daughter and NN, they decide to replace part of the medication with another type that NN can administer periodically through a syringe. Together they also decide that the daughter will support the client in taking in the other medication. NN talks to the daughter several times. She supports her and gives her tips on how to deal with her mother. As a consequence, the daughter does not need to contact the GP any more. NN stimulates the daughter to call on her two brothers to also take part in caring for their mother. Finally, NN arranges with the daughter that NN will continue to visit the client every month to keep an eye on the situation.
	Hypothetical	A nurse from a regular home care organization would perform an intake with the client. The client would not accept care after which the nurse would conclude that the client does not want and need home care services. There would be no further actions.
Results	**Real**	The client gets the medication that she needs.
		The GP has to invest less time in talking to the client and her daughter than before.
		The daughter feels supported and can handle the situation better.
		NN has diagnosed the client and can bring in additional care quickly if the situation deteriorates.
	Hypothetical	The client runs (minor) health risks because she would not, or only partly, get the medication she needs.
		The GP would have to invest more time in talking to the client and her daughter.
		Additional home care could not be brought in quickly in an emergency situation because regular healthcare organizations would have to diagnose the situation first.
		There is a chance that after some time the daughter would be burdened too heavily and not be able to support her mother any more. Additional professional services would have to be brought in or the client would have to be admitted in a nursing home.

The interviews provided rich data on the daily work of NNs. NNs described in detail the background of their clients, the activities they perform and the perceived results. The answer to the fourth question (what do you think would have happened to the client if you would not have intervened?) illustrates how NNs compare their own work to that of other professionals in healthcare and social services. This allows us to contrast the perception of professional work that is narrowly defined under the influence of taylorization with professional work that includes a broader range of articulation work.

An empirical analysis of articulation work contributes to a better understanding of organized professionalism. In order to explore in depth the articulation work that NNs perform, we analysed the differences between the work of NNs in the Visible link project and their perception of the hypothetical situation. As a first analytical step, we read back each report and compared the real and hypothetical situation. We noted that NNs spend much more time with clients, their relatives and other professionals (e.g. GPs, youth care workers and employees of housing associations) than they would have done in their capacity as nurse at a regular home care organization. This is not surprising since the Visible link project enables NNs to independently decide what type of support is most needed for clients and how much time is invested in providing this support. NNs thus are not constrained by the taylorized financial system in regular home care that is based on fixed products. As a second analytical step, we closely investigated reports to find out how NNs use this 'extra' time. During this second step, we used the concept of articulation work from Strauss et al. (1985) as a sensitizing concept to interpret data theoretically while still keeping an open mind to new, emerging types of articulation work in the neighbourhood setting.

First, we looked at articulation work that Strauss (1985: 8) calls "the meshing of numerous tasks, clusters of tasks, and segments". In the interviews, NNs indicated that they perform and combine a wider variety of tasks than professionals at regular home care organizations. They are not only involved in specialized medical treatments, but also perform 'easier' tasks like washing and administering medication. Furthermore, NNs combine, extend, or shorten the execution of tasks in order to establish a 'total arc of work'. They do not feel obliged to fit their work in predefined time slots, as professionals in regular home care organizations are required to do. We call the integration of tasks in one professional domain 'intraprofessional articulation work'. Second, we looked at the meshing of 'efforts of various unit-workers (individuals, departments, etc.)' and "actors with their

various types of work and implicated tasks" (Strauss 1985: 8). In our analysis, we noticed that NNs meet up and talk on the phone with other professionals in order to coordinate care and support between service providers, ranging from GP's and hospitals to elderly care institutions. In the regular home care system, they are hardly allowed to do this because this activity cannot be captured in a 'product'. We labelled these activities as 'interprofessional articulation work'. Finally, we found that NNs regularly engage with clients and relatives in order to stimulate self-management of clients and active involvement of the social network. We identified these activities as 'lay articulation work'.

Three types of articulation work

In our analysis, we identified three types or articulation work that is performed on the neighbourhood scale: intraprofessional, interprofessional and lay articulation work. Intraprofessional articulation work comprises alignments of tasks that NNs individually perform when dealing with clients. Interprofessional articulation work entails the work of a NN that is aimed at improving cooperation and coordination between professionals from different organizations and sectors. Lay articulation work refers to the efforts of the NN to organize and stimulate informal care and self-management. According to NNs, the three types of articulation work distinguish the work in the Visible link project from the work of regular home care workers. It should be noted that the three types of articulation work vary between NNs. For example, some NNs invest more time involving relatives in the support of clients than others. Despite these individual differences, all NNs engage in the three types of articulation work during their daily activities. Jointly, these types of articulation work form an important basis of their professionalism. In our analysis, we also pay attention to the tensions and dilemmas that come with articulation work. Articulation work is not always a smooth process because it entails conflicting perspectives, interests and values.

Intraprofessional articulation work

Our analysis of the reports shows that the daily work of NNs varies widely: from health education and preventive home visits to psychosocial care and medical–technical interventions. NNs perform articulation work in order to align those tasks to each client's specific needs. They do so from the first moment they get

into contact with a client and set a diagnosis. Setting a diagnosis can be quite complicated because nurses encounter clients with complex, multiple problems who distrust professionals and try to avoid professional care. Usually, clients of NNs have a long history of social, physical and mental problems, including long-term unemployment, addictions to drugs and alcohol, physical and mental disabilities, problematic family situations, psychoses, anxiety disorders and paranoia. These clients have little family or friends to fall back on.

In order to get insight into clients' needs and convince them to accept help, NNs use unconventional approaches and invest a significant amount of time 'just talking' to gain clients' trust. By phoning up clients, visiting them at their homes — multiple times if necessary — or contacting clients indirectly via others — like neighbours or a GP — NNs try to build a relationship with clients and convince them to accept care. During home visits, the NN assesses a client's needs and tries to provide care without evoking resistance. In this process, they perform articulation work by mixing, extending, or sometimes shortening tasks that cannot always by captured in separate 'products', as is shown in a case of an 80-year-old couple that displays signs of dementia:

> NN visits the couple. The conversation is difficult and the atmosphere is grim. The man is verbally aggressive when NN asks the couple questions about their well-being. NN ends the conversation and comes back a week later. After that, NN visits the couple once a week to administer medication through a syringe to the woman and to stay in touch with the couple. Slowly the relation between NN and the couple improves. NN notices that the woman takes too much pain medication because she forgets she already has taken a dose. This causes abdominal pain. NN arranges another system for administering medication to make sure the woman does not use too much of it. NN checks the use of medication weekly and asks the GP to subscribe additional medication for the abdominal pain.

The example shows how a NN articulates different aspects of her work, including talking to clients and gaining trust, adjusting the medication system and monitoring the situation, in order to prevent the illness trajectory to go off track. In other cases, NNs take time to talk to clients and gradually start to assist them

with washing, while simultaneously convincing clients to accept other forms of home support.

Although intraprofessional articulation work encompasses various tasks, some things are left out. Our analysis of the reports shows that NNs in the Visible link project are not involved in making financial decisions about the allocation of scarce resources, such as personnel and client budgets. NNs can determine who receives support and what type of support is provided without concern for budget. They are not being held accountable for the effectiveness and efficiency of their choices. Financial decisions regarding the Visible link project are made on a macro level by the Ministers of Health and Internal Affairs and thereby are kept out of articulation work of NNs.

Interprofessional articulation work

Although NNs deliver care themselves, they often enlist formal services from regular service organizations after some time. They introduce professionals from regular service organizations to clients, subsequently deliver care together and after some time delegate care to regular professionals altogether. By doing so, they try to make the client 'fit' (again) in the regular public service system, giving themselves time to focus on the next difficult case in the neighbourhood. NNs not only bring in professionals from other organizations, they also coach other professionals — especially lower educated auxiliary nurses, health assistants and home helps — and coordinate different services that clients receive. Coordination encompasses 'new' professionals who are brought in and 'old' professionals that were already engaged in service provision. Interprofessional articulation work thereby entails the coordination of different professionals that are involved with a client. Exemplary is a case where professionals from a home care organization call the NN because they feel treated disrespectfully by the 19-year-old son of a 46-year-old woman with multiple sclerosis. They also fail to reach an agreement about the type and amount of care the client should receive, especially with regard to lifting the client in and out of bed as the client refuses the use of a mechanical lift:

NN organizes a meeting with the client, the client's son, a former partner of the client and the home care professionals who are involved. The outcome of the meeting is that the son helps the professionals to lift his mother in and out of bed. In case he is not at home, professionals use the mechanical lift. The meeting also results in an agreement about what services are provided by the professionals from the home care organizations. NN coaches the other professionals how to deal with the client and her son, among other things by organizing another meeting with the involved parties. NN also organizes a course for professionals on how to use the mechanical lift. After a while, NN organizes a meeting with the GP and the former partner of the client and discusses if it is still possible for the client to live at home. They conclude that the client has lost a lot of weight, faces several other problems and has to be admitted to a hospital. The client is reluctant to go at first, but finally agrees.

Another example is a young couple, who both have a mental disability: a woman, 26-year-old with a chronic muscle disease and a man, 32-year-old with a history of drug addiction. They live in an unclean home, partly caused by domestic animals that are not properly cared for. After neighbours file complaints at the housing association, the NN visits the couple:

NN talks to the couple and analyses their problems: an unclean home, a deteriorating relation with the professionals that support them in managing their household, reluctance towards other types of support or care, bad eating habits and obesity. After the first visit, NN calls a home care organization and applies for domestic services for the couple. The home care organization states that the house needs to be cleaned thoroughly and professionally before domestic services can be granted. NN also contacts the GP and organizes a multidisciplinary meeting with the GP and professionals from the housing association and the home care organization. Together, they draw up a plan of action that includes an upgrade of the support the couple receives and a thorough cleaning of the house. NN talks several times to the couple and convinces them to accept the help that is offered. Furthermore, NN advices the woman to go to a dietician and stimulates her to go to a centre for daytime activities that is aimed at people with a mental disability. NN urges the man to seek help from a psychiatrist. NN will monitor the situation closely and coordinate the support the couple receives in the period to come.

Coordination is particularly important in cases of clients with multiple problems who have to deal with multiple professionals. According to NNs, these professionals often do not effectively work together. Especially when professionals are specialized, have different backgrounds and work for different organizations, there is a risk of miscommunication, overlap and insufficient care. By articulating the activities of these professionals, NNs contribute to the integration of public services.

However, NNs sometimes struggle with other professionals, e.g. social workers, who also profile themselves as 'general professionals' that coordinate the efforts of different professionals. Other 'general professionals' do not automatically accept the authority of the NN as the primary link between services. In some cases, this results in conflicts between NNs and other professionals over who should provide and organize care. Furthermore, NNs are sometimes pressured by organizations to refer clients to them and not to other organizations. In several cases, NNs feel that this pressure, emanating from competition between home care organizations, endangers their autonomy to decide together with a client what the best choice of care is.

Lay articulation work

NNs are not only involved in delivering and organizing care by professionals, but also stimulate 'informal' care and self-management of clients. Stimulating informal care and self-management of clients involves subtle articulation work that is aimed at minimizing the amount of professional care by organizing and supporting social networks and by educating clients how to best take care of themselves. This third type of articulation work primarily entails interactions with clients, their relatives (mostly a partner or children), neighbours and volunteers. Most of the interactions are casual and take place during other activities (e.g. while delivering care).

The activities informal care givers perform often have a social or practical function, like going shopping with a client, accompanying a client to a hospital, walking the dog together, or going to a community centre for social activities. Especially when a partner or children are involved, informal care also constitutes activities like helping clients with washing, dressing, or administering medication. In processes of lay articulation work, NNs investigate whether informal care is possible by talking to friends, neighbours and relatives. If they are willing and able to help, NNs coach them how to best support clients. Also, they bring

in people from voluntary organizations, as the case of a 71-year-old woman illustrates. In this situation, a GP signals that the woman has feelings of grief and guilt, but is unsure how to deal with these feelings. He calls the NN who visits the client at home:

> NN visits the client and notices that her house is packed with lots of plants and several domestic animals. The garden is neglected and full of trees and bushes. The woman is sad and tells about her loneliness and feelings of guilt after her husband passed away. Recently her dog died too. NN urges the client to go to social activities in a neighbourhood centre and proposes to apply for support with household activities and enlist a volunteer service that can do some work in her garden. NN also signs up the client at an organization for social services, after which a social worker pays a visit. The social worker aims to find a volunteer to undertake social activities with the client.

In addition to stimulating informal care, NNs try to strengthen self-management of clients. In one case, a GP suspects that a 58-year-old woman with a mild mental disability has thrombosis in a leg. However, the client is afraid of hospitals and does not want to go there for tests. After calling a professional from a home care organization, who also fails to convince the client, the GP calls the NN:

> NN visits the client several times, provides information and advice and offers to accompany the client to the hospital for tests. After some time, the client agrees. The tests show that the woman does not have thrombosis; she does however need treatment from a dermatologist. NN regularly accompanies the client to the hospital. It turns out that the client needs to be admitted to the hospital after all. NN regularly talks to the woman a lot and finally convinces her to get admitted. After coming home from the treatment, NN brings in home care to help the client putting on compression stockings she now needs. Next NN teaches the woman how to put on the stockings herself. NN also arranges for a medication system through which the client can administer medication herself, a transportation pass that she uses to go to the hospital independently and brings in social and healthcare workers to support the client in household activities, administration and personal hygiene.

NNs stimulate self-management of clients by talking to them and explaining how they can manage their physical, mental, or social problems, but also by doing things together. Activities include providing clients information about social and healthcare services in the neighbourhood; helping them to apply for those services; advising clients on how to deal with other healthcare professionals, family and friends; encouraging clients to undertake social activities; and learning clients about personal hygiene and the use of medication. By articulating different elements of professional work, and gradually transferring tasks to informal care givers and clients, NNs substitute professional home care for informal care.

Nevertheless, lay articulation work is not easy. Frequently NNs experience difficulties in stimulating self-management when clients do not have the motivation or competences to care for themselves. Also informal care is not always the answer, especially when clients do not have a strong social network or the social network is part of the problem. In these situations, bringing in people from voluntary organizations only provides a partial and temporary solution since volunteers often are not equipped to deal with those difficult clients who tend to avoid care and social contacts.

Discussion

Our study illuminates the classic organizing work that is an inherent part of today's organized professionalism on the neighbourhood scale. The analysis of articulation work contributes to the literature on organized professionalism in three ways. First, articulation work redirects current attention for 'new forms of organizing' to 'existing forms of organizing' within professional work. In the debate on organized professionalism, much emphasis is put on the increasing need for professionals to organize their work and adopt new organizational roles in response to changing expectations of service delivery. This is exemplified by Noordegraaf's remark that "organizing and managing have become important for professionals and for the work settings in which they operate. Both professional work and work settings need to be structured, steered, financed and facilitated, in order to render services amidst challenging circumstances" (2007: 1362). This line of reasoning suggests that managing and organizing are traditionally not (so much) part of professional work. Yet, our empirical study and earlier sociological studies of articulation work demonstrate that professionals in healthcare

and other domains, such as social work, airport traffic control and IT, always have engaged in organizing and coordinating as part of their professional work (Strauss et al. 1985; Grinter 1996; Schmidt and Simone 1996; Suchman 1996; Berg 1999; Schmidt 1999; Star and Strauss 1999; Allen, Griffiths and Lyne 2004; Timmermans and Freidin 2007; Ferreira, Sharp and Robinson 2011). Hence, a focus on articulation work introduces classic forms of professional organizing into the debate on organized professionalism, thereby broadening its analytical scope.

Second, the empirical analysis demonstrates that even though articulation work could be considered a case of 'classic' and 'inherent' organizing of professionals, it does acquire new meaning due to changing organizational conditions, policies and societal demands. Our empirical analysis and historical description of home care demonstrate that contemporary NNs perform articulation work differently than NNs in the 1970s. Articulation work of today's NNs is performed in a highly specialized and fragmented field of public services. This organizational setting requires 'interprofessional articulation work' of nurses who join-up specialized services in care, housing and welfare on the scale of neighbourhoods (Lowndes and Sullivan 2008). Moreover, 'lay articulation work' of NNs closely aligns with societal and policy demands to transform the traditional welfare state of 'entitlements' into a society where 'every citizen participates' (see also Liljegren, Höjer and Forkby 2014). Professionals increasingly attempt to substitute formal for informal care by stimulating self-management and enlisting the social network of clients on the neighbourhood scale. Both 'interprofessional articulation work' and 'lay-articulation work' are contemporary forms of articulation work which are combined with more traditional 'intraprofessional articulation work', i.e. the meshing of professional tasks such as medical interventions, prevention and health education.

Third, our study builds on the conceptual shift from conflicting logics to organized professionalism, but takes it one step further. When organizing is an inherent part of professionalism, the question 'who' organizes or 'should' organize becomes less relevant. Instead, the question in the debate on organized professionalism becomes what kind of organizing is done and who benefits from this. To answer this, more detailed empirical accounts of daily professional work in different domains are required. As our empirical account of the daily work in the nursing domain demonstrates, different types of organizing work are necessary. For example, interprofessional articulation work between care, welfare and

housing seems particularly suitable for multi-problem cases. Clients with several problems — e.g. ill health, debts and depression — usually do not fit into the specific client categories and specialized services of regular providers. In these cases, articulation work by NNs seems to get them right back on track. Yet, it could be argued that clients with less complex and varied problems still could benefit from a certain extent of task division and specialization in home care. For example, if someone has one specific problem regarding diabetes, he or she benefits more from the help of a nurse who is specialized in diabetes than from the help of a NN. Also division of labour can contribute to an efficient delivery of services as NNs spend much more time with clients than other professionals. It therefore seems necessary to differentiate between types of articulation work and extent of specialization, depending on the specific needs of clients and the necessity of efficiency gains.

A limitation of our study is that we have not conducted a systematic comparison between NNs and other home care workers. Instead, we relied on the experiences of NNs in assessing hypothetical situations. Furthermore, the project of the NN is still not systematically embedded in Dutch healthcare system due to its pilot phase and temporary funding. Therefore, the transitions that we describe in this chapter may not be of a structural kind, although international studies on organized professionalism (e.g. Cohen et al. 2002; Gleeson and Knights 2006; Waring and Curie 2009; Noordegraaf 2011; Witman et al. 2011) indicate that 'organizing professionals' are here to stay. With regard to future studies on organized professionalism, we recommend that scholars do not only study new organizational roles and responsibilities of professionals, but also focus on (the relation with) traditional articulation work in different professional domains. This might generate new insights in professional–organizational dynamics in addition to mediation, co-optation, co-creation and other types of creative mediation (Gleeson and Knights 2006; Waring and Currie 2009).

Conclusion

Our research aim was to investigate how Dutch NNs engage in articulation work on the neighbourhood scale and what the consequences are for the delivery and organization of home care. Articulation work is at the heart of professional work and encompasses coordination between actors, e.g. professionals, clients

and managers, and meshing of professional work, organizational tasks and social worlds (Strauss et al. 1985; Gerson and Star 1986). Our empirical study demonstrates how, due a tayloristic work division, articulation work was removed from neighbourhood nursing and transferred to central planning departments from the 1980s onwards. The recent introduction of the Visible link project brought articulation work back into the professional domain. In this project, NNs still provide medical and emotional care to clients, but are also responsible for managing their own work, establishing organizational and professional connections between care, welfare and housing and stimulating informal care and self-management of clients. By doing so, they establish a total arc of work and contribute to more integrated public service provision on the neighbourhood scale.

Nevertheless, our analysis also demonstrates that articulation work is not the silver bullet for resolving all tensions in the organization and delivery of public services. Although articulation work solves certain problems, like fragmentation of services, it creates and enhances other ones, like competition between organizations about clients' referrals, struggles with other professionals over the question who coordinates and difficulties when encountering the limits to informal care and self-management. Furthermore, the study demonstrates what is currently 'left out' of articulation work. In the Visible link project, NNs do not concern themselves with financial decisions about the allocation of scarce resources such as personnel and client budgets. Consequently, potential value conflicts about this allocation are kept away from NNs. It could therefore be argued that articulation work of the Dutch NN is an example of 'partial' organized professionalism: some elements of work are being articulated, whereas other elements stay disarticulated. Partial organizing then is not necessarily the result of a taylorized system, as the Visible link project demonstrates. It can also be a conscious policy choice to keep different types of organizing apart, thereby 'unburdening' professionals with difficult value conflicts (e.g. Thacher and Rein 2004), such as the conflict between ensuring financial sustainability on a macro level and accessibility of care for individual clients.

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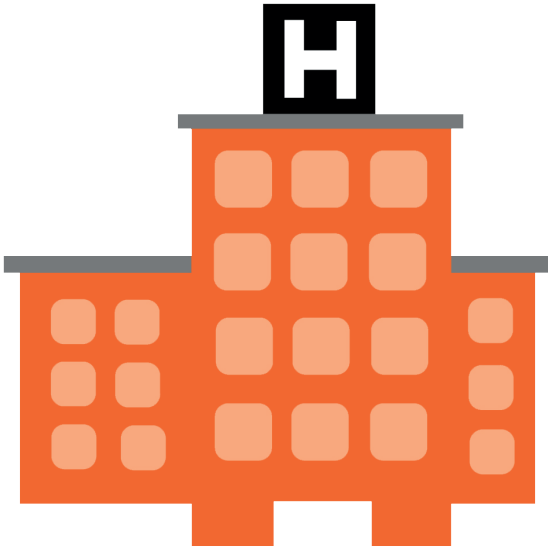
CHAPTER 7

Politics of evidence-based policy: How professional work in small-scale emergency departments is made invisible



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Abstract

Evidence-based policy making is not always neutral, but can serve as a political instrument to legitimise certain types of evidence, problem definitions and solutions. Moreover, quantitative outcome-oriented studies are frequently prioritised over qualitative research, including studies that focus on the work of professionals. The subjective and selective character of evidence-based policy making potentially leads to ill-designed and ineffective policies. Using the concept of invisible work, we analyse the representation of professional work in the evidence-base of a new policy on Dutch emergency care. Based on an empirical study in and around hospitals, we identify four repertoires of emergency care: acute and complex care, uncertain diagnostics, low-complex care and physical-social-mental care. We find that the new policy is primarily based on quantitative studies on the first repertoire, focusing on acute, high-risk and complex emergency care that is predominantly provided in large-scale emergency departments. This is due to selective use of evidence, informed by a narrow definition of quality and the political goal of concentration of care. Professional work in the other three repertoires, comprising the majority of work in small-scale emergency department, is rendered invisible. This potentially impedes improvement of care for a large group of patients. Our study calls for a heightened sensitivity for the (in) visibilities that are produced in evidence-based policy making and emphasizes the importance to include insights from both small- and large-scale emergency departments.

Introduction

Although the relation between science and policy has a long history, the last three decades there has been a surge of interest in the use of scientific evidence in policy making (Marston and Watts 2003; Van Egmond 2010). This trend of *evidence-based policy making* is influenced by factors such as the expansion and availability of scientific knowledge, the decline in deference to government, a focus on effectiveness and efficiency of policies and a demand for greater accountability of (semi-)public organizations (Davies, Nutley and Smith 2000a; Sanderson 2002a; Marston and Watts 2003). The use of science in policy making is embodied in varies forms, ranging from advice of an individual expert to long-term studies by science advisory institutions (Van Egmond 2010).

However, what counts as legitimate evidence for policy is far from clear. From a rational perspective, evidence is that which "can be independently observed and verified, and there is broad consensus as to its contents (if not its interpretation)" (Davies et al. 2000: 2). In this perspective, policies are based on scientific research that is gathered and assessed objectively and value-free, and subsequently implemented in practice (Fischer 1998; Young et al. 2000; Bax, De Jong and Koppenjan 2010). This view has been criticized from interpretivist perspectives, which state that scientific knowledge is inconclusive and has no unique claim to objectivity, facts depend upon underlying meanings and consequences of policies are ambiguous (Fischer 1998; Davies and Nutley 2000; Mulrow and Lor 2001; Young et al. 2002; Bax, De Jong and Koppenjan 2010). In this perspective, dominant actors can even turn evidence-based policy into 'policy-based evidence' (Rosenstock and Lee 2002; Sharman and Holmes 2010; Strassheim and Kettunen 2014).

Debates over what counts as evidence for policy often result in the prioritisation of quantitative evidence, such as survey research, cost-benefit analysis and economic modeling (Fischer 1998; Sanderson 2002a; Nutley, Davies and Walter 2003; Epstein, Farina and Heidt 2014). Evidence gathered by qualitative methods, such as ethnographic data, is frequently devalued as 'subjective' or 'soft' (Marston and Watts 2003). The prioritisation of quantitative evidence leads to policies that are based upon a *selective understanding* of professional work. Particularly work that cannot be "mapped, flowcharted, quantified, measured" (Nardi and Engeström 1999: 1) runs the danger of being neglected in evidence-based policy making.

The neglect of work in policies is not necessarily a bad thing as it allows for professional discretion and prevents undesirable reification of work (Suchman 1995). However, it can also impede legitimacy of work, lead to ill-designed policies, produce feelings of alienation by professionals and endanger the effectiveness of policies (Star and Strauss 1999; Tummers 2013). It is therefore important to study the representation of work in policies. Yet, little is known about how certain elements of professional work are (not) accounted for in evidence-based policy making and what the consequences are. We propose that the sociological concept of 'invisible work' (Star and Strauss 1999) makes an important contribution to the understanding of the representation of work in evidence-based policy making. We use this concept to study the case of a new policy on Dutch emergency care. Our research question is: *How is professional work made (in)visible in a new policy on emergency care in the Netherlands and what are the consequences?* We address this question by empirically studying the representation of professional work in a policy document and by conducting a multi-sited qualitative study of professional work in and around hospitals. Our study contributes to the understanding of the (in)visibility of work in policies and the consequences of this (in)visibility for policy and practice.

Professional work in evidence-based policy making

The debate about evidence-based policy making has long been characterized by a dichotomy between rational and interpretivist perspectives (Hoppe 2005). In line with other authors that have tried to find a middle ground between these ideal-typical perspectives (e.g. Fischer 1998; Hajer 2003; Hoppe 2005), Sanderson (2009: 300) has introduced the notion of "intelligent policy making". Based on the pragmatist philosophy of John Dewey, Sanderson (2006; 2009) argues that we need models for policy making that create room for learning, innovation, experimentation and ethical and moral concerns. The term intelligent policy making denotes policy making as a practical, deliberative process in which a wide range of intelligence is used: both quantitative and qualitative scientific studies alongside tacit knowledge, informal routines and context-based citizen experiences (Sanderson 2009, see also Parsons 2002; Marston and Watts 2003; Epstein, Farina and Heidt 2014). In this view, evidence-based policy making is a reiterative endeavour of trial and error that never reaches a final or complete state

but aims to produce "appropriate solutions" (Sanderson 2009: 714) and "creative responses" (Sanderson 2002b: 127).

Intelligent policy making tries to strike a balance between objectivism and 'anything goes' relativism. It does so by calling for attention for things that cannot easily be assessed quantitatively but are nevertheless important for policies, including professional work. Star and Strauss (1999: 9) argue that we can identify work by looking at "straining muscles, finished artifacts, a changed state of affairs". However, what work exactly looks like in healthcare, the setting of our study, is not always obvious. On the basis of ethnographic research in hospitals, Strauss et al. (1985) identify different types of work that professionals perform: machine work (the use of technical equipment), medical safety work (reducing hazards that endanger patients' health), comfort work (relieving patients from discomforts), sentimental work (supporting patients in coping with anxiety and depression) and articulation work (coordination and integration of care). Strauss et al. (1985) argue that patients equally perform work, for example by monitoring medical equipment, catching staff's errors and ensuring their own comfort. The different types of work are carried out and intermingled during a care trajectory, which involves the unfolding of a patient's disease and the organization of work done over that course (Strauss et al. 1985).

Strauss et al. (1985) argue that machine work and medical safety work are emphasized in formal representations of medical work, while other types of work are often neglected. This observation is in line with Atkinson's (1995: 34) notion that "great tracts of work remain all but invisible" in hospitals. Atkinson points to the emphasis in research and policy on the formal interactions between doctors and patients, ignoring a variety of other activities, for example performed in hospital laboratories, during informal encounters between professionals and in activities of cooperation and competition between medical disciplines. Similarly, Montgomery (2005) questions the idea of professional work in healthcare as solely a rational endeavour, aimed at applying objective, scientific evidence in hospital settings. Montgomery shows how doctors draw on tacit diagnostic skills and everyday experiences in making clinical judgements about patients. She argues that although scientific and rational elements are often emphasized in representations of clinical work, "understanding medicine as a practice that focuses on care for patients serves patients and physicians far better" (Montgomery 2009: 9). In sum, professional work in healthcare is multifaceted, with different elements of work intermingling in daily practices. Straus et al. (1985),

Atkinson (1995) and Montgomery (2005) show that accounts of work often focus on medical-technical activities of doctors, including machine work and medical safety work, making other types of work that are equally important in providing good care *invisible*.

Making work visible and invisible in policies

Work is not visible or invisible in itself but only from a particular perspective or position (Suchman 1995; Muller 1999). This point is clearly articulated by Star and Strauss (1999: 20), who state that "work may become expected, part of the background, and invisible by virtue of routine (and social status). If one looked, one *could* literally see the work being done – but the taken for granted status means that it is functionally invisible" (emphasis in original). Examples of work that is often invisible to outsiders include domestic service work (Rollins 1985; Star and Strauss 1999), the work of technicians in laboratories (Shapin 1989), nursing in home care (Lupton 2013) and the work of patients in self-managing their disease (Oudshoorn 2008). On the basis of other empirical studies, Nardi and Engeström (1999) identify four types of invisible work: (1) work done in invisible places, such as ICT-work in back-office facilities, (2) work defined as routine that actually requires considerable problem solving and knowledge, such as the work of telephone operators, (3) work done by unseen people such as maids and (4) informal work processes that are not part of formal job descriptions but are important for the functioning of workplaces. Furthermore, Hampson and Junor (2005) distinguish between routine and non-routine invisible work. Invisible routine work entails activities that are not captured in job descriptions, but that happen on a regular, routine-like basis. Invisible non-routine work comprises actions of workers to deal with the unexpected and unplanned.

What these studies illustrate, is that the (in)visibility of work in policies is a consequence of several mechanisms, including the extent to which work is routinized, the degree to which it can be captured in job descriptions and other formal representations and the degree to which it can be seen by outsiders. The dominance of knowledge on easily measurable elements in evidence-based policy making (Fischer 1998; Sanderson 2002a; Nutley, Davies and Walter 2003) can lead to a situation in which non-measurable elements of work are neglected and thereby become invisible. In particular, jobs or tasks that can be routinized, captured in a description and made visible to outsiders, are suited to be used as

evidence in policy making. Less visible elements of work run the danger of being ignored.

A new policy on emergency care

We study a case of evidence-based policy in which the visibility and invisibility of professional work is problematic, namely the making of a new policy on emergency care in the Netherlands. Guttman, Zimmerman and Schaub Nelson (2003) identify four potential functions of emergency care: treating patients that need medical care as a result of a trauma or an acute episode of an illness; providing medical care that is available only at that specific facility; a temporary site of care when regular providers are unavailable; delivering care on a regular basis. In the Netherlands, emergency care is provided in hospitals. Patients can be brought in by ambulance, but can also be referred by general practitioners or come in by themselves. Patients are treated in the hospital emergency department, or stabilized, and subsequently either sent home or admitted in another department in the hospital. Patients with minor conditions, e.g. uncomplicated sport injuries or shallow wounds, receive emergency care in separate primary care facilities.

Early 2013 the Association of Health Insurers, responsible for contracting care from hospitals in the Netherlands, issued a new policy document on emergency care: 'Vision on quality of emergency care'. Among other things, the document proposed concentration of emergency care in fewer hospitals. The proposed policy is in line with developments in other Western countries where concentration of care is an important element of healthcare reform (e.g. NHS London 2007; Yudkin 2014). The Association based the policy on a review of clinical studies on quality of emergency care, conducted by a consultancy firm. However, professionals and hospital boards argued strongly against the policy. They posed that it was based on flawed evidence and painted an incomplete picture of the professional work that is performed in emergency departments (e.g. Idzenga 2012; Gaakeer and Van den Brand 2013). The introduction of the new policy on emergency care in the Netherlands thereby provides an interesting case for studying the (in)visibility of professional work in evidence-based policy making.

A multi-sited qualitative study of emergency care

For our empirical study, we adopted a qualitative research design. We conducted: (1) a document analysis of the policy 'Vision on quality of emergency care' and (2) observations and interviews in and around two small-scale and one large-scale emergency department.

Document analysis of the 'Vision on Quality of Emergency Care'

The goal of the document analysis was threefold: (1) gaining insight in the 'evidence-base' of the policy by analysing what kind of evidence the consultancy firm used in the study on which the policy is based, (2) investigating what elements of professional work were made visible and (3) assessing the political and practical implications of the policy. We did so by examining the choices the authors made in the design and execution of the research and the justification for those choices, the type of evidence that was in- and excluded, the references that the authors made to other policy documents, the elements of professional work that were brought to the fore and the conclusions and policy implications that were included in the document.

Observations and interviews in and around emergency care departments

As a second step, we conducted a multi-sited qualitative study of professional work in emergency care. By doing so, we aimed to record "ordinary, everyday activities that take place in naturally occurring contexts" (Davies, Nutley and Smith 2000b: 300). In this study, we define 'professional work' rather broadly as encompassing the activities done by workers in emergency departments, i.e. nurses, receptionists, medical doctors and residents (doctors who have obtained their license and are now in training to become a medical specialist).

We conducted observations in two emergency departments in Dutch hospitals that are usually typified as small-scale (less than 350 beds) during a period of 10 weeks. One of the emergency departments was located in an urban area and was combined with a primary care facility ('Riverside Hospital'). On this site, observations were held for 25 hours. In the other small-scale hospital, located in a rural area with a primary care facility in the immediate proximity ('Countryside Hospital'), 40 hours of observations were conducted. Furthermore, we carried out 20 hours of observations in a large-scale hospital (more than 600 beds) in an urban environment ('UrbanCare Hospital'). Finally, we conducted fieldwork

in a primary care facility that provided emergency care and in an ambulance call centre where emergency calls ('112') were answered and ambulances were coordinated (12 hours of observation in both settings). During the observations in the emergency departments and primary care facilities, we sat behind the desks where patients and ambulance personnel reported to the nurses or a secretary when they came in. By sitting behind the desk we were able to see how professionals established priorities between patients and how they discussed cases.

During the observations, we conducted ethnographic interviews that lasted up to 30 minutes with over 30 medical doctors, general practitioners, residents, nurses, ambulance drivers, physician assistants and managers. In addition, we conducted five semi-structured follow-up interviews with a nurse, a manager, a resident, a medical doctor and a secretary. In the interviews, we focused on several aspects of professional work, including the content of work, the rationale behind some of the decisions we witnessed during the observations, the collaboration and coordination with colleagues within and outside their work place and the arrangements with other facilities about the referrals of patients. We took field notes during the observations and ethnographic interviews, which we wrote out directly afterwards. The follow-up interviews were recorded and transcribed verbatim.

Analysing repertoires of emergency care

We had no previous experience in doing research in emergency care and had certain expectations of what we would encounter during the observations. We envisioned situations such as those that can be seen in the television series *ER*. We discussed how we would deal with the sight of patients that were severely injured, heavily loosing blood and possibly even people dying. However, the professional work in emergency departments was much more like 'regular' healthcare than we expected. Although 'saving lives' is an aspect of professional work in small emergency departments, the vast majority of patients require less acute and complex treatment. This observation demarcated the start of our analysis.

After our observations and interviews were finished, we took a closer look at the different kinds of patients that entered the emergency departments. First, we noticed that some of the patients had to wait quite some time (often the ones that came in by themselves), while others were treated immediately (often the patients that came in by ambulance). Second, we analysed the way professionals dealt with those different groups of patients. Some patients were treated

exclusively by nurses and residents, while others needed treatment by medical specialists. Also the duration, ranging from approximately fifteen minutes to, in exceptional cases, five hours or more, and the complexity of the treatments varied. We furthermore saw that some patients had to be admitted to the hospital after treatment, while others could go home. As a third step in our analysis, we looked at the organizational processes and structures that were in place to provide care to patients. We noticed that for different categories of patients, different organizational activities were performed, including communication and collaboration between professionals in the emergency department and with other actors inside and outside the hospital.

On the basis of the three analytical steps, which we had not defined beforehand but created during the analysis of our findings, we inductively identified four *repertoires of professional work*. The Oxford English Dictionary defines a repertoire as "a stock or range of regularly performed or easily exhibited skills, techniques, abilities, etc.; a collection of typical features". Just as the performance of an artist depends on the skills that he/she possesses and exhibits in a given arena, emergency care is enacted by healthcare professionals who adapt their medical and organizational skills to a certain context and the needs of patients. The use of the repertoire metaphor allows us to not only analyse the work that professionals perform, but also to study the relationship with the organizational context and the characteristics of patients. We validated the four repertoires through member check with the respondents in all three research sites, who indicated that they recognized the four repertoires as being representative of their work.

A new policy on emergency care

Before discussing the four repertoires, we analyse the policy document 'Vision on quality of emergency care'. The document comprises an introductory chapter, two chapters that discuss the scientific evidence that is used as input for the new policy and a concluding chapter with implications and recommendations.

A political agenda

The first line of the document refers to the 'Healthcare headlines', an agreement between health insurers, hospitals and the Ministry of Health. The Healthcare

headlines aim to "ensure that concentration and distribution of care will be realized by insurers and care providers if this is deemed desirable in the light of quality, efficiency and innovation" (page 5). After this, the authors state that the new policy on emergency care should strengthen 'selective purchasing' of healthcare services. Selective purchasing means that health insurers are allowed to purchase care from a limited number of providers, while they used to be obliged to purchase from any licensed provider. The espoused aim of selective purchasing is to improve quality and lower costs by concentration of hospital care in smaller number of facilities (Dutch Cabinet 2012). So, right from the start, it is clear that the study of the consultancy firm is not an explorative analysis of quality of emergency care, but is designed to match the political agenda of concentration of care. This is further illustrated on page 7:

> "It is important to mention that the optimal volumes we describe for different care trajectories do not have the same 'status' as minimum performance norms. These are descriptions of the desired situation for realizing optimal care, based on best practices and literature, on the basis of the vision on Dutch healthcare as formulated in the Healthcare headlines."

The evidence-base of the policy

The document goes on by distinguishing six types of acute, high-risk and complex emergency care in chapter two and three: severe physical traumas, acute neurology, acute cardiology, acute vascular surgery, acute obstetrics and 'other' (a list of approximately forty conditions). Subsequently, the authors argue on page 6:

> "The aim of this document is to produce a quality vision that 'covers' various diagnoses that fall within different care trajectories [the six types of emergency care]. That is why the quality vision is composed per care trajectory, based on the largest volume of a specific (coherent group of) diagnosis."

Furthermore, they state: "we consider volume-indicators as 'proxy-outcome indicators'" (page 7). The latter three extracts from the document are important as they show that the authors are selective in their review by (1) composing a "quality vision" for a limited number of acute conditions and extrapolating this to other treatments within the same type of care (called 'trajectory') and (2) assuming that there is a positive correlation between volume and clinical outcome

for each treatment. In other words: the more frequently healthcare professionals perform those treatments, the better the outcomes for patients are supposed to be.

The consequences of the volume-quality reasoning become clear in chapter three of the policy document. Here, the authors present quality indicators for each of the types of emergency care (excluding the 'other' category), based on a review of clinical studies. For example, the authors of the policy document discuss quality of acute obstetrics, which they define as "reducing perinatal mortality and morbidity of pregnant women, new-borns and mothers" (page 27). They only include studies in the review that provide easily measurable outcomes, e.g. infant mortality and low birth weight, that match this specific definition of quality of care for acute, high-risk and complex treatments. Other potential notions of quality, that may be important in non-complex and non-acute situations, such as comforting the mother, providing information and organizing the transfer back home, are not taken into account.

Implications of the policy

The selective use of evidence, driven by a political agenda and a narrow definition of quality of care, is not without consequences. The fourth chapter of the policy document, entitled 'Implications and follow-up steps of the vision on quality', starts with the following section (page 43):

> "When comparing the current situation of the landscape of emergency care with the optimal volumes and facilities that we described, one will find many discrepancies. In the light of quality of care (and secondly also of efficiency and labour market problems), this discrepancy can only be solved by concentrating streams of emergency care and related Intensive Care Units in a smaller number of hospitals, providing more specialized care. For basic emergency care, citizens will always be able to use facilities in their own neighbourhood, in the form of an integrated primary care facility and an emergency department care function."

The policy recommends pressuring hospitals to concentrate complex and acute emergency care in a smaller number of larger, more specialized hospitals. At the same time, the authors mention the need to establish "facilities for basic emergency care" (page 39) for the treatment of cases "for which extensive medical facilities are not required" (page 39). Although the authors acknowledge that

the "majority of patients" (page 39) should be treated in a facility for basic emergency care, they do not go into what such an emergency facility would look like and what kinds of conditions should be treated there. Consequently, they also do not review studies to provide criteria for quality of basic emergency care. Instead, the authors only provide some general statements about the need for good diagnostic tools and well-trained doctors and nurses in such facilities. Thus, although the new policy has a major impact on the total organization of emergency care, only a selective part of professional work in this setting seems to be taken into account.

Repertoires of emergency care

In order to assess what professional work exactly is made (in)visible by the selective use of evidence in the policy document, we now turn to four repertoires of professional work that we inductively identified in our analysis of daily healthcare practices in and around emergency departments. The repertoires each entail a different perspective on (good) professional work in different situations, including the conditions of patients, the professional skills required and the organization of care. For each repertoire, we describe an illustrative situation

Table 1. Repertoires of professional work

Repertoire of professional work	Patients' conditions	Professional skills	Organization of care
1. Acute and complex care	Acute danger of death or major health damage	Expert knowledge and routines aimed at achieving optimal medical outcomes	'Taylorized' teamwork in high-tech facilities
2. Uncertain diagnostics	Symptoms that are hard to classify or possible relapses in a chronic disease, often leading to hospital admission	Excellent diagnostic and communicative skills and knowledge of the background and medical history of patients	Presence of a wide range of diagnostic tools and good collaboration between the emergency department and other hospital departments
3. Low-complex care	Minor health issues	Routine medical skills, good planning and communicative skills	Collaboration between the emergency department and primary care facilities
4. Physical-mental-social care	Multi-problems (medical-psychological-social)	Empathy, good diagnostic skills, good communicative and organizing skills, knowledge of other (long-term) social and medical services	Collaboration between the emergency department and home care, nursing homes, mental care and primary care facilities

that we encountered during our fieldwork. Although in each of the described situations a certain repertoire is dominant, elements of other repertoires can be recognized as well. This illustrates the complex and layered character of professional work in emergency care. Thus, while the distinction of professional work in four repertoires is analytically useful to show what elements are (in)visible in the new policy, we acknowledge that in practice the boundaries between repertoires are blurred. The four repertoires of professional work are summarized in table 1.

Repertoire 1: Acute and complex care

The first repertoire comprises the acute and complex care (aimed at 'saving lives') that is prominent in the policy of the Association of Health Insurers. Good quality of care in this repertoire is defined in medical terms, for example mortality rate after a heart attack. Out of the four repertoires, this is the repertoire we observed the least in the small hospitals in our study. During our observations at the ambulance call centre, we noticed that acute and complex cases were usually referred to one of the larger (university) hospitals in the region, where specialized medical doctors and technological infrastructure that are necessary for adequate treatment are available, and not to emergency departments in small hospitals. However, also small hospitals sometimes have to deal with acute and complex cases. Some patients have to be stabilized at the nearest facility before they can be transferred by ambulance to a larger, more specialized facility. Other patients come to the emergency department by themselves with complaints that turn out to be more serious than initially thought.

Riverside Hospital: small-scale emergency department in an urban area.

The phone rings at the desk of the emergency department. Sandra, the secretary, answers the phone and hears a man calling from a car, saying that he is coming in with his almost two-year-old daughter. The little girl is limp and has respiratory problems. Sandra looks details about the girl up in the hospital information system and finds that she came in the emergency department two weeks ago with the same complaints. The girl was then treated with antibiotics and went home. Sandra says to Bart, the coordinating emergency care nurse, that the girl is on the way and that she expects it to be nothing serious this time either. A few minutes later a car stops in front of the emergency department. The father jumps out of the

car, lifts his daughter from the back seat and runs through the door. The mother of the girl climbs behind the wheel and parks the car.
Sandra and two other emergency care nurses bring the little girl and her father straight to the examination room. Soon, it does turn out to be something serious and the girl is transferred to a children's treatment room. The girl cries and moans constantly and has a dangerously low saturation. She is also very pale and keeps fainting or falling asleep: she looks exhausted. Tom, a resident, goes straight to the treatment room while Bart calls a paediatrician. The paediatrician arrives shortly because he was still in the hospital. A little while later a woman in leisurely clothing comes into the emergency department, throws down her coat and goes straight to the treatment room. It turns out to be a second, more experienced paediatrician who was also called.
After an intense time the child is stabilized and admitted to the paediatrics department at the hospital. One of the emergency care nurses says to me: "A little while ago, when we worked with the same team and the same paediatrician, we had a child that stopped breathing. That's why everything ran smoothly now: everyone knew what to do, but also where to find little needles, little oxygen masks et cetera."

In order to provide good care in the first repertoire, professionals at the emergency department work together as a team where everyone does his or her specialized task in a 'taylorized' way. Nurses escort patients (and often ambulance personnel) directly after they come in to a treatment room, prepare equipment and hand out medical tools to residents and medical doctors. The latter perform the treatment, predominantly aimed at stabilizing patients. The more complex the case, the more rapidly specialized medical doctors are brought in and the more high-tech instruments are used. During the first minutes after arrival at the emergency department, the pace is fast and all other patients that have less urgent conditions have to wait. After patients are stabilized, they are usually admitted in the hospital, often at the intensive care unit, or transferred to a larger, more specialized hospital.

Repertoire 2: Uncertain diagnostics

The second repertoire comprises patients with symptoms that are hard to classify, often leading to hospital admission. Sometimes these patients come by themselves; at other times they are brought in by ambulance. The complaints

of these patients do not immediately lead to a diagnosis (e.g. a patient that is short of breath and has a slight deviation on an ECG). Like a resident stated with regard to such a patient he just admitted: "there's something funny about this patient, we don't really trust it". Another category comprises patients with chronic diseases that possibly have a temporary relapse (e.g. a patient with a chronic heart condition and a slight chest pain). The first step in dealing with these patients is making sure they are not in immediate and life threatening danger, which would lead to repertoire one. Next they are diagnosed and treated at the emergency department, often after consulting a medical specialist. When this is done, sometimes after several hours, they are admitted in the hospital. Good quality of care in repertoire two is partly defined by medical outcomes, but more so by the speed with which a patient is diagnosed, treated and admitted and the way initial uncertainty is communicated with a patient.

Countryside Hospital: small-scale emergency department in a rural area.

A man comes in the emergency department together with his wife and walks to the desk. He is sent in by a general practitioner and says he has severe stomach ache. Mandy, an emergency care nurse, walks with the man to a treatment room. Five minutes later also Michelle, a resident, walks in the treatment room. After fifteen minutes Michelle comes back to the desk and starts a discussion with resident Greg and nurse Sylvia about the use of morphine. Michelle says that the patient scored an eight (out of ten) on the pain scale and that she therefore gave him 10 milligrams of morphine. Greg and Sylvia both say that they do not like to give morphine in these situations; they have had better results with other painkillers. A few minutes later nurse Mandy returns to the desk and says that the morphine does not work: "no wonder with such a body" (the patient is heavy).

Michelle decides to wait with prescribing other painkillers until the results from laboratory tests that she requested come back. Meanwhile she enters the symptoms of the patient in the electronic patient record, making use of the protocol 'acute stomach ache'. Michelle says to me that she suspects that the patient has acute pancreatitis (a condition of the pancreas). She also says that the patient told her that he drinks about 2.5 litres of beer a day. Her diagnosis seems to be confirmed by the results from the laboratory that appear on her screen about an hour later. She subsequently calls Jeff, a surgeon. This is necessary because the general practitioner that sent in the patient explicitly asked for the opinion of a surgeon. Michelle suspects that Jeff will confirm her diagnosis and will refer the patient to the internal

medicine department. However, after Michelle discusses the symptoms of the patient and the results from the laboratory, Jeff thinks that it is not pancreatitis and says that he will come to the emergency department to examine the patient. In the meantime, Michelle orders a CT-scan on the request of Jeff. She is still convinced that the patient suffers from pancreatitis and grumbles to me about the fact that Jeff does not believe her.
After a short while Jeff comes in and goes to see the patient in the treatment room together with Michelle. When they come back to the desk, Jeff says that he thinks it is pancreatitis after all because of the excessive alcohol use of the patient. He calls a doctor from the internal medicine department and after a short conversation gives the phone to Michelle. He asks her to pass on all the relevant information and to take care that the patient is admitted in the hospital. Fifteen minutes later a nurse comes in and brings the patient to the internal medicine department.

Professional work in the second repertoire mainly comprises dealing with uncertainty. Nurses, residents and medical doctors have to come up with a diagnosis quickly, but also need to be able to alter their initial diagnoses after unexpected results from the laboratory or changes in the symptoms that patients exhibit. Professionals need to possess broad and general medical and social knowledge to assess often varied and complex symptoms and communicate well with patients (e.g. for reassurance and to provide information) and colleagues (e.g. about conflicting diagnoses). Knowledge of the medical background of the patients is very useful in this process. Nurses and residents also need to know when it is time to consult a specialized medical doctor. Collaboration with other departments is crucial to admit patients in the hospital after they are treated at the emergency department, in order to minimise waiting time for patients and to free up capacity for new patients.

Repertoire 3: Low-complex care

The third repertoire includes patients that have minor conditions, but may experience a high level of discomfort, and can be helped relatively easily and go home quickly after treatment. Typical examples are a patient with a fishhook in a finger or a patient with a sprained ankle. These patients often come in by themselves. Some of them are redirected to primary care facilities; others end up in emergency departments. In UrbanCare Hospital, the large hospital in our

study, collaboration between emergency care and primary care was largely absent. As a consequence, 'easy' patients had to be treated at emergency departments, which sometimes led to frustration among professionals who found this a waste of time and capacity. In Countryside Hospital, there was a good collaboration between the emergency department and the primary care facilities, with nurses as gatekeepers that decided in which facility a patient should be treated.

Countryside Hospital: small-scale emergency department in a rural area.
A man walks in with his approximately ten-year-old son who holds a blooded handkerchief in front of his nose. He comes to the desk where secretary Kim asks him whether he has already been at the primary care facility. The man says he has not. Meanwhile, nurse Rose has come to the desk and examines the blooded nose. She says that it would be wise for the man to go to a primary care facility first in order to be sure whether it is necessary that a medical doctor at the emergency department treats his son. The man says that he did not know that there are only medical doctors here. Rose says: "that doesn't matter" and explains, together with Kim, that the man should walk out the door and that the primary care facility is just a few meters to the left. The man answers that he is happy that it is so close by, says: "sorry, this is the first time this has happened" and walks out.

The third repertoire comprises care that is medically standard, non-acute and non-complex, but that can have quite an impact on patients. They are sometimes scared and not sure how to act. In the third repertoire, professionals have to perform basic medical tasks to deal with minor conditions, but they must also be able to communicate well with patients: sometimes referring them to another facility, comforting them if necessary and informing them if they have to wait for other patients that are treated with more urgency. Usually low-tech medical equipment and basic medical skills suffice, although professionals have to have diagnostic competences to rule out potentially graver conditions. Quality of care comprises good medical outcomes (that is usually the easy part), short waiting times and patient friendly communication. Professionals realize that what is minor harm for themselves can be a real drama for patients (and their parents in case of children).

Repertoire 4: Physical-mental-social Care

The fourth repertoire comprises patients with a combination of physical, psychological and social issues that only have a minor medical condition, but have nowhere else to go. An example is an elderly woman with multiple chronic conditions, who does not have family and friends and who is brought to the emergency department with very high blood sugar levels. Professionals at emergency departments are reluctant to send such patients home after treatment when they know there is no support of caregivers or relatives. However, they also know that there is often no medical reason to keep the patients at the hospital. This is sometimes an ethical dilemma.

Riverside Hospital: small-scale emergency department in an urban area.

On a Saturday afternoon, Wendy, an emergency care nurse, and Soraya, a resident, stand in a corner talking. Wendy's shift is already over, but she wanted to talk to Soraya about a patient, an elderly man, that came in the night before. The patient was sent in by his general practitioner and was examined at the emergency department by Soraya. Although the patient wasn't feeling well, Soraya assessed that his condition was medically not serious enough to justify admission in the hospital. She decided to send the man home, although the nurses did not agree. They thought that the patient was very vulnerable and weak. Moreover, they saw that his wife and daughter had trouble handling the situation. "But that is not what we are for", Soraya had said to the nurses, speaking about the risk that if the patient had to be admitted, it could lead to a long stay in the hospital without a strict medical reason.

Because the resident has the final say, Wendy and the other nurses had no other option than to accept the fact that the patient was sent home. Later that night however, the patient died at home. The nurses, especially Wendy, felt very bad about that. "Of course it is terrible for the patient, but I find it the worst for his wife and daughter. I really wish this situation would have gone different. They already were in such terrible shape." Soraya however insists that at that time there was no medical reason to keep the patient in the hospital. She tells Wendy that she will call up the family to express her condolences and that she regrets the whole situation, but that there was no other option.

Professional work in the fourth repertoire primarily entails a range of organizing activities. Providing care requires cooperation between emergency departments and home care, nursing homes, primary care, mental care, patients and patients' families. Countryside Hospital belonged to a 'care group' that also included

a home care organization and nursing homes, which made it easy to organize continuity of care. This mediated the risk of patients returning to an unsafe environment. In Riverside Hospital however, patients were often sent home without additional care or admitted to the hospital, where they sometimes resided for a considerable amount of time because there was no other place they could go. In the absence of good collaboration with long-term care institutions, dealing with these multi-problem patients is challenging for professionals at emergency departments. Professionals have to be empathic, but also clear to patients and relatives about the limits of the care they can provide in the hospital. Furthermore, they have to be able to distinguish medical complaints from psychosocial complaints and act accordingly by either referring patients to other facilities or admitting them in the hospital. Good quality of care in the fourth repertoire comprises a good diagnosis and adequate medical treatment, which can be difficult as the example shows, but also the organization of various types of (long-term) care that patients need.

Conclusion and discussion

Our research question was: *How is professional work made (in)visible in a new policy on emergency care in the Netherlands and what are the consequences?* This study shows that the Association of Health Insurers primarily presents the repertoire of acute and complex care, which is predominantly provided in large-scale emergency departments, in the new policy on emergency care. This is due to selective use of evidence, informed by a narrow definition of quality and the political goal of concentration of hospital care. In particular, the Association of Health Insurers only includes studies in the policy that focus on quantitatively measurable outcomes of specialized professional work, such as mortality. Subsequently, the authors argue that volume is a good proxy for quality for these treatments and apply the quality-volume relation to emergency care at large. They thereby ignore alternative notions of quality of care that can be found in the repertoires of uncertain diagnostics, low-complex care and physical-mental-social care, which entail the majority of care in small-scale emergency departments.

Moreover, the visibility of the first repertoire in the policy emphasizes specialized professionals that perform acute and complex treatments in a 'taylorized' way in high-tech facilities. However, care in the other three repertoires asks for

professionals that are able to communicate well with patients, possess creativity in coming up with diagnoses, plan and organize care efficiently, collaborate with other professionals and take their own responsible decisions when needed. In the policy, these other elements of work are deferred to the a-specific notion of 'basic emergency care' and hardly receive attention. It is not that this work *cannot be seen* but in a policy that focuses on acute, high-risk and complex care, invisibility is the consequence.

For the Netherlands and other countries that are involved in concentration and specialization of hospital care, the invisibility of a large portion of professional work is problematic because it leads to a policy that possibly impedes improving quality of care for a large group of patients. That is, if the policy indeed results in concentration of emergency care in fewer, larger and more specialized facilities, that could be beneficial to patients in the repertoire of acute and complex care. However, if all policy attention is geared to repertoire one, possibilities for improving quality of care in the other three repertoires are left unexplored. These repertoires comprise specific professional skills and an organization of care that equally require attention. This is not only important from a patient perspective, but also because the current organization of the repertoires of uncertain diagnostics, low-complex care and physical-mental-social care might be inefficient. For example, it could be argued that part of these repertoires entail "overutilization" or "inappropriate utilization" of emergency departments (Malone 1998). Both from the viewpoint of quality and efficiency it is therefore crucial that policy decisions are based on a complete picture of the multi-faceted work of professionals and take a broad range of evidence and potential policy measures into account.

Our study makes three contributions. First, it introduces the notion of (in) visible work (Star and Strauss 1999) to the literature on evidence-based policy making. This sociological concept allows scholars to gain in depth insights in the relation between work in daily practices and the representation of work in policies. Second, the study provides an empirical example of the mechanisms by which certain elements of professional work are made (in)visible in evidence-based policy making. Although it is generally acknowledged that practice-based experiences are often neglected in such processes (Parsons 2002; Sanderson 2002a; 2002b; Marston and Watts 2003; Epstein et al. 2014), detailed insights in the nature of the (in)visibility of professional work in policies has been lacking so far. Third, this study adds an analysis of different types of professional work in

small-scale emergency departments to the literature on health policy. Together with other studies of emergency care, for example of different types of patients that seek emergency care (Guttman, Zimmerman and Schaub Nelson 2003), these insights can contribute to emergency care reform.

Finally, this study is not a critique of evidence-based policy making as such. Rather, it is an empirical plea for cultivating a broader and more reflexive approach to evidence in policy making, or more accurately: "intelligent policy making" (Sanderson 2009). In our perspective, intelligent policy making in emergency care entails a heightened sensitivity for the invisibilities that are produced by rendering specific aspects of work visible. Intelligent policy making includes quantitative and qualitative research, gathered in small- and large-scale departments, carefully attending to different types of evidence in order to make policy as 'grounded' in care practices as possible. Intelligent policy making thereby makes evidence for policy more empirically contestable, which, we would say, is an important step to enhancing the scientific, political and practical robustness of evidence-based policy making.

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CHAPTER 8

Conclusion and discussion: Scaling care

Analysing multiplicity

The research question of this dissertation is: *How is scale in Dutch healthcare socially constructed and what are the consequences for the organization and provision of care?* I arrived at this question after reflecting on the public and scientific debates on scale. In the public debate on Dutch healthcare, the expectations of scale are high. Among other things, it is assumed to contribute to efficiency, affordability, integration, customer satisfaction and quality. In efforts to realise these high expectations, policy makers, healthcare executives and others deploy policies and strategies that are (implicitly) aimed at finding the 'optimal scale'. The optimal scale perspective can be traced back to traditional economic studies on scale that focus on 'efficiency' and 'economies of scale'. A large number of studies in organization and public administration literature go one step further and also take the relation of scale with elements like performance and democratic legitimacy into account. Yet, these studies still assume there is an 'optimal scale' for organizations. By reducing issues regarding scale to a technocratic and one-dimensional exercise, however, this approach fails to account for the multiple scales of organizing that have to be dealt with in healthcare, the multiple values that are at stake and the multiple ways in which people make sense of scale. In order to better understand what scale is and how policies and strategies regarding scale work out in practice, it is necessary to put the multiplicity of scale central in research.

Based on human geography and more recent insights from organization and public administration literature, I therefore chose an alternative approach to scale. From a social constructivist perspective, scale is not 'given', but only becomes real and gains meaning in social (inter)action. This approach puts the multiplicity of scale central. What scale is, on what scale(s) healthcare is provided, and how, is an outcome of the interplay between the multiple interests, values and perceptions of the people that are involved and broader social and political processes. This means that generalised statements about scale, such as 'small-scale care is more patient-oriented' or 'large-scale care is more efficient', should be viewed critically. Whether that is true in a specific situation, and what trade-offs and compromises are being made, should be subject of study. Besides, such a statement ignores that 'small- and large-scale care' have different meanings for different people. To explore the multiplicity of scale, I empirically studied the public debate on scale and a case for each of the four major developments

that I discussed in Chapter 1 (mergers, de-institutionalisation of long-term care, decentralisation of care to municipalities and concentration of hospital care). While in the empirical chapters I have studied this multiplicity, in this final chapter I bring the different findings together. I will show what the different empirical cases and theoretical perspectives have learned us about scale in Dutch healthcare and what the theoretical and practical implications of this study are.

The following sections present the conclusions of my research. In the second section, I discuss what scale *is* from a social constructivist perspective. I inductively distinguish three dimensions of scale: scale as structure, scale as space for social action and scale as symbol. In the third section, I explain that the dynamic nature of scale makes it more appropriate to talk about *scaling* than about scale. In the fourth and fifth section, I go deeper into this by discussing how and why scaling takes place as a result of scalar *politics* and scalar *work*. As regards scalar politics, I reflect on the public debate, health policies and organizational strategies that inform and are informed by changes in scale. I then turn to the work that people perform in relation to a certain scale in daily practice, acknowledging that also this work is highly political. The final sections comprise theoretical implications and recommendations for policy makers, managers and professionals.

Three dimensions of scale

Using various research methods and theories, and by 'zooming in' and 'zooming out', I explored the social construction of scale in different settings. In some chapters (e.g. Chapter 4), scale has been foregrounded and put at the centre of analysis. In other chapters (e.g. Chapter 7), scale is more on the background. The different methodological and theoretical approaches allowed me to both study scale and the social processes that take place on and across scale. This has led me to a definition of scale that comprises three dimensions: scale as structure, scale as space for social action and scale as symbol. The three dimensions inductively result from my analysis of the different ways in which scale is enacted in the public debate, policies, strategies and practices. The dimensions are distinct, ideal-typical ways of looking at scale, which combined provide a better understanding of what scale is, how changes in scale take place and why scale is such an important and contested topic in Dutch healthcare. They result from the use of a social constructivist perspective that takes into account tangible and material

elements *(structure)*, human action and interaction *(space for social action)* and sensemaking *(symbol)*. I will discuss the multifaceted nature of scale in detail in the remainder of this section.

The first dimension is *scale as structure* and can be traced back to the traditional approach in economic, organization and public administration literature, combined with the importance of materials that is shown in the previous chapters. This dimension conceptualises scale as something tangible and measurable: for example the number of clients in a facility for elderly care, the number of doctors in a hospital or the turnover of a home care organization. In this dissertation, scale as structure refers to organizations (Chapter 2 and 3), facilities (Chapter 5), geographical areas such as neighbourhoods (Chapter 6) and departments within organizations (Chapter 7) that are thought to have clear boundaries and can easily be demarcated from their environment.

The dimension of scale as structure is prominent in the public and political debates in Dutch healthcare. It is relevant in two ways. First, the attention of policy makers, executives and others with regard to scale is often geared towards changing the structural dimension of scale in order to achieve certain goals, for example in the case of executives who engage in mergers to improve the market position of their organization (Chapter 2). Scale is then used instrumentally. Second, it is relevant because materials such as buildings have consequences for the way managers and professionals organize and provide care. For example, managers in small-scale care make material adaptations to homes or construct new apartment buildings to deal with the value conflicts they experience in their daily work (Chapter 5).

However, my research shows that scale is much more than something that can be demarcated, measured and used instrumentally. The second dimension is *scale as space* for social action (cf. Lefebvre 1991). This dimension emphasizes that what we define as 'scale', such as the neighbourhood and a small-scale home, is also a site where managers, professionals and patients interact and where care is organized and delivered. It is a physical space "for control and domination, but also the arena where cooperation and competition find a fragile stand-off" (Swyngedouw 2004: 35). Such a perspective from within shows that the way scales are designed and what they look like from outside does not always match with the daily realities of the people involved. For example, the idealistic picture of small-scale homes that is painted in policies and the public debate, is different from the practices on the ground where managers also have to deal with angry

neighbours, scheduling problems and lonely clients (Chapter 5). And the policy image of emergency care as something that is predominantly acute and complex does not match with the daily realities of professionals in small-scale emergency departments (Chapter 7).

By looking at scale as a space for social action, which I have done particularly in Chapter 4, 5, 6 and 7, it becomes clear that the boundaries between what is defined as 'a scale' (in a structural way) and its environment are fuzzy. The social relations of people take place on a scale, but equally so across scales. For example, professionals in emergency departments work in a demarcated physical space, but also interact with others across different departments, hospitals and primary care facilities. The organization and provision of emergency care in small-scale departments can only be fully understood when its relations with other spaces are taken into account, for example by looking at protocols for referrals and informal communication with ambulance drivers. This second dimension of scale emphasizes that activities on a scale are intertwined in organizational and material arrangements and cannot easily be demarcated and 'carved out' of its social fabric, as the scale as structure dimension implies. Scale is much more alive and permeable than often thought.

The third dimension is *scale as symbol*. This dimension emphasizes that people in processes of sensemaking (Weick 1995) attribute meaning to scale, which becomes symbolic for different definitions of 'good' and 'bad' care. For example, people may define a scale as 'human', 'close by', 'megalomaniac' or 'bureaucratic'. By doing so, certain scales and changes in scale become appropriate (e.g. de-institutionalisation of long-term care to small-scale homes) and others inappropriate (e.g. mergers that result in large-scale organizations). This often entails political activities of 'scale framing' (Van Lieshout et al. 2012; 2014). Scale framing refers to the rhetorical strategies that actors deploy to frame phenomena at a certain scale. For example, 'the neighbourhood' has become a symbol in policies and strategies that are aimed at stimulating integrated care, self-management and informal care (Chapter 5). The symbolic use of the neighbourhood scale, emphasising 'professional autonomy' and 'civic duties', helps policy makers to decentralise care, call upon the responsibilities of citizens and make budget cuts.

The third dimension of scale illuminates that scale is not only something that is measurable and/or a physical space for action, but also highly moral, psychological, social and cultural. This is particularly visible in Chapter 4 where I show that in the public debate people employ four discourses to attribute symbolic

meaning to scale: human scale, professional scale, business scale and system scale. Each discourse comprises an ideal-typical notion of what scale means and looks/should look like and how it should contribute to improving care. Scale then becomes a symbol for broader ideological views on how healthcare should be organized and provided and what roles patients, professionals, executives and policy makers should play. Scale as symbol emphasizes that scale is not one thing but different things, which can be used to convey an ideological message or to achieve a political goal.

From scale to scaling

The three dimensions of scale are analytically separated, but intrinsically connected and subject to continuous change in practice. They are "perpetually redefined, contested and restructured in terms of their extent, content, relative importance and interrelations" (Swyngedouw 2004: 33). I therefore argue that it is more appropriate to speak of 'scaling' than of 'scale'. Scale is never one thing and a 'fait accompli', but (re)created as different things for different people in different times and places: it is continuously 'under construction'. This also helps to understand why changes in scale of care often do not meet the high expectations and have such unpredictable effects. A lot of attention in current literature and practice is focused on changes in the structural dimension of scale. Those changes are also the most visible. However, changes in this first dimension cause changes in the other dimensions as well. Although these latter changes often remain invisible from the outside, they are very real in their effects. For example, de-institutionalisation of long-term care, replacing care from large-scale institutions to small-scale homes (Chapter 5), does not only result in structural changes in organizations and buildings. It also affects social practices and symbolic meanings of these scales, leading to a new 'social fabric' and changes in processes of sensemaking. Managers perform a lot of justification work to make small-scale care 'workable' for themselves and professionals; clients and their relatives form new interpretations of what they can expect from small-scale care provision; neighbours try to find ways to relate to small-scale care in their neighbourhood. These changes in social action and symbolic meaning again call for changes in structural aspects of scale, for example when managers replace care from small-

scale homes in regular neighbourhoods to larger buildings with small-scale apartments. The three dimensions of scale thereby continuously interact.

The notion of 'scaling' also entails that scale is both a part and the outcome of public debates, health policies, organizational strategies and daily practices. Outcome in the sense that the three dimensions of scale become real and meaningful as a result of debates, policies, strategies and practices. However, it is also constitutive because it enables and disables activities. For example, Chapter 6 shows how the notion of the 'neighbourhood scale' is used in policies and strategies to stimulate collaboration between professionals from different organizations and to promote an active role for informal caregivers. So, the neighbourhood facilitates collaboration and informal care. At the same time, the integration between 'basic' care and 'specialized' home care becomes more difficult due to the changes in policies and strategies. This is because specialized care is organized on a larger scale, for instance the municipality or the region. As professionals increasingly focus on the neighbourhood, collaboration with other professionals outside the neighbourhood runs the danger of receiving less attention. Thereby, the neighbourhood scale also disables certain actions and calls for new debates, policies, strategies and work, for instance aimed at integrating basic and specialized care. In sum, the concept of scaling entails both the interaction between the three dimensions of scale and the notion that scale is both a part and the outcome of social processes. In the next sections, I go one step further and discuss *how* and *why* scaling takes place and what the *consequences* are. I do so by analysing two interrelated activities that drive scaling: *scalar politics and scalar work*.

Scalar politics

Scalar *politics* refers to the contested nature of scale, i.e. the power struggles, the health policies, the organizational strategies, the interests and the values that play a role in discussions on scale and drive changes in scale. These processes change the importance and role of scales, sometimes create new scales, "but – most importantly – these scale redefinitions alter and express changes in the geometry of social power by strengthening power and control of some while disempowering others" (Swyngedouw 2000: 70, 71). In line with MacKinnon (2011), I use the term 'scalar politics' instead of the more established term 'politics of scale' to analyse the political nature of scale in Dutch healthcare. MacKinnon argues that

it is often not scale *per se* that is object of contestation between actors, but that political projects have scalar aspects and repercussions. I have found the same in my research. The cases that I studied are not all explicitly about scale, but do make clear that political and social developments and ideas of what good care is, have intended and unintended consequences for what scale looks like and means. In this section, I analyse scalar politics by looking at the contested nature of scale in the *public debate, in healthcare policies and in organizational strategies*. Scalar politics are predominantly aimed at the use of and changes in scale as structure and scale as symbol (the first and third dimension of scale in my definition). At the same time, the changes in those dimensions also have an impact on scale as space for social action (the third dimension), which I will discuss in the next section.

A heated public debate about scale

The different discourses (human, professional, business, system) that actors use in the public debate make scale implicitly and explicitly part of political struggles. The *symbolic* dimension of scale is central in these struggles. For example, in the human scale and professional scale discourses, actors define scale in positive terms ('personal attention', 'professional freedom') and contrast those with negative connotations of managers and executives, who are 'miles away, at the top of the organization'. Scale in these discourses becomes a symbol to argue for a greater role for patients and professionals in healthcare, for example by strengthening patient participation in healthcare organizations and protecting professional autonomy. In contrast, the use of abstract notions of scale in the business scale and system scale discourses denotes actors' attempts to define scale as something that should be planned, organized and structured 'from above'. Making healthcare abstract subjects it to structural, policy-driven change, specifically by 'marketization' or 'economization' of healthcare. Actors thereby use scale symbolically to prioritise the role of executives and politicians, who are in a position to reform healthcare 'from above', over professionals and patients who have to undergo these changes 'on the work floor'.

So, actors use scale symbolically in the various discourses to rhetorically contest power positions. At the same time, the use of language makes certain activities regarding the *structural* dimension of scale desirable, and others undesirable. A good example is the public discussion of mergers. The human scale and professional scale discourses heavily criticise healthcare mergers, as leading

to 'inhumane', 'distant' and 'bureaucratic' large-scale organizations. Mergers are associated with 'overpaid executives' and 'empire-building strategies'. However, in the business scale discourse, used predominantly by executives, a merger is a perfectly reasonable instrument to deal with market pressures and calls for greater efficiency. Executives also use other discourses to legitimise mergers, for instance, by arguing that the efficiency gains of mergers allow them to invest in small-scale care and training for professionals. The public discussion about mergers therefore shows that the symbolic meanings of scale in the various discourses represent ideologies and are used to legitimise and contest certain activities regarding scale as structure.

Health policies and organizational strategies on scale

The political nature of scale, expressed in contestations over the symbolic use of scale and consequently the legitimacy of certain structural changes in scale, is not restricted to the public debate. It can also be seen in health policies and organizational strategies. To continue with the example of mergers, the analysis in Chapter 2 shows that decisions to merge are closely related to what happens in the policy context. According to executives, important drivers for mergers include increased competition in healthcare, selective contracting of hospital care by insurers and decentralisation of long-term care to municipalities. A merger is not an organizational decision taken in isolation from the outside world, but something influenced by health policies. At the same time, mergers induce new policy measures, such as the 'merger test' (*fusietoets*) introduced after public and political unrest about negative consequences of mergers (Chapter 4). The mergers example shows how scalar politics, i.e. contested ideas of the symbolic meaning of scale and accompanying activities regarding scale as structure, inform health policies and organizational strategies and thereby drive scaling.

Another example of scalar politics can be found in Chapter 7. In a new policy document, which is heavily criticized by hospitals and professionals, the Association of Health Insurers argues for concentrating acute and complex emergency care. The policy fits the political agenda of the Ministry of Health for the concentration of complex hospital care, selective contracting and a reduction in the number of emergency departments. However, the focus on acute and complex care in this policy document makes other types of emergency care invisible. In particular, the Association of Health Insurers paints an image of emergency care that should be provided in large-scale, specialized departments. Emergency care

in small-scale departments is not visible in this image and falls off the political agenda for the future of emergency care, thus leaving unexplored the possibilities for improving quality of non-acute and non-complex emergency care. This example shows how scalar politics can make some scales visible, defined as relevant sites for policy making and social action, while others can be made invisible, neglected and considered irrelevant. In sum, discussions and decisions on scale in the public debate, in policies and in organizational strategies are not neutral but are informed by scalar politics. These politics emerge in contests over symbolic meanings of scale and activities regarding scale as structure (e.g. merger and 'upscaling' of emergency care to larger hospitals).

Scalar work

The section on scalar politics shows that debates and decisions on scale can be characterised by contested symbolic meanings of scale, each informed by a different discourse and set of values. The contestations are possible because actors like policy makers and executives operate at a certain distance from practice, allowing them to design, plan or map scale from 'above'. Values and discourse that are associated with the one symbolic meaning of scale then clash with other values and discourses, resulting in conflicting ideas on what changes in scale as structure are possible and appropriate. For example, based on the considerations regarding proximity of care that underlie the human scale discourse, actors argue against closing small hospitals. This sometimes clashes with the professional scale discourse that demands a larger scale to guarantee quality of medical care.

However, in the daily practices of scale as space for social action (the second dimension of scale), multiple symbolic meanings and structural changes are not only debated, but have to be made compatible. This requires scalar *work*. Policy makers and executives often do not have to deal with the practical consequences of their decisions. Dealing with scale 'on the ground', and combining the meanings of different actors in the daily organization and provision of care, is the job of middle managers and professionals. Due to the practical difficulties and 'thick relations' with patients (O'Kelly and Dubnick 2006) that middle managers and professionals experience in everyday practice, they have to perform work to combine different meanings. For instance, small-scale care for the elderly and people with a disability (Chapter 5) has to be affordable, offer freedom of choice

for clients *and* stimulate the integration of clients in society. And care on the scale of the neighbourhood (Chapter 6) has to improve quality, accessibility *and* integration of care.

Dealing with conflicting meanings in practice requires hard work. According to Star and Strauss (1999: 9) we can identify work by looking at "straining muscles, finished artifacts, a changed state of affairs." Work involves behaviour, the language people use to give meaning to their daily life and the use of materials. As professionals and middle managers have to weigh, combine and prioritise meanings, this work is not only practical, but also highly *political*. On the one hand, the work of people is influenced by the 'meso' and 'macro' level power struggles and ideologies of scalar politics. On the other hand, work entails agency to make political decisions on a micro level, for example on whether or not to spend resources on new small-scale homes or on who is eligible for receiving neighbourhood care. In the process, they also make structural changes in scale (e.g. adaptations in buildings) and produce new symbolic meanings of scale (e.g. in justifying these changes vis-à-vis stakeholders). Where scale then emerges is "in the fusion of ideologies and practices" (Delaney and Leitner 1997: 97).

In the empirical chapters, I used two theoretical concepts to analyse the work that middle managers and professionals perform in healthcare practices: justification work (Jagd 2011; Boltanski and Thévenot 2006) and articulation work (Strauss et al. 1985). Actors perform justification and articulation work to *reconcile* different values, tasks, responsibilities and social worlds. This work has consequences for what scale means and looks like. I do not claim that these types are the most important or the only two that are relevant to a better understanding of scale. Neither do I argue that this work is *completely* aimed at scaling, as concepts like 'scalecrafting' (Fraser 2010) assume, but rather that the work of people has scalar aspects and repercussions (cf. 'scalar politics', MacKinnon 2011). I use the concepts of justification work and articulation work as examples of what consequences the work of the actors can have on what a scale means and looks like. This work is performed in a certain physical space (the second dimension of scale), but also influences structural aspects of scale (in particular buildings) and the symbolic meaning of scale.

Justification and articulation work

Actors perform *justification work* to deal with conflicting values that occur in the organization and provision of care. Chapter 5 shows that managers resolve

value conflicts in small-scale care by striking compromises between values and justifying their decisions vis-à-vis clients, their relatives and neighbours. For example, they resolve the value conflict between freedom of choice and efficiency by calling on clients to undertake activities together. However, justification work is more than a rhetorical exercise. It also involves material objects, for instance by managers using technological devices to monitor care from a distance and thereby resolving the value conflict between affordability and continuity of small-scale care. Finally, justification work entails actors' behaviour, for example changing working methods and schedules. Through justification work, managers reconcile different values (e.g. affordability, continuity of care, freedom of choice and efficiency) to ensure that clients can receive small-scale care. The analysis shows that some managers can organize care in archetypical small-scale houses, despite value conflicts. Other managers, however, see these value conflicts as unsolvable and choose to develop large-scale buildings with small-scale apartments. So, the way managers perform justification work has important consequences for what small-scale care in practice looks like materially (the first dimension of scale) and means for the actors that are involved (the third dimension).

Articulation work is aimed at connecting and integrating tasks, responsibilities and social worlds. It differs from justification work in the sense that it does not involve conflicting values. Instead, articulation work aims to reconcile the elements of care work that belong to one 'illness trajectory' of a patient (Strauss et al. 1985) but are separated between people and organizations. An illness trajectory comprises medical treatment, but also activities like planning and coordinating. An example of articulation work on the neighbourhood scale can be found in Chapter 6. There I argue that, due to the taylorist work division, articulation work was removed from neighbourhood nursing and transferred to central planning departments in the 1980s. The analysis shows how a new project (the 'Visible link') allows neighbourhood nurses to perform articulation work again to integrate the fragmented home care services. Because of this work, the geographical scale of the neighbourhood becomes relevant in healthcare. Although 'the neighbourhood' also exists without neighbourhood nurses, it only has meaning in healthcare when services are actually organized and provided on that scale. The articulation work of neighbourhood nurse accomplishes just that, for example by collaborating with other professionals that operate in the same neighbourhood and by stimulating informal care by relatives and neighbours.

Because of this work, the neighbourhood is constructed as a real and meaningful scale for the organization and provision of healthcare.

Theoretical implications

By looking at scale from a social constructivist perspective, this dissertation has provided new insights in what scale is and how changes in scale are enacted in Dutch healthcare. A contribution to organization and public administration literature is the notion of scale as a three-dimensional construct: scale as structure, scale as space for social action and scale as symbol. In order to understand how scales are perceived, what role they play in social and political processes, what the underlying rationales are and what the consequences are for the organization and provision of care, all three dimensions have to be taken into account. The three dimensions are mutually constitutive: changes in one dimension, have an effect on the other two. Changes in scale as structure are often conscious, explicit and easily recognisable as such. Changes in scale as space for social action and scale as symbol are not always associated with scale, but nevertheless have real consequences for how scale is perceived and what actions are (im)possible and (un)desirable. Future studies on scale could take the three dimensions as a starting point to analyse in other settings (e.g. businesses or healthcare in other countries) and or/involving other actors (e.g. customers and patients), how and why changes in scale take place and what the consequences are.

Another finding is that changes in the three dimensions of scale ('scaling') are driven by scalar politics and scalar work. Importantly, the political nature of scale is not limited to 'macro-level' debates and decisions, but is at the same time enacted in the daily work on a 'micro-level' where actors have to reconcile different values, tasks, responsibilities and social worlds. In this process, they also make subtle structural changes in scale and provide new symbolic meanings to scale in interaction with stakeholders. Scale can therefore not be separated from the context in which it is constructed, but is intrinsically connected to the public debate, the dynamics of health policies and organizational strategies, and the work of managers and professionals 'on the ground'. This has resulted in a dissertation that is about scale, but equally about the politics and the work that (explicitly and implicitly) influence and are influenced by scale. For further research, it would be interesting to study how some major structural changes in

scale in the Netherlands, in particular further decentralisation of long-term care and concentration of medical care, influences scale as a space for social action and the symbolic meaning of scale. The policy expectations of decentralisation and concentration are high, but more empirical studies are needed to investigate whether the up to now mainly hypothetical advantages can indeed be realised in practice.

The findings of this study point to the importance of language, work and materials in issues regarding scale. Human geography literature and some studies in organization and public administration on the social construction of scale, have devoted quite some attention to the rhetorical nature of scale in the form of 'scalar discourses' or 'scalar narratives' (e.g. Kaiser and Nikiforova 2006; Spicer 2006; Van Lieshout et al. 2012; 2014). Indeed, I have shown in this dissertation that language is important in processes of scale-framing and sensemaking of and on scales, in particular with regard to the dimension of scale as symbol. However, a focus on discourse sometimes leaves the structural dimension of scale and the work that people perform implicit. Scaling is not only a rhetorical, fluid, open and dynamic process, but also becomes fixed as activities are structured on a certain scale. Importantly, scalar fixes are always temporary; even materials like small-scale homes can be adapted, demolished and reconstructed. But by taking the material conditions of scale and the work of actors into account, it becomes better understandable how scales can change *and* be stable over a longer period of time.

Finally, this dissertation emphasizes the relevance of the study of scale. The idea of scale as a social construction has led some scholars to abandon the notion of scale because "there is no such thing as a scale" (Thrift 1995: 33). These authors argue for 'flat ontologies' because using scale as an analytical construct would inevitably make the large, the global and the macro more important than the small, the local and the micro. Flat ontologies, or network approaches, would emphasize the linkages between different places and practices, not a priori prioritising one over the other (Marston, Jones and Woodward 2005). I agree with these authors that there is no inherent hierarchical relation between scales and that what we call scales are constructed and connected in multiple ways. However, we live in a world where people make, act upon and attach meaning to things like nations, regions, municipalities, neighbourhoods, large-scale organizations and small-scale facilities. We can therefore still treat scales as objects of enquiry: they may not be 'real' in an ontological way, but this dissertation shows

that as 'epistemological constructs' (Jones 1998; Moore 2008) they have very real consequences for policy makers, managers, professionals and patients.

Recommendations for practice

This dissertation also generates recommendations for practice. All actors should be aware that the changes they make in scale as structure, for example by de-institutionalising care or by engaging in mergers, impacts the social fabric of scale (the second dimension) and its symbolic meaning (third dimension). In other words: structural changes in scale can have unpredictable consequences for managers, professionals and patients in the daily organization and provision of care. It actually requires a lot of work to make structural changes in scale 'workable' in daily practice. At the same time, when the symbolic meaning of a certain scale changes, for example as a consequence of changing societal preferences, the other dimensions (should) change as well. This requires policy makers, executives, managers and professionals to be highly sensitive to the scale that is needed in a particular situation and the consequences of structural, social and symbolic changes in and around scales.

For *policy makers*, this dissertation calls for "intelligent policy making" regarding scale (Sanderson 2009), which considers a wide variety of elements: 'macro-level' aspects of quality, affordability and accessibility as well as 'micro-level' experiences of managers, professionals and patients. In other words, policies that are aimed at changing the structural dimension of scale, should also take the other two dimensions into account. This calls for nuance in the political arena: 'small is beautiful' (e.g. in the case of long-term care) or 'bigger is better' (e.g. in discussions about concentration of hospital care) does not do justice to the three-dimensional nature of scale. All kinds of intermediate forms are possible: small-scale facilities within large-scale organizations, small-scale organizations that are part of a large-scale network, large-scale organizations in which middle managers and professionals have a large degree of autonomy et cetera. It is the interplay of the three dimensions of scale that has certain consequences; there is no causality between scale as structure (in terms of the size of an organization or facility) and positive or negative outcomes. Policy changes in scale as structure should also be justified on the basis of the impact on scale as space for social action and scale as symbol.

Also *executives and managers* should be aware that scale is a multifaceted concept, in which changes in the one dimension of scale have an impact on the other dimensions. Therefore, they should include a wide range of values and perspectives in decisions on scale. Their work determines for a large part what scales of organizations, facilities and departments look like and how care is organized on these scales. This position creates major possibilities *and* responsibilities. In making decisions on scale, it is important that executives and managers do not just look for vertical legitimisation from their supervisors, superiors and inspectorates, but also involve clients, professionals and other organizations in their environment. By constantly justifying their decisions to relevant others, and adapting these when necessary, executives and managers can account for the different social realities and symbolic meanings of scale that are present.

The implication of this dissertation for *professionals* is that they should not settle for only providing care and leaving the organizational work to executives, managers and staff departments. The work of professionals is an important factor in how patients and others experience the organization and provision of care on a certain scale (e.g. a neighbourhood, a facility). In particular, professionals have the opportunity to reconcile different symbolic meanings of scale in their daily work. They are the ones who can combine calls for more efficiency, better quality, more innovation and thereby organize and deliver care in a way that is meaningful for the different actors that are involved. Furthermore, professionals have unique knowledge of how health policies and organizational strategies aimed at making structural changes in scale, work out for patients. They should use these insights to facilitate better-informed decisions on scale, for example by taking on organizational roles and participating in public debates on scale.

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Summary

Scale of care is a much debated topic in Dutch media, the political arena and the boardrooms of organizations. Depending on who one asks, large-scale, small-scale, upscaling or downscaling is expected to contribute to more efficiency, affordability, integration, patient satisfaction and quality of care. In line with these high expectations, changes in scale play an important role in several developments in Dutch healthcare. In this dissertation, I focus on four major developments: (1) mergers between healthcare organizations, (2) de-institutionalisation of long-term care, (3) decentralisation of care from the state to municipalities and (4) concentration of hospital care. In discussions and policies concerning the four developments, Dutch policy makers, healthcare executives and others easily equate changes in scale with positive or negative outcomes. For example, downscaling is supposed to lead to more patient centredness, upscaling to more market power. The idea that there is a clear causal relation between scale and certain outcomes leads to a search for the 'optimal scale', often in terms of efficiency. This leads to such statements as: 'the optimal scale for nursing homes is between 100 and 200 beds'.

However, the optimal scale approach is problematic in three ways. First, it ignores the multiplicity of organizational forms in Dutch healthcare, both within and between sectors. As each organization is unique in the mix of services it delivers, the facilities it has, the patient groups it serves and the geographical area in which it is active, it is impossible to establish one optimal scale that is applicable to all organizations. Second, the optimal scale approach obscures the multiple and sometimes conflicting values that are at stake in healthcare, such as quality, accessibility, innovation, equity and affordability. One scale that might be optimal in terms of the one value might be sub-optimal in terms of another value. These value conflicts are highly political and cannot be reduced to a cost-benefit analysis. Third, the optimal scale approach leaves no place for the multiple, subjective and changeable perceptions of scale that people have. People might experience the same scale differently, depending on how they make sense of it. To account for the multiplicity of scale in organizational forms, values and perceptions, I opted for a perspective from the field of human geography. This perspective conceptualises scale as a social construction.

The social constructivist approach emphasizes that scale is not 'given', but the result of human (inter)action, sensemaking, language and the use of materials. What we call micro, macro, local, regional, small and large is not inherent to the world, but a consequence of how we make, perceive, define and classify things.

For example, Dutch hospital organizations can be perceived as large-scale when compared to the scale of hospitals several decades ago. However, when one takes hospital organizations in the US into account, Dutch hospitals are small-scale. In addition, previous studies have shown that changes in scale are not rational shifts in functional tasks and responsibilities that have predictable outcomes, as is often assumed, but dynamic, political and unpredictable processes. Because of this unpredictability, the high expectations and the frequent use of changes in scale as a governance instrument in Dutch healthcare, empirical studies of the workings of scale in practice are necessary. I conducted such studies on the basis of the following research question: *How is scale in Dutch healthcare socially constructed and what are the consequences for the organization and provision of care?* I employed a multi-method research design, including a survey, a discourse analysis, interviews and observations, to explore the social construction of scale in organizational strategies, health policies, the public debate and daily practices.

Chapter 2 is about motives for mergers in Dutch healthcare. Since the 1980s, healthcare sectors in many OECD countries, including the Netherlands, have become increasingly concentrated as a result of mergers. This has fuelled a public and scientific debate about the consequences of mergers and the desirability of further upscaling of healthcare organizations. Although there is an increasing amount of research on the effects of mergers between healthcare providers, detailed empirical insights in why they merge and how mergers are influenced by (changes in) health policy, are lacking. Among other things, policy changes are aimed at strengthening competition on the 'healthcare market' and increasing financial risk for providers. Healthcare organizations also have to deal with de-institutionalisation of long-term care and mental healthcare and decentralisation of home care to municipalities. These changes may stimulate providers to merge, for example to strengthen their market position or improve efficiency.

To study why healthcare providers merge, a survey was sent to Dutch healthcare executives. The final sample consisted of 239 respondents, of which 155 (64.9 per cent) had been involved in at least one merger case between 2005 and 2012. The findings show that that the dominant motives for mergers were improving healthcare provision (important for 69 per cent of the executives) and strengthening market/bargaining power (63 per cent). Also efficiency (46 per cent) and financial reasons (28 per cent) were important drivers of merger activity in healthcare. Pressure from external or internal stakeholders was rarely a

reason to merge (12 per cent). The analysis also suggests that upscaling of healthcare organizations is influenced by changes in policy, in particular with regard to increasing pressure from competitors, health insurers and municipalities.

Chapter 3, based on the same survey of Dutch healthcare executives, focuses on the reasons why some merger trajectories are abandoned. This is an under researched topic in healthcare, although studies from other sectors estimate that between 11 per cent and 28 per cent of all intended mergers are abandoned and that the consequences of merger abandonment can be substantial. Based on studies in other sectors, it was expected that the following elements would play a role in merger abandonment: antitrust laws, pressure from external and internal stakeholders, the discovery of performance problems during the merger process, executives' merger experience, organizational diversification and differences between organizations in sector, size and ideology.

38 per cent (n=53) of the executives in the study reported that their merger case ended prematurely (n=53). The most frequently mentioned reasons of merger abandonment were changing insights on the desirability and feasibility of the merger during the merger process (32 per cent), incompatibilities between executives (30 per cent) and insufficient support for the merger from the supervisory board (15 per cent). Also other internal stakeholders, like works councils, client advisory councils, middle management and professionals influenced merger abandonment. Besides the antitrust authority, external stakeholders hardly played a role in merger abandonment. Finally, there were no significant differences in organization/sector characteristics, such as diversification and size, between completed and abandoned mergers.

Chapter 4 focuses on the way scale of healthcare organizations is socially constructed in the Dutch public debate. Insights from the 'spatial turn in organizational studies', the work of French philosopher and sociologist Henri Lefebvre and studies from human geography served as a theoretical framework. The analysis focused on texts from newspapers between 1990 and 2014 and resulted in four discourses on scale: the human scale, the professional scale, the business scale and the system scale. Each discourse emphasizes certain physical and non-physical spaces and comprises an ideal-typical notion of scale. For example, the professional scale discourse focuses on the physical spaces healthcare professionals inhibit, such as examination rooms and wards. This discourse emphasizes the

distance between management and professionals (the 'top of the organization' where managers operate far away from the 'work floor' that belongs to professionals). Also in the human scale discourse, physical spaces, such as homes and neighbourhoods, play an important role. Contrary, in the business scale and system scale discourses, spaces that are largely non-physical are more important (the market, the policy arena).

The social construction of scale in newspaper texts is not a neutral rhetorical exercise. By putting the physical spaces of patients and professionals central in the first two discourses, and by contrasting those with the spaces of managers, actors try to legitimise and naturalise a greater role for patients and professionals in healthcare. At the same time, the use of non-physical, abstract notions of space in the business scale and system scale discourses denotes attempts to construct scale as something that should be planned, organized and structured from 'above' by executives and policy makers. The findings implicate that debates about scale are informed by multiple discourses, involving notions of health policy, market power and efficiency as witnessed in merger decisions, but also broader perspectives on patient centredness, professionalism and quality of care.

Chapter 5 zooms in on small-scale homes for the elderly and people with a disability. Building on theory on justification, developed by French sociologists Luc Boltanski and Laurent Thévenot, the chapter analyses the way middle managers and executives deal with conflicting values in small-scale care. Based on interviews and observations, three value conflicts were inductively identified: affordability of care versus 24-hour supervision; freedom of choice of clients versus an efficient organization of care; integration of clients into society versus legitimacy from the neighbourhood. Managers perform 'justification work' to strike compromises between the conflicting values. For example, they install baby phones and cameras so professionals are able to monitor clients from a distance, allowing for both affordability of care and 24-hour supervision. At the same time, managers discuss the allocation of funds with clients and their relatives. In processes like these, managers continuously justify their decisions vis-à-vis the people that are involved.

The concept of 'justification work' helps to understand how managers deal with value conflicts in the organization and provision of small-scale care. This work is not only rhetorical (justifying compromises to others), but also involves the use and adaptation of material objects (e.g. babyphones) and the remodel-

ling of professional behaviour (e.g. through working methods and schedules). The chapter demonstrates that the transition of long-term care from large-scale secluded facilities to small-scale homes in regular neighbourhoods is accompanied by multiple and conflicting values. Striking compromises between these conflicting values and subsequently justifying the compromises, requires hard work by managers. The findings illustrate the importance of detailed studies on scale 'from the inside', paying attention to how the work of actors gives scale shape and meaning.

Chapter 6 stays at the neighbourhood scale and focuses on the work of neighbourhood nurses in a new project, namely the 'Visible link' (in Dutch: 'Zichtbare schakel'). Traditionally, neighbourhood nurses perform a wide variety of tasks, ranging from health education to complex nursing tasks. Over the last decades however, their work was subdivided into specific tasks and partly distributed to other care workers, managers and central planning departments. In the Visible link project, neighbourhood nurses are given the responsibility to reduce the fragmentation that emerged. They should do so by providing a broad range of services again, as well as organizing and coordinating services that are delivered to clients by other professionals. The work of neighbourhood nurses is analysed with the use of the concept of 'articulation work'. The concept is developed by medical sociologist Anselm Strauss and colleagues to understand the often invisible work that professionals perform to coordinate and integrate different activities around clients.

On the basis of interviews with neighbourhood nurses, three types of articulation work are identified: intraprofessional, interprofessional and lay articulation work. Intraprofessional articulation work comprises alignments of the different tasks that neighbourhood nurses individually perform when dealing with clients. Interprofessional articulation work entails the work of a neighbourhood nurse that is aimed at improving cooperation and coordination between professionals from different organizations and sectors. Lay articulation work refers to the efforts of the neighbourhood nurse to organize and stimulate informal care and self-management. The analysis shows that scale, in this case the neighbourhood scale, influences and is influenced by the work of professionals who have to reconcile different tasks and responsibilities. Doing so enables them to meet policy expectations and improve quality of care for clients.

Chapter 7 entails an analysis of Dutch small-scale emergency departments in the light of the introduction of a new policy. Among other things, the policy proposed concentration of emergency care in fewer hospitals. The policy evoked resistance from professionals and hospital boards who argued that the evidence-base of the policy was flawed and ignored important aspects of professional work in emergency care. To investigate whether this is the case, both the policy document and daily work practices in and around emergency departments were analysed. Observations and interviews, conducted primarily in small-scale emergency departments and to a lesser extent in large-scale departments, resulted in four so-called repertoires of emergency care: acute and complex care, uncertain diagnostics, low-complex care and physical-social-mental care. Each repertoire comprises certain patients' conditions (e.g. minor health issues in the repertoire of low-complex care), professional skills (e.g. routine medical skills in the same repertoire) and organizational features (e.g. good collaboration between the emergency department and primary care facilities).

The new policy is primarily based on quantitative studies on the first repertoire, focusing on acute and complex emergency care that is predominantly provided in large-scale emergency departments. By focusing on the first repertoire, the policy makes the majority of professional work in small-scale emergency departments invisible. This has consequences: if all attention of policy makers is geared to repertoire one, possibilities for improving quality of care in the other three repertoires are left unexplored. These other repertoires comprise specific professional skills (e.g. communicative and organizing skills) and an organization of care (e.g. informal collaboration between departments and facilities) that are much harder to measure quantitatively, but are nonetheless crucial for the quality and efficiency of small-scale emergency care. The analysis exemplifies that policy definitions of large- and small-scale care do not always match with the realities on the ground.

Chapter 8 comprises the conclusions of this study of scale in Dutch healthcare. The different methodological and theoretical approaches in the empirical chapters have led to a definition of scale that comprises three dimensions: scale as structure, scale as space for social action and scale as symbol. The dimensions are distinct, ideal-typical ways of looking at scale, which in combination help to understand what scale is and how changes in scale take place. Scale as structure conceptualises scale as something tangible and measurable, for example the

number of clients in nursing home or the turnover of a hospital. Scale as space for social action emphasizes that scale is also a space where managers, professionals and patients interact and where care is organized and delivered. Scale as symbol comprises the rhetorical use of scale which shapes and conveys ideological views on how healthcare should be organized and provided.

Changes in the three dimensions are enacted in different ways. As regards scale as structure, changes are often conscious, explicit and easily recognisable as such. Changes in scale as space for social action and scale as symbol are not always associated with scale, but nevertheless have real consequences for how scale is perceived and what actions are (im)possible and (un)desirable. Drivers of such changes are 'scalar politics' and 'scalar work'. Scalar politics refers to the power struggles, the policies, the organizational strategies, the interests and the values that lead to structural changes in scale and provide new meanings to scale. Scalar work entails the actions of people who have to deal with the multiple symbolic meanings and structural changes in practice. Notably, the political nature of scale is not limited to 'macro-level' debates and decisions, but is also enacted in the daily work on a 'micro-level' where actors have to reconcile different values, tasks and responsibilities.

Due to the dynamic character of scale, it is more appropriate to speak of 'scaling' than of 'scale'. Scale is never one thing and a 'fait accompli', but (re) created as different things for different people in different times and places: it is continuously 'under construction'. This calls for nuance in the public and political debate: statements like 'small is beautiful' (e.g. in the case of long-term care) or 'bigger is better' (e.g. in discussions about concentration of hospital care) do not do justice to the three-dimensional nature of scale. Policy makers, executives, middle managers and professionals should be aware that the changes they make in scale as structure, for example by de-institutionalising long-term care or by engaging in mergers, impacts the social actions that take place on a scale (the second dimension) and its symbolic meaning (the third dimension). This requires all actors to be highly sensitive to the scale that is needed in a particular situation and the consequences of structural, social and symbolic changes in and around scales.

Samenvatting

Schaalgrootte in de zorg is regelmatig onderwerp van discussie in de Nederlandse politiek, de media en de bestuurskamer. En hierbij zijn de verwachtingen van schaal hooggespannen. Afhankelijk van wie je het vraagt, zou grootschaligheid, kleinschaligheid, schaalvergroting of juist schaalverkleining moeten bijdragen aan meer efficiëntie, toegankelijkheid, patiënttevredenheid en kwaliteit van zorg. Veranderingen in schaal spelen dan ook een belangrijke rol in verschillende ontwikkelingen in de Nederlandse zorg. In discussies en beleid gericht op de vier ontwikkelingen stellen beleidsmakers, zorgbestuurders en anderen veranderingen in schaal vaak gelijk aan positieve of negatieve uitkomsten. Schaalverkleining zou bijvoorbeeld leiden tot meer patiëntgerichtheid en schaalvergroting tot een betere marktpositie. Het idee dat er een duidelijk causaal verband is tussen schaal en bepaalde uitkomsten leidt tot een zoektocht naar de 'optimale schaal', vaak in termen van efficiëntie. Dit resulteert in uitspraken als: 'de optimale schaal van een verzorgingshuis is tussen 100 en 200 bedden'.

Denken in termen van optimale schaal kent echter drie grote problemen. De eerste is dat de verschillen tussen en binnen sectoren zo groot zijn dat het bestaan van één optimale schaal voor al die verschillende soorten zorg en organisaties een illusie is. De tweede is dat er geen rekening wordt gehouden met de conflicterende waarden waarmee zorgorganisaties te maken hebben: een schaal die optimaal is in termen van efficiëntie, hoeft dat in termen van kwaliteit of toegankelijkheid zeker niet te zijn. Dergelijke waardenconflicten behoren tot het politieke debat en kunnen niet worden gereduceerd tot een kosten-baten analyse. De derde tekortkoming is dat er in deze manier van denken geen ruimte is voor de verschillende manieren waarop mensen organisaties ervaren. Een organisatie die grootschalig is in termen van omzet of aantal medewerkers, kan in de beleving van medewerkers en patiënten juist heel kleinschalig aanvoelen (en andersom). Om de 'meervoudigheid' van organisatievormen, waarden en ervaringen met betrekking tot schaal te kunnen onderzoeken, koos ik in dit proefschrift voor een perspectief uit de sociale geografie. Hier wordt schaal gezien als een 'sociale constructie'.

Het sociaal constructivistische perspectief gaat ervan uit dat schaal niet is 'gegeven', maar het gevolg is van menselijke (inter)actie, betekenisgeving, taal en het gebruik van materialen. Wat we micro, macro, lokaal, regionaal, klein en groot noemen is geen natuurlijk onderdeel van de wereld, maar een gevolg van hoe we dingen maken, ervaren, definiëren en classificeren. Of we bijvoorbeeld ziekenhuizen in Nederland 'grootschalig' of 'kleinschalig' noemen, hangt vol-

ledig af van het perspectief dat we kiezen. Vanuit historisch perspectief zijn de Nederlandse ziekenhuizen grootschalig, maar in vergelijking met sommige Amerikaanse ziekenhuizen juist kleinschalig. Daar komt bij dat eerder onderzoek heeft laten zien dat veranderingen in schaal geen eenvoudige verschuivingen in taken en verantwoordelijkheden zijn, zoals vaak wordt gedacht, maar dynamische, politieke en onvoorspelbare processen. Vanwege deze onvoorspelbaarheid, de hoge verwachtingen van schaal en het belang van veranderingen in schaal bij hervormingen van de Nederlandse zorg, zijn empirische studies naar schaal noodzakelijk. Ik heb dergelijke studies uitgevoerd op basis van de volgende onderzoeksvraag: *Hoe is schaal in de Nederlandse zorg sociaal geconstrueerd en wat zijn de gevolgen voor de organisatie van zorg en de zorgverlening?* Aan de hand van een vragenlijstonderzoek, een taalanalyse (discoursanalyse), interviews en observaties heb ik de sociale constructie van schaal onderzocht in strategieën van zorgorganisaties, beleid, het publieke debat en de dagelijkse zorgpraktijk.

Hoofdstuk 2 gaat in op motieven voor fusies tussen zorgaanbieders in Nederland. Sinds de jaren '80 vinden in veel OESO-landen, waaronder Nederland, steeds meer fusies plaats. Dit heeft geleid tot een publiek en wetenschappelijk debat over de consequenties van fusies en de wenselijkheid van verdere schaalvergroting in de zorg. Inzichten in de motieven voor fusies zijn echter beperkt. Datzelfde geldt voor de invloed van wijzigingen in beleid op fusies. Beleidswijzigingen zijn onder andere gericht op het versterken van concurrentie op de 'zorgmarkt' en het vergroten van financiële risico's voor aanbieders. Daarnaast is sprake van de-institutionalisering (verplaatsing van langdurige zorg en geestelijke gezondheidszorg van grootschalige instituten naar kleinschalige woningen in de wijk) en decentralisatie van thuiszorg naar gemeenten. Deze veranderingen zouden een stimulans kunnen zijn voor zorgorganisaties om te fuseren, bijvoorbeeld om hun marktpositie te versterken of efficiëntievoordelen te behalen.

Om te onderzoeken waarom zorgaanbieders fuseren is een vragenlijst uitgezet onder Nederlandse zorgbestuurders. 239 respondenten vulden de vragenlijst in, waarvan 155 respondenten (64,9 procent) betrokken waren bij minstens één fusie tussen 2005 en 2012. De resultaten laten zien dat zorginhoudelijke redenen (van belang voor 69 procent van de bestuurders) en het verbeteren van de markt-/onderhandelingspositie (63 procent) de belangrijkste fusiemotieven waren. Ook efficiëntie (46 procent) en financiële overwegingen (28 procent) speelden een rol. Druk van externe of interne betrokkenen vormde zelden een reden om te

fuseren (12 procent). Daarnaast laat de analyse zien dat schaalvergroting in de zorg wordt beïnvloed door veranderingen in beleid, in het bijzonder het beleid dat zorgt voor toenemende druk op zorgaanbieders van concurrenten, zorgverzekeraars en gemeenten.

Hoofdstuk 3, gebaseerd op hetzelfde vragenlijstonderzoek onder Nederlandse zorgbestuurders, richt zich op de redenen dat sommige fusietrajecten voortijdig worden afgebroken. Dit is een thema dat nog weinig is onderzocht in de zorg, hoewel studies uit andere sectoren schatten dat tussen 11 en 28 procent van alle voorgenomen fusies voortijdig wordt afgebroken en dat de gevolgen van afgebroken fusies groot kunnen zijn. Gebaseerd op eerdere studies was de verwachting dat verschillende factoren een rol zouden spelen in het voortijdig afbreken van fusies, waaronder druk van externe en interne betrokkenen, het ontdekken van problemen tijdens het fusieproces en de ervaring van bestuurders met fuseren. Datzelfde geldt voor verschillen tussen organisaties in de sector waarin ze actief zijn, de omvang en de ideologie.

38 procent (n=53) van de bestuurders in het onderzoek gaf aan dat de fusie waarbij ze waren betrokken voortijdig is beëindigd. De meest genoemde redenen voor het afbreken van een fusie waren voortschrijdend inzicht in de wenselijkheid en haalbaarheid van de fusie gedurende het fusieproces (genoemd door 32 procent van de bestuurders), inhoudelijke en persoonlijke verschillen tussen bestuurders (30 procent) en onvoldoende steun voor de fusie van de Raad van Toezicht (15 procent). Ook andere interne betrokkenen, zoals Ondernemingsraden, Cliëntenraden, middenmanagement en professionals waren van invloed op het afbreken van fusies. Behalve de Mededingingsautoriteit speelden externe betrokkenen nauwelijks een rol. Ten slotte waren er geen significante verschillen in organisatie- en sectorkenmerken, zoals omvang en ideologie, tussen wel en niet afgebroken fusietrajecten.

Hoofdstuk 4 behandelt de wijze waarop in de Nederlandse media wordt gesproken over schaal van zorgorganisaties. Inzichten uit de organisatiekunde, het werk van de Franse filosoof en socioloog Henri Lefebvre en studies uit de sociale geografie dienden als theoretisch raamwerk. De analyse richtte zich op krantenartikelen tussen 1990 en 2014 en resulteerde in vier verhalen (discoursen) over schaal: de menselijke schaal, de professionele schaal, de bedrijfsmatige schaal en de systeemschaal. Elk verhaal benadrukt bepaalde fysieke en niet-fysieke ruimtes en

bevat een ideaaltypische opvatting van schaal. Het verhaal over de professionele schaal richt zich bijvoorbeeld op de fysieke ruimtes die professionals innemen, zoals spreekkamers en verpleegafdelingen. Het verhaal benadrukt de afstand tussen management en professionals: de 'top van de organisatie' waar managers zich bevinden ver weg van de 'werkvloer' die toebehoort aan professionals. Ook in het verhaal van de menselijke schaal spelen fysieke ruimtes, zoals huizen en buurten, een belangrijke rol. In de verhalen van de bedrijfsmatige schaal en de systeemschaal staan juist plaatsen centraal die grotendeels niet-fysiek zijn ('de markt', 'de beleidsarena').

De sociale constructie van schaal in krantenartikelen is niet een neutrale retorische exercitie. Door de fysieke ruimtes van patiënten en professionals centraal te stellen in de eerste twee verhalen, en door deze af te zetten tegen de ruimtes van managers, proberen actoren een grotere rol voor patiënten en professionals in de zorg te legitimeren. Tegelijkertijd gebruiken andere actoren juist niet-fysieke, abstracte ruimtes in de verhalen van de bedrijfsmatige schaal en de systeemschaal om schaal te definiëren als iets dat zou moeten worden gepland, georganiseerd en gestructureerd 'van boven' door bestuurders en beleidsmakers. De analyse laat zien dat verschillende verhalen een rol spelen in debatten over schaal. Hierin zijn thema´s als beleid, marktpositie en efficiëntie van belang (net als bij fusieprocessen), maar ook patiëntgerichtheid, professionalisme en kwaliteit van zorg.

Hoofdstuk 5 zoomt in op kleinschalige woningen voor ouderen en mensen met een beperking. Voortbouwend op theorie over rechtvaardiging, ontwikkeld door de Franse sociologen Luc Boltanski en Laurent Thévenot, richt de analyse zich op de wijze waarop middenmanagers en bestuurders omgaan met conflicterende waarden in de kleinschalige zorg. Op basis van interviews en observaties worden drie waardenconflicten onderscheiden: betaalbaarheid van zorg versus 24-uurs toezicht, keuzevrijheid voor cliënten versus een efficiënte organisatie van zorg en integratie van cliënten in de samenleving versus legitimiteit van de buurt. Managers verrichten 'rechtvaardigingswerk' om compromissen te kunnen sluiten tussen de conflicterende waarden. Ze installeren bijvoorbeeld babyphones en camera's zodat professionals cliënten op afstand kunnen monitoren. Hiermee wordt zowel betaalbare zorg als 24-uurs toezicht gerealiseerd. Tegelijkertijd bespreken managers met cliënten en hun familieleden hoe het beschikbare budget zo goed mogelijk kan worden ingezet. In dit soort processen rechtvaardigen managers voortdurend hun keuzes tegenover de betrokkenen.

Het concept 'rechtvaardigingswerk' helpt om te kunnen begrijpen hoe managers omgaan met waardenconflicten die ze tegenkomen bij het organiseren en leveren van kleinschalige zorg. Dit werk is niet alleen retorisch van aard (het rechtvaardigen van compromissen tegenover anderen), maar houdt ook in dat managers materialen gebruiken en aanpassen (bijvoorbeeld babyphones) en het gedrag van professionals beïnvloeden (bijvoorbeeld door nieuwe werkmethoden en roosters). Het hoofdstuk laat zien dat de transitie van langdurige zorg vanuit grootschalige instituten naar kleinschalige woningen in de wijk gepaard gaat met conflicterende waarden. Managers moeten hard werken om compromissen tussen deze conflicterende waarden te sluiten en de compromissen te rechtvaardigen. De uitkomsten illustreren het belang van gedetailleerde studies van schaal 'van binnen uit', gericht op de wijze waarop het werk van mensen schaal vormt en betekenis geeft.

Hoofdstuk 6 richt zich op de schaal van de wijk. Het werk van wijkverpleegkundigen in een nieuw project, de 'Zichtbare schakel', staat centraal. Traditioneel hebben wijkverpleegkundigen een breed takenpakket, variërend van verzorging tot complexe verpleegkundige handelingen. Gedurende de laatste decennia is hun werk echter steeds verder opgeknipt in specifieke taken en gedeeltelijk ondergebracht bij andere zorgverleners, managers en planners. In het project van de Zichtbare schakel geven beleidsmakers wijkverpleegkundigen de verantwoordelijkheid om de fragmentatie die is ontstaan terug te dringen. Dit dienen ze te doen door het opnieuw uitvoeren van een breed takenpakket en door het organiseren en coördineren van de diensten die worden geleverd aan cliënten door andere professionals in de wijk. Het werk van de wijkverpleegkundigen is geanalyseerd met behulp van het concept 'articulatiewerk'. Dit concept is ontwikkeld door de medisch socioloog Anselm Strauss en zijn collega's om het vaak onzichtbare werk te kunnen begrijpen dat professionals verrichten om verschillende activiteiten rondom cliënten te coördineren en integreren.

Een analyse van interviews met wijkverpleegkundigen leverde drie typen articulatiewerk op: intraprofessioneel, interprofessioneel en informeel articulatiewerk. Intraprofessioneel articulatiewerk bevat het afstemmen van de verschillende taken die wijkverpleegkundigen zelf verrichten bij cliënten. Interprofessioneel articulatiewerk slaat op het werk dat wijkverpleegkundigen verrichten om de activiteiten van andere professionals, uit verschillende organisaties en sectoren, te coördineren. Informeel articulatiewerk gaat over de inspanningen van

wijkverpleegkundigen om informele zorg en zelfzorg van cliënten te organiseren en stimuleren. De analyse laat zien dat schaal, in dit geval de schaal van de wijk, van invloed is op en beïnvloed wordt door het werk van wijkverpleegkundigen die verschillende taken en verantwoordelijkheden verenigen. Hiermee komen professionals tegemoet aan verwachtingen van beleidsmakers en proberen ze de kwaliteit van zorg voor cliënten te verbeteren.

Hoofdstuk 7 bevat een analyse van spoedzorg in kleinschalige Nederlandse ziekenhuizen in het licht van de introductie van een nieuw beleidsdocument. In het document stelt Zorgverzekeraars Nederland onder andere voor om spoedzorg te concentreren in minder ziekenhuizen. Het beleidsvoorstel riep weerstand op bij professionals en ziekenhuisbesturen die vonden dat het onderzoek dat ten grondslag lag aan het beleid van slechte kwaliteit was en belangrijke aspecten van professioneel werk op spoedeisende hulpposten negeerde. Observaties en interviews, vooral uitgevoerd in kleinschalige ziekenhuizen en voor een beperkt deel in grootschalige ziekenhuizen, leidden tot vier typen spoedzorg: acute en complexe zorg, onzekere diagnostiek, laag-complexe zorg en somatische-sociale-psychische zorg. Elk type bevat bepaalde klachten van patiënten (bijvoorbeeld lichte gezondheidsklachten in het type laag-complexe zorg), professionele vaardigheden (bijvoorbeeld routinematige medische vaardigheden in hetzelfde type) en organisatorische kenmerken (bijvoorbeeld goede samenwerking tussen de spoedeisende hulp en eerstelijnscentra).

Het nieuwe beleid is vooral gebaseerd op kwantitatieve studies van acute en complexe spoedzorg (het eerste type), die voornamelijk wordt geleverd op spoedeisende hulpposten in grootschalige ziekenhuizen. Door te focussen op het eerste type negeert Zorgverzekeraars Nederland de meerderheid van het professionele werk op kleinschalige spoedeisende hulpposten. Wanneer alle aandacht van beleidsmakers is gericht op het eerste type spoedzorg, blijven mogelijkheden voor het verbeteren van zorg in de andere drie typen onderbelicht. Deze andere typen bevatten specifieke professionele vaardigheden (bijvoorbeeld communicatieve en organisatorische vaardigheden) en een organisatie van zorg (bijvoorbeeld informele samenwerking tussen ziekenhuisafdelingen) die veel moeilijker te meten zijn. Deze zijn niettemin cruciaal voor de kwaliteit en efficiëntie van zorg op kleinschalige spoedeisende hulpposten. De analyse laat zien dat beleidsdefinities van grootschalige en kleinschalige zorg niet altijd overeenkomen met de realiteit in de praktijk.

Hoofdstuk 8 bevat de conclusies van deze studie naar schaal in de Nederlandse zorg. De verschillende methodologische en theoretische perspectieven in de empirische hoofdstukken hebben geleid tot een definitie van schaal die bestaat uit drie dimensies: schaal als structuur, schaal als ruimte voor sociale processen en schaal als symbool. De dimensies zijn verschillende manieren van kijken naar schaal, die in combinatie helpen om te begrijpen wat schaal is en hoe veranderingen in schaal plaatsvinden. Schaal als structuur ziet schaal als iets dat tastbaar en meetbaar is, bijvoorbeeld het aantal cliënten in een verzorgingshuis of de omzet van een ziekenhuis. Schaal als ruimte voor sociale processen benadrukt dat schaal ook een plaats is waar managers, professionals en patiënten interacteren en waar zorg wordt georganiseerd en geleverd. Schaal als symbool bevat het spreken over schaal waarmee opvattingen over ′goede zorg′ worden gevormd en overgebracht.

De drie dimensies veranderen op verschillende manieren. Veranderingen in schaal als structuur zijn vaak bewust, expliciet en eenvoudig herkenbaar. Veranderingen in schaal als ruimte voor sociale processen en schaal als symbool worden niet altijd geassocieerd met schaal, maar hebben niettemin consequenties voor hoe schaal wordt ervaren en welke acties (on)mogelijk en (on)wenselijk zijn. Dergelijke veranderingen worden veroorzaakt door 'schaalpolitiek' en 'schaalwerk'. Schaalpolitiek verwijst naar de machtsstrijd, het beleid, de strategieën van organisaties, de belangen en de waarden die leiden tot structurele veranderingen in schaal en nieuwe betekenissen aan schaal verschaffen. Schaalwerk bevat de activiteiten van mensen die in de praktijk moeten omgaan met de verschillende symbolische betekenissen en structurele veranderingen. Het politieke karakter van schaal is overigens niet voorbehouden aan debatten en beslissingen op macro-niveau, maar is ook terug te zien in het dagelijkse werk op micro-niveau waar mensen verschillende waarden, taken en verantwoordelijkheden moeten verenigen.

Vanwege het dynamische karakter van schaal is het beter om te spreken over 'schalen' als werkwoord in plaats van 'schaal' als zelfstandig naamwoord. Schaal is nooit eenduidig en een 'fait accompli', maar heeft verschillende betekenissen en verschijningsvormen voor verschillende mensen. Schaal is continu 'under construction'. Deze constatering dwingt tot nuance in het publieke en politieke debat: uitspraken als 'hoe kleiner hoe fijner' (bijvoorbeeld in het geval van langdurige zorg) of 'groter is beter' (bijvoorbeeld in discussies over concentratie van ziekenhuiszorg) doen geen recht aan het driedimensionale karakter van schaal. Beleidsmakers, bestuurders, middenmanagers en professionals zouden zich

bewust moeten zijn van de onderlinge samenhang van de drie dimensies. Veranderingen die worden doorgevoerd in schaal als structuur, bijvoorbeeld door het de-institutionaliseren van langdurige zorg of het initiëren van fusies, hebben gevolgen voor de sociale en symbolische dimensie van schaal. Dit vereist sensitiviteit van alle betrokkenen voor de schaal die nodig is in een bepaalde situatie en voor de consequenties van structurele, sociale en symbolische veranderingen op en rondom een schaal.

Dankwoord

‘Stel dat het nu weer voorjaar 2009 zou zijn, en je wist wat je nu weet, wat zou je dan zeggen tegen het voorstel om promotieonderzoek te gaan doen?’ Dat is de vraag die anderen, en overigens ook ikzelf, de afgelopen jaren meerdere keren hebben gesteld. En zonder uitzondering was het antwoord: ‘ja!’ Niet dat het schrijven van een proefschrift in combinatie met consultancy en politieke activiteiten geen uitdagingen opleverde. Zeker omdat ik ook nog wel eens wilde ontspannen, sporten en mijn familie en vrienden zien. Maar wat een geweldige tijd was het. De nieuwe ervaringen die ik heb opgedaan, plaatsen waar ik ben geweest, vaardigheden die ik heb geleerd, mensen die ik heb ontmoet; ik had het allemaal voor geen goud willen missen. En daarvoor ben ik dank verschuldigd aan veel mensen.

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Het is gezien, het is niet onopgemerkt gebleven.

About the author

Jeroen Postma was born on December 11th 1982 in Rotterdam, the Netherlands. He obtained a Master's Degree in Business Administration (Human Resource Management) from Erasmus University Rotterdam in 2006. After finishing his Master's thesis on the work of professionals in nursing homes, Jeroen began working as an advisor on organizational and personnel affairs for a long-term care organization. In 2009, he moved to Dutch consultancy firm BMC and started with his PhD-research at the institute of Health Policy and Management (iBMG) at Erasmus University. As a consultant, Jeroen has led and participated in projects for healthcare organizations and the Ministry of Health. The projects included developing business cases, conducting policy evaluations and advising on organizational strategy (in particular mergers). For his PhD-research, Jeroen studied cases in home care, elderly care, care for people with a disability and hospital care, using both quantitative and qualitative research methods. He publishes about his research in national journals and newspapers and international peer reviewed journals. Jeroen now works as a researcher at the iBMG and teaches courses in healthcare governance, strategy of healthcare organizations, policy sciences and research methods.

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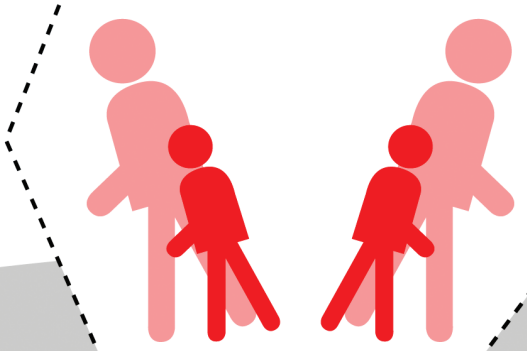

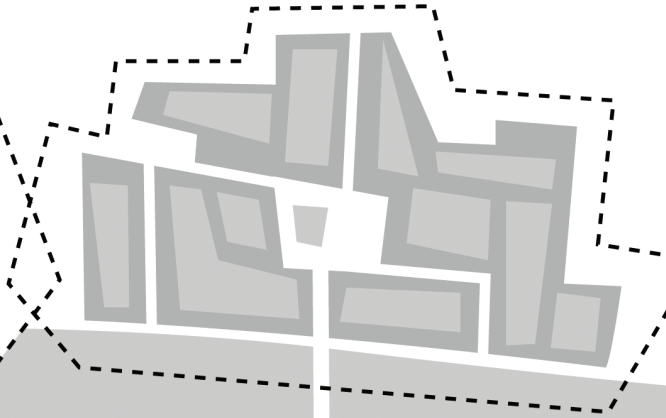

SCALING CARE

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