The ethnography of caring networks

Disentangling a governance order in-the-making

Networked governance arrangements have increasingly occupied the center stage in public debates about how to organize contemporary societies, including healthcare. Moving beyond polished ideas and discourses of networks, this book shifts attention from networks as well-demarcated governance structures to seeing networks as dynamic and emerging social phenomena. The cases of networking in older person and hospital care put forward the *multiple, ongoing, place-based, multi-layered,* and *multi-purpose* nature of networking. The book offers a lived view of networking, uncovering relations, interactions, and dynamics among actors during policy reforms. The ethnography of caring networks is a plea against overly romanticizing network governance, and a plea for care—from a critical-pragmatist perspective—for a governance order in-the-making that relies on networks. It is an invitation to acknowledge the practice and mundanity of network governance for healthcare policy and practice, leaving room for the *dark* and the *light* side of networking as a way of public problem-solving. This book will be of interest to anyone seeking to better understand the doings, workings, and meanings of caring networks.

Oemar van der Woerd is a Postdoctoral researcher in the Department of Healthcare Governance and the Erasmus Center for Healthcare Management of Erasmus University Rotterdam. Through ethnographic research methods, he aims to shed light on how situated actors work within networked healthcare settings.

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The Ethnography of Caring Networks
Disentangling a governance order in-the-making

De etnografie van zorgende netwerken
Het uiteenrafelen van een sturingsorde in de maak

Thesis

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Oemar Sardjoe van der Woerd
born in Helmond, the Netherlands.

Erasmus University Rotterdam

Doctoral Committee

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Voor mijn lieve ouders,
Hendrik van der Woerd en Treesje Chantikoemarie Ramkisoen,
die mij vervullen met trots en dankbaarheid.

Contents

Preface

It is the evening after the IZA conference ('*Integraal Zorgakkoord*', a policy plan to reorganize care on a regional level) had taken place in the Beatrix theatre in Utrecht on 4 March 2024. While travelling back home by train, the conference puzzles me. It has been a busy week with a move from the Southern part of Rotterdam to the East. When I get home, I decide to write down some reflections among the still unpacked moving boxes. I share my experiences with Wilma, one of my supervisors, on the telephone. Just before that call, I send her and some other colleagues a dramatized summary to organize my thoughts. This memo is entitled *The IZA world*:

> *Welcome to the world of IZA where the belief in 'together' as a structure is great; it seemingly takes on religious proportions to solve problems through regional networks. You can (almost) not disagree with collaboration. But is this the only future scenario? […] The IZA world is characterised by a 'can-do' mentality: "What are <u>you</u> going to do to make the IZA a success?" I wonder, who is IZA actually for? Which responsibilities are shifting, and with what consequences for actors? What do citizens notice? […] I had hoped for more reflection; have I remained for too long in a distant observation mode?*

Over the last five years, I have had the privilege to recurrently traverse the administrative and policymaking levels of the healthcare system (e.g., shop-floors, management, and national authorities) to study how affected actors shape and make sense of a networked model of care. More recently, I started to refer to this as the disentanglement of a governance order *in-the-making*. Often perceived as a 'vague figure' myself, I was curious about actors' work practices. 'Being there' in lively shop-floors, intimate board-

rooms, policy halls, clinics, network meetings, and crowded conference rooms, helped me to study actors' interactions up close.

In analysing the making process of a governance order, I started calling myself a 'network researcher'—perhaps fuelled by reading the biography of Anil Ramdas (*In wat voor land leef ik eigenlijk?*) and his ideas on identity-making, written by Karin Amatmoekrim. Travelling between administrative and policymaking levels, however, was often not as a neutral 'fly on the wall', but rather entwined in many (conflicting) narratives. It was a process to learn how to critically question dominant narratives, and how to create alternative ones. Underlying the excerpt above is a process of discovery of my own identity as a network researcher. Disentangling a governance order in-the-making hence helped me to get to know myself. I am grateful for this making process and have enjoyed it greatly.

My gratitude and appreciation go out to the people who opened up their work practice: (neighbourhood) nurses, (specialized) physicians, middle managers and directors, end-responsible executives, network coordinators, project leaders, local and national policymakers, representatives of system-level agencies, and politicians. Because of their openness it became possible to travel between different work practices. Designer Debby Peeters has illustrated this playfully in the cover of this thesis.

Writing a thesis is a collective work. In order to study actors' work and interactions, interaction with *other* peers to make sense of (ongoing) findings is the backbone of this thesis. The many mundane research moments mattered. I am therefore grateful to my supervisors, Wilma van der Scheer and Roland Bal, for their close involvement, many encounters, lively discussions, and leeway provided to discover (or close) paths. During this process, I was allowed to mingle with colleagues and projects from both the Healthcare Governance section and the Erasmus Center for

Healthcare Management. Moving between both places has been a privilege that I gradually became more aware of in research and teaching. Importantly, the work presented in this thesis would not have been possible without colleagues who carefully organise important research moments, such as Susan, Petra, and Bianca.

This thesis tries to analyze a governance order in-the-making, but the thesis itself is also not final. My hope is that it will contribute to a more nuanced public debate about the prophecy of (caring) networks in a changing society.

Oemar van der Woerd
Rotterdam, March 2024

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Caring in a network society

Introductory chapter

> *During a small-scale conference on network governance in the Dutch hospital sector mid-2019, a hospital executive stated: "Networks are not new. Over a long period of time, care provision has been organized by collaborating healthcare organizations. What is new, however, is what it means for us [hospital executives] in terms of how to govern them." Interestingly, two hospital executives reached out to us [researchers] to set up this conference. They wanted to explore whether their experiences in and with networks were recognized by other managers, as well as regulators, health insurers, and policymakers. As questioned by another hospital executive: "Are networks an intermediate phase towards a new mode of doing in healthcare?"*
> *(Observational field notes, 2019, original emphasis)*

A deep dive into the mushy in-between

Coming to grips with the increasing number of networks hospitals are involved in is becoming a persistent governing issue for hospital executives. Whilst being held accountable by internal and external regulators for organizational performance, they feel that involvement in *multiple* networks comes with uncertainty about their organizations' and their own position. Whilst creating, nurturing, and maintaining networks is increasingly seen as a solution to pressing healthcare issues like growing older person populations and workforce shortages, governing them is becoming more and more part of a manager's job and daily routine. As a result, networks may be problematic for managerial and professional practice. After all, networks require the reconfiguration of entrenched professional, organizational, administrative, geographical, and institutional boundaries, reconsidering current working patterns and mental frameworks. The intended transformation, towards a networked model of care, seeks for governance arrangements root-

ed in collective rather than siloed responsibilities—heading towards a promised land that embodies the great expectations of a network logic. Whilst acknowledging the importance of this transformation, this thesis aims to stick with the unknown and mushy in-between spaces in healthcare governance and policy contexts (Meurs, 2022; Oldenhof, 2015), disentangling a governance order *in-the-making* that relies on a network logic.

This introductory chapter unpacks the logic for public problem-solving in contemporary network society, working up towards an understanding of the relevance of studying the doings, workings, and meanings of caring networks in the field of healthcare governance. For this, I describe the analytical shift from seeing networks as *a* seemingly well-demarcated governance structure for instrumental-technical purposes to seeing networks as emerging social phenomena, capturing on the ground actor-level governing practices. Such a conceptualization of processes of network*ing* informs the research aims and questions that will guide the ethnographic work in this thesis—in other words: an empirical deep dive into the mushy in-between.

The romanticization of networks as a grand narrative of governance

In recent decades, networked governance arrangements have increasingly occupied the center stage in public debates about how to organize contemporary societies (Isett et al., 2011). Making use of the multitude of interacting networks within the contemporary 'network society' (Castells, 2000) is fundamental to how society is shaped, and an important resource to bring about organizational and policy change. Apparent consensus exists about networks as:

[…] a *new* process of governing; or a *changed* condition of ordered rule; or the *new* method by which society is governed (Rhodes, 2007, p. 1246, original emphasis).

Networks contrast with traditional managerial forms of governance that are based on top-down reasoning like command and control (Powell, 1990). These forms have sprouted under the umbrella of New Public Management (NPM) since the 1980s to reform the provision of public services towards greater efficiency (Osborne, 2006). Today, adopting a network logic is seen in many fields of policy and practice as the panacea to multifaceted problems like poverty, air pollution, demographic changes, refugee streams, and unfolding crises like the COVID-19 pandemic (e.g., Ferlie et al., 2011; Innes & Booher, 2016). These problems are often referred to as 'wicked problems' or 'grand challenges' as they are rather unstable and continuously evolve (Ferraro et al., 2015; Head & Alford, 2015). In healthcare, central to this thesis, increasing older person populations with severe and varied care needs—alongside increasing workforce shortages—threaten the accessibility and quality of services (Leijten et al., 2018). In response, networks receive continued interest in the field of healthcare governance to foster 'integrated' care provision, tailored to the needs of citizen populations (Ferlie et al., 2013).

The popularity of networks reflects a broader trend of interactive governance strategies in the fields of public administration and public policy (Bartels & Turnbull, 2020). Theoretical streams of literature like network governance, collaborative governance, co-creation, and citizen participation have gained traction within the era of New Public Governance (NPG) (Osborne, 2006). Here, a network logic can be broadly understood as a boundary-spanning idea that aims to mobilize a diverse set of interdependent actors with specific (knowledge) resources and capacities to enhance collective problem-solving (Kickert et al., 1997; Koppenjan & Klijn, 2004). More specifically, networks are viewed as:

> […] sets of formal and informal institutional linkages between governmental and other actors structured around mutual interests in public policymaking and implementation (Rhodes, 2007, p. 1244).

Networks are often touted among (public) organizations, policymakers, politicians, managers, and professionals as a means to adequately address problems that are ill-suited for being tackled individually. Interlinking the practices and experiences of network actors is considered necessary to foster public innovation within contemporary societies (Sørensen & Torfing, 2016). In doing so, networks provide the infrastructure to process complexity. This refers to the pluralization of politics and social life (Lash, 2003), the emergence of a dynamic set of governance and policymaking processes (Osborne, 2006), and the layering of institutional arrangements (e.g., state, market, civil society, and hybrid forms) upon existing ones that may constrain or enable network actions (Stoker, 2006). Attention has been given to how governments establish policy networks (Klijn, 2002). Yet, they are not the only or primary network initiator. As this thesis shows, networks entail a mixture of voluntary professional and organizational initiatives, as well as initiatives that are reactions to policy changes or either imposed or forced by dominant institutions (DiMaggio & Powell, 1983). Nowadays, networks have become a 'buzz word' (Penkler et al., 2019); a term that is loosely (over)used in administrative, political, civic, and media arenas without clearly expressing what it entails. The proliferation of networks in healthcare as a solution strategy comes with conceptual ambiguity, problematizing research focus, methodological coherency, and the formulation of apt implications for policy and practice (Nowell & Milward, 2022).

Underlying the widespread attention to networks for problem-solving lies a consensual, romanticized belief that networks are suitable to cope with the complexity of contemporary societies. This response to romanticize networks refers to generalized ideas

and modelized conceptualizations of networks as more-or-less accepted 'integrated' solutions to everything in the fields of public administration, public management, and organizational science (e.g., Ansell & Gash, 2007; Ferraro et al., 2015; Provan & Kenis, 2007). Importantly, the romanticization of networks is not a thoughtless description to downplay the relevance of networks for problem-solving. I carefully use this term to describe the dominant instrumental-technical view on networks, and how this reflects a broader instrumental rationality in public administration that complexity can be captured in an overall narrative. The great expectations of networks are, for instance, reflected in various healthcare policy reforms that rely on (regional) networks (e.g., Lorne et al., 2019; Schuurmans et al., 2021). Caring for regional populations and their needs is becoming increasingly central in *how* networks are created. In the Netherlands, central to this thesis, stimulating the creation of networks is considered among policymakers and practitioners an important means to (re)organize care. Paradoxically, this must occur within a healthcare system of regulated competition (Engelen et al., 2023).

The widespread fascination of networks makes me curious about the doings, workings, and meanings of networks in the field of healthcare governance. This informs an interpretative and practice-based approach to caring networks that will be presented later on. For now, being aware of the fuzziness of the network concept, it is important to provide a working definition of caring networks:

> Informed by Rhodes (2007)' description of networks, **caring networks** can be understood as more-or-less formalized or informal networked governance arrangements in the field of healthcare that consist of nodes and ties between multiple actors in attempts to (re)organize care provision for citizen populations, ranging from healthcare organizations and professionals to policymakers and regulators. These initiatives may originate voluntarily or are policy-

> induced in response to, among others, the fragmentation of care services, scarcity of workforce resources, or emerging crises like the COVID-19 pandemic.

From a theoretical stance, scholars argue that networked policies are 'imperfect' (Bannink & Trommel, 2019). This is because the construction of networks as a 'collective'—and enforcing actors to take part in accompanying processes of deliberation and trust-building (Ansell & Gash, 2007)—comes with often various (conflicting) actor perspectives that cannot be easily harmonized into an integrated one (La Grouw et al., 2020). Shared objectives cannot be simply assumed as views on the problem at hand may differ, as well as the perceptions on how to respond to them (Gray, 1989). For 'the network' it is hence challenging to accomplish shared objectives. Illustratively, de Graaff et al. (2023) show how the COVID-19 pandemic as a multi-framed crisis impacted decision-making and actor participation over time. The end terms of networked policies may involve recurrent negotiation processes in which actors attempt to steer from their *own* position. Such actor dynamics informs an understanding of networks beyond rationality and linearity (Peters, 2017). Being sensitive to how networks 'become into being' by tracing and engaging with the *plurality* of actions and interactions of *multiple* actors may inform creative and intelligent ways of processing public problems (Clegg et al., 2005; Haraway, 2016). Furthermore, attending to the complexities of networks may lead to actions directed at "engaging, sensemaking, deliberating, tinkering, dealing with conflict" rather than finding definite solutions (Greenhalgh et al., 2023, p. 20). This is exactly what this thesis tries to pursue in the field of healthcare governance.

The network logic unpacked: An empirical deficit for everyday governance

The theoretical observation of the romanticization of network governance will guide the ethnographic work presented in this thesis. Inspired by an interpretative and practice-based understanding of networks (Bevir & Waring, 2020), I signal an empirical deficit within network scholarship for 'everyday governance' in a multi-network context—that is, an approach that seeks to capture the enactment of grand narratives of governance by actors (and their relations and interactions) in specific situations and particular settings. This empirical deficit can be attributed to two main assumptions: (1) networks are more-or-less placeless and context-free, and (2) networks are given and bounded entities. Both assumptions seemingly focus on formal aspects of networks. This thesis covers social interaction in relation to formal *and* informal network dynamics.

A first assumption is that networks take shape within a vacuum and are more-or-less stable, as if it doesn't matter in which environment they 'exist' and must function, and for which purposes (e.g., a particular system or sociocultural and geographical context) (Oldenhof, Postma, et al., 2016; Pollitt, 2011). Networks are often approached as a structure to be 'managed' with managerial strategies (McGuire, 2002), and a means for achieving common goals (Koppenjan & Klijn, 2004). This instrumental-technical perspective to networks revolves around the question of how to accomplish 'effective' networks for a seemingly clear purpose, often referred to as 'purpose-oriented networks' (e.g., Carboni et al., 2019). This perspective to networks takes on an 'outsider' overview perspective in which the optimal configuration can be unraveled, and, if not efficient enough, can be altered. Research focuses on optimal network configurations and properties, as well as the determinants for making networks a well-functioning governance structure (Peeters et al., 2022; van der Weert et al., 2022). Under

which conditions networks are most effective (i.e. to what extent networks reach their objectives), and with which barriers and facilitators, are important directions for generating evidence about desirable outcomes of networks in this literature (e.g., Cunningham et al., 2019; McInnes et al., 2015). This reflects the romanticized belief and conviction that networks—when well applied—can fix all problems.

Second and related, networks are often assumed to be given and bounded entities. This means an understanding of the existence of *a* network that is seen as 'whole', with a clear overview of participating and non-participating actors, for which solutions to emerging network problems can best be found on a network level, and the management of such processes can best be carried out by *a* network manager (e.g., McGuire, 2002; Provan & Kenis, 2007). In this literature, networks are viewed as something 'out there', seemingly overlooking the day-to-day work of actors and relational processes both in *and* outside network contexts to produce network governance in specific situations and particular settings (Feldman & Khademian, 2007). These instrumental-technical accounts of networks result in valuable descriptions, categorizations, and models of network governance, but provide limited insights into the lived experiences and perceptions of networks as they stop when it becomes unruly and messy. This reduces the complexity involved in the artistry of everydayness of networks. Until now, relatively little attention has been paid to *how* actors navigate through the particularities and complexities of network governance in practice (van Duijn et al., 2021). I intend to further build on this. Furthermore, conceiving networks as bounded entities is difficult to hold as networks are enmeshed in a wider 'web of networks' with multiple co-existing purposes, actors, interests, and lines of power and influence. This thesis shows that such entanglements create new and unpredictable interdependencies. In particular, as I will show, networks cannot be reduced to professional or organizational matters alone as they are 'layered' phenomena—referring to the various relational practices of actors on differ-

ent policymaking layers. Being aware of the unbounded and layered nature of networks helps uncover how networks reconfigure managerial and professional practice.

Notably, recent empirical accounts within network scholarship have started adopting a more actor-level and context-sensitive understanding of networks. This has led to the following insights that inspired the ethnographic work conducted in this thesis. For instance, *a* network often relates and interacts with a broader 'population of networks' which may influence network functioning (Nowell et al., 2019); actor-positioning processes are not fixed in time, but are subject to change during collaborative processes (Vandenbussche et al., 2020); networked policy strategies are politically contested, and interpreted and shaped differently by local actors (van Duijn et al., 2021); multiple values are at play and lead to value prioritization among actors (Zonneveld et al., 2022), and value conflicts induce different ways of strategizing (Oldenhof et al., 2022); power dynamics between actors can have far-reaching consequences for the level of (democratic) representation (Waring & Crompton, 2020); and the extent to which network involvement is perceived as effective is legitimized differently by actors (Peeters et al., 2023). Such empirical work shows the action and inaction of actors matters in network governance, confirming that networks are no easy fix to complex problems, nor that they can be decoupled from the environments in which they are embedded. These insights point us towards a more nuanced understanding of network governance, as after all:

> If governance is constructed differently, contingently and continuously, we cannot have a tool kit for managing it (Rhodes, 2007, p. 1259).

Despite such nuance put forward by Rhodes (2007), supported with more recent empirical work, the tendency to romanticize networks still appears alive and well in network scholarship and in

various fields of policy and practice. We seemingly still favor universalism over particularism.

This thesis addresses an empirical deficit for everyday governance—namely, a lack of understanding of networks 'from within' (Bevir, 2013). Its approach values contextual, processual, temporal, and performative dynamics and knowledge of networks in relation to everyday governance (Butler, 2010; Pollitt, 2011). 'Looking through the eyes' of actors is seen as the appropriate level of analysis, rather than the assumed existing network. From this stance, central questions do not necessarily relate to how to accomplish effective networks in the midst of contingencies, but encompasses an actor-level focus on sensemaking, interaction, and framing processes related to the enactment of networks in everyday governance (Crossley, 2010).

> Sensemaking involves turning circumstances into a situation that is comprehended explicitly in words and that serves as a springboard into action (Weick et al., 2005, p. 409).

Research questions raised in this thesis thus relate to what networks do *in practice*, i.e. how networks are built over time, through which (conflicting and interfering) actions, with what purposes, with whom (and whom not), and through which interactions and (power) dynamics, and with what (un)intended consequences for everyday governance. To answer these questions, I present an interpretative practice-based approach to networks as a complementary yet *alternative* analytical approach to investigating networks from an instrumental-technical perspective. To clarify, governance refers in this thesis to:

> […] all processes of governing, whether undertaken by a government, market or network; whether over a family, tribe, corporation, or territory; and whether by norms, power, or language (Bevir, 2012, p. 1).

In taking this approach, I follow an abductive, empirically-grounded, and engaged mode of doing research in a multi-network healthcare context. This allows me to develop a granular understanding of networks as practice against the grand narrative of network governance. The empirical chapters in this thesis put forward the multiple, ongoing, place-based, multi-purpose, and multi-layered nature of networks. A practice-based and open-ended understanding of networks remains limited to the margins of mainstream network thinking. Here, then, lies the innovation of this thesis. What the study of networks as practice encompasses will thus be elaborated on next.

Figure 1. *'Sky Mirror (for Hendrik)'* (2017) from British artist Anish Kapoor standing on the square in front of Museum De Pont, Tilburg. The rectangular towering sculpture made from stainless steel reflects the changing appearance of the skies above Tilburg, bringing 'the heavens down to earth' in a particular place, continuously changing its reflection. Photo taken by Peter van Trijen.

A peopled reading of healthcare governance: Putting caring networks as practice upfront

Moving beyond polished ideas and discourses of networks—and avoiding universalistic thinking about networks in relation to problem-solving—this thesis aims to shift attention from networks as *a* seemingly well-demarcated governance structure for instrumental-technical purposes to seeing networks as emerging social phenomena, capturing on the ground actor-level governing practices for specific purposes. I refer to this as the study of network*ing*. *Table 1* summarises the differences between the study of networks and networking.

Table 1. The study of networks and networking

	Networks	Network*ing*
Description	A governance structure	Governing practices
Rationale	Instrumental-technical	Interpretative and practice-based
Ontology	Whole, neat, and fixed	Fragmented, imperfect, and open-ended
Epistemology	Conditions and contingencies	Particularities and complexities
Mode of inquiry	Theory-driven and distanced	Empirically-grounded and engaged
Actors	Actors as static objects	Actors as situated dynamic subjects
Context	Placeless, context-free	Emplaced, context-sensitive
Knowledge	Universalist ideals, outcome-based	Partial and enduring not-knowing
Strengths	Abstract and recognizable	Real-life understandings
Limitations	Practical applicability	Generalizability

The analytical shift from networks to networking can be best understood as a shift *from static to lived* that focuses on "meanings in action" and "actors' own interpretations of their beliefs and practices" (Rhodes, 2007, p. 1259). Approaching networking as a verb entails a practice-based exploration that concentrates on the (everyday) actions and interactions that specific actors undertake in concrete situations—and the dynamics between them—against wider webs of governance and institutional arrangements (Feldman & Orlikowski, 2011; Nicolini, 2012). It aims to explore how network governance is continuously produced and reproduced through the day-to-day work of actors, how they navigate through particularities and complexities, and how this may impact larger governance structures (Yanow, 2015a). Practices are formed by the assumptions and beliefs that actors develop in relation to a new policy paradigm like network governance over competition in healthcare, central to this thesis (Bevir & Waring, 2020).

Given its interactive nature, a practice-based governance approach offers fertile ground to explore networking processes among a *variety* of actors that operate on *different* organizational and policy levels. The sculpture *Sky Mirror (for Hendrik)* (2017) designed by Anish Kapoor, shown in *Figure 1*, exemplifies this aspiration. By bringing down the grand narrative of networks for public problem-solving ('the heavens') to the specific, concrete, emplaced, and mundane ('the earth'), I aim to create a more nuanced and plural image of how networking ensues in everyday governance in healthcare.

Understanding networks as a practice and an emergent process is not to minimize or eliminate instrumental-technical theoretical notions. It rather foregrounds the lived perceptions and sensemaking processes of actors in their own cultural-historical, strategic, and geographical environments in which they are embedded (Bevir & Waring, 2020). Underlying this is an understanding of 'embedded agency', which means that actors' action repertoire is determined by the contexts in which they are situated (e.g., social, organizational,

institutional, political) (Thornton & Ocasio, 2008). Networking cannot be simply decoupled from the existing governance arrangements in which it is aimed to have an effect. These may articulate logics of the state, market, and civil society (and hybrid forms), as well as sector-specific logics of regulation, service delivery, and professional autonomy that may compete with and potentially complicate networking (van de Bovenkamp et al., 2016). Focusing on everyday governance allows investigation of how actors make the multiple logics work in their own setting, and how this relates to existing accountability schemes. This further builds on research that shows the strategizing and legitimizing efforts of healthcare managers, regulators, informal caregivers, and physicians (among others) while navigating mixed-up and conflicting governance arrangements (e.g., Berghout et al., 2018; van der Scheer, 2013).

In all, putting networks as practice upfront may uncover dynamics, dependencies, rationalities, ways of governing, and relational patterns among actors who engage (or not) in networking (i.e. managers, physicians, nurses, patients, policymakers, insurers, consultants) (Jones et al., 2019). This approach is especially relevant in the field of healthcare governance as inducing actors to network is increasingly prioritised in healthcare reforms. It will direct the course of this thesis as each empirical chapter nuances our insights into the great expectations of networking, against the broader policy context of Dutch healthcare. The remaining sections of this introductory chapter present the research aims and questions, and elaborate on a multi-sited ethnographic methodology to study cases of networking.

Research aims and questions

This thesis aims to contribute to our comprehension of how network governance unfolds within the healthcare domain, and with what consequences this comes for both policy and practice. The re-

puzzling of healthcare governance towards a more networked model of care is at the heart of this exploratory and empirically-grounded thesis, and manifests itself into two main themes in the empirical chapters. The first theme entails an exploration of how actors like healthcare managers and professionals navigate through a multi-network context, i.e. what it means to work in and with networks, which strategies these professionals are being developed for this, and how this impacts their work (Chapter 2, 3 and 4). The second theme entails how a network logic 'comes into being', i.e. how it is constructed by actors as policy and governance devices during large-scale policy reforms that rely on regional networks, and how this impacts themselves (Chapter 5 and 6). Zooming out, as reflected upon in the discussion chapter, both themes bring forward implications for networking as a process of becoming. They refer to a 'making' process of a network logic for public problem-solving, which seeks to address collective responsibilities rather than siloed ones. The theoretical exploration and conceptualization of networking leads to the formulation of the main research question:

> *How does networking unfold in the everyday governance actions and interactions of affected actors, and with which consequences does this come for their role and work?*

The main research question is supported by several sub-questions. To explore how multiple networks are processed, and how actors cope with emerging challenges in their respective contexts, I zoom in to the hospital sector, in which hospital executives have to deal with multiple networks. Here, I am particularly interested in how they govern or are governed by networks. Therefore, the first sub-question asks:

> *How do hospital executives experience a network of collaborations, and how do they deal with perceived challenges for governability?*

Second, despite the widespread attention to (regional) networks as a policy promise to deal with complex public problems, relatively little is known about how networks are built, evolve, and are maintained. The second sub-question is thus:

> *How do actors in a non-urban region in the domain of older person care deal with situated problems to create, nurture, and sustain a regional network to cope with increasing and varied care demands? What does this teach us about governing a complex policy issue through a networked response?*

Third, to seek a solution for the problem of competition and tensions between networks, (regional) network platforms offer an interesting case study as they may facilitate, enable, and regulate distributed network actions. Analyzing how a network platform is actually used in constituent actors' work practices leads to the third sub-question:

> *How does a network platform work towards network governance from the perceptions of participating actors like medical specialists and hospital managers, and which frictions and dynamics emerge through and within the network platform?*

Fourth, despite the importance attached to facilitative support and mediation in enabling networks to take shape, little is known about the precise roles and activities that mediating actors play in collaborative governance. The fourth sub-question therefore asks:

> *How do mediating policy figures interact with regional actors and national authorities to develop collaborative governance in regional older person care? What does this teach us about network formation as a contingent and purposeful policy strategy for institutional transition?*

Lastly, this thesis focuses on how actors in relation and in response to each other make up 'the region' as a new collective governance object, and as a particular and purposeful strategy for collaborative governance. The final sub-question therefore concerns:

> *How do healthcare providers and national authorities shape the region as a governance object for organizing and delivering older person care? What does this teach us about constructing a governance object as a particular and purposeful strategy for collaborative governance?*

In the remainder of this introductory chapter, I will describe the research background and elaborate on my methodological approach.

A policy orientation towards regionalization in Dutch healthcare

Over the past two decades, the Netherlands has developed a rather complex institutionalized healthcare system of both public and private governance arrangements, mixing up market-driven arrangements with state-led regulation (Engelen et al., 2023). The dominant policy paradigm of regulated competition exists next to professional self-regulation and decentralization (van de Bovenkamp et al., 2016). The pluralist healthcare system entails many stakeholders (e.g., central and local government agencies, (not-)for-profit healthcare providers, insurers, professional, and patient associations) with diverging interests and power relations. No decisive central authority hence exists. Authorities like the Ministry of Health (MoH) have limited institutional power over field parties. From a historical view, networks emerged to cope with such a fragmented institutional context, and the ambiguous rules and demands it produced. Increasing (and stringent) quality

regulations asked for collaboration across traditional professional and organizational boundaries, resulting in the upsurge of disease-specific care pathways to coordinate care, and mergers to cope with scale issues (Postma & Roos, 2016).

Yet, this must take shape in a competitive system. Whilst in the last decade networks were mostly initiated by healthcare organizations, nowadays networks have become more formalized in healthcare policy and regulation in the midst of market prescriptions. Following a dominant policy discourse of organizing care closer to citizens' homes, the policy orientation has shifted in recent years to the 'regionalization' of healthcare to deal with emerging problems like growing older person populations, and labor market shortages (Schuurmans et al., 2021). This is understood as a more cooperative way of organizing care for the population in a specific geographical area, valuing collaboration through regional networks over competition among healthcare organizations to maintain the quality of care for a growing group of citizens. This is especially a pressing issue for non-urban areas with a burgeoning population of fragile older persons and severe workforce shortages, especially among highly educated professionals like physicians and specialized nurses (van de Bovenkamp et al., 2022). Regionalization in Dutch healthcare reflects a broader international policy trend in which regions are seen as the administrative place to provide a more networked model of care (e.g., Lorne et al., 2019). In the Netherlands, the aim of the regionalization policy, however, also conflicts with the existing policy paradigm of regulated competition and decentralization of health and social care. This complicates the sharing of responsibilities as these are siloed and directed towards individual organizations and professionals rather than the region. This policy context informs the study of caring networks, as I elaborate on below.

A multi-sited ethnography to study caring networks

This thesis applies a multi-sited ethnography to study caring networks 'from within' (Bevir, 2013), trying to understand the social worlds of networking (Goffman, 1989). Ethnographic research is advocated by many for exploring the changing roles and practices of actors in relation to network governance (Rhodes, 2007; Zilber, 2014). In the field of public administration, attention to the connections between macro and micro analytical levels (and the interactions among affected actors) is particularly encouraged (Bussemaker et al., 2023). A multi-sited ethnography does not confine itself to a single location, but instead follows an object or idea around a multitude of places (Marcus, 1995). Such an approach is suitable for studying networking as it encompasses issues that cut across professional, organizational, administrative, geographical, and institutional boundaries. Networking does not confine itself to a single location, nor a specific actor like a healthcare manager or professional. This allows the researcher to follow unexpected and surprising developments, actors, or topics. A multi-sited ethnography approach hence may help to develop theoretical contributions to established network and collaborative governance theory (Strauss & Corbin, 1990).

In this thesis, a multi-sited ethnography approaches networking as emerging social phenomena that consists of various actor constellations and interactions, enabling analysis of how a policy discourse that relies on networks unfolds and is enacted through actors' actions and interactions on the ground, and with what consequences this comes for policy and practice (Ball, 2016). This supports a rigorous description of the links between actors and their actions in relation to network governance rather than *only* focusing on organizational, professional, or policy levels. This is exactly what I aim to carry out in this thesis; studying the shifting notions of loca-

tions in relation to networking in order to analyze "webs of relations between actors, institutions and discourses" (Hannerz, 2003, p. 60). Tracing the emergent relational connections that are a feature of networking as it is lived in specific situations and particular settings may help generate empirically-grounded knowledge for healthcare policy and practice.

Informed by the exploration of network and collaborative governance theory, the notion of networking guided my ethnographic fieldwork. This helped to counterbalance the romanticization of network governance, and the fuzziness that comes with engaging in a networked healthcare field (Nadai & Maeder, 2005). As a starting point, I aimed to question underlying assumptions of dominant network theories and discourses. The consequence of an ethnographic approach to networking is that the observational sites are multiple and not always clear beforehand due to their fragmented character. As a result, I often had to follow traces without knowing where these would lead to. Networking remains something emergent and hard to grasp as the precise actors, sites, perspectives, and relationships are not straightforward beforehand. Because networking is 'multiply situated' and covers many social worlds, determining field demarcations was cumbersome (Van Duijn, 2020). This required engagement across the boundary of a single well-demarcated field like *a* set of healthcare organizations or *a* group of professionals. I came to the realization that my ethnographic efforts to understand networking are inherently partial; a view from nowhere does not exist (Haraway, 1988).

In an attempt to offer as complete as possible a picture of networking and generate knowledge that would be of use for policy and practice, I engaged with a variety of actors who act at various organizational and policy levels of the Dutch healthcare system. I intended to develop a thorough understanding of the (changing) context in which networking takes place. For this, the variety of ethnographic methods like (non-)participant observations, inter-

views, and document analysis were helpful as it allowed me to adapt and focus on such changes. The particularities and complexities of the Dutch healthcare system make the study of networking in this thesis situated and thus difficult to generalize to other settings. Exposing underlying mechanisms allow for more generalized conclusions. Situated findings are theoretically generalizable as they apply to wider international debates on networked policies, and how this is enacted in actors' lifeworlds (Langley, 2021).

Constructing cases of networking

The focus on networking in this thesis didn't emerge a priori, but developed gradually. This thesis started with the observation that network governance is touted among policymakers and practitioners as a solution strategy in response to pressing issues healthcare is facing. From there, I selected and derived what the relevant finding-places would be to ethnographically study networking (henceforth referred to as 'cases of networking'). This process fueled a recurrent evaluative process of how to understand networking as emerging social phenomena, steering the directions of the constructed cases (Zilber, 2014). For instance, being confronted with an increasing number of various policy advisors in the RegioZ project context made me curious about their role and position 'in-between' policy and practice, and broader working practices. Following them up-close and in action eventually led to the formulation of a particular case, and led to a rather unexpected perspective of so-called 'mediating policy figures' (see Chapter 5) to networking which emerged *during* my ethnographic work. Although a limitation of single case studies is that findings are difficult to generalize, they may demonstrate elements or mechanisms relevant to other settings and contexts.

Table 2 provides an overview of the cases of networking, each with a mixture of ethnographic methods, on which I elaborate on below. Interesting to note is that the cases are diverse in terms of origin and (institutional) history. Chapter 2 is, for instance, about a 'network of collaborations' that emerged rather untamed over time. Whilst Chapter 3 is about an existing and robust network platform with a rich institutional history, Chapter 4 focuses on the making of a regional network. The latter is similar for Chapters 5 and 6, which unravel how a network logic comes into being during large-scale policy reforms.

Table 2. Overview of the cases of networking

Chapter	Case description	Main actors	Main concepts	Data sources	Research questions
2	Managing (through) a network of collaborations	Hospital executives; healthcare system actors	Managerial work; network management; multiple network involvement	Semi-structured interviews; participant observations; inventory overview; expert meeting	How do hospital executives experience a network of collaborations, and how do they deal with perceived challenges for governability?
3	Regional network-building in older person care	Nursing home managers; nurse practitioners; physicians; project coordinators; health system actors	Network-building; network governance; regionalization	(Non-)participant observations; semi-structured interviews	How do actors in a non-urban region in the domain of older person care deal with situated problems to create, nurture, and sustain a regional network to cope with increasing and varied care demands? What does this teach us about governing a complex policy issue through a networked response?

4	The workings of a network platform in the hospital sector	Medical specialists; hospital executives and managers; supporting staff and network managers	Network platforms; integrated care governance; function creep	Semi-structured interviews; (non-)participant observations	How does a network platform work towards network governance from the perceptions of participating actors, and which frictions and dynamics emerge through and within the network platform?
5	Mediating policy figures and large-scale healthcare change	Policy advisors of health system actors; nursing home managers and professionals	Mediating work; mediating policy figures; collaborative governance	Semi-structured interviews; (non-)participant observations	How do mediating policy figures interact with regional actors and national authorities to develop collaborative governance in regional older person care? What does this teach us about network formation as a contingent and purposeful policy strategy for institutional transition?

6	The caring region as a governance object in-the-making	Nursing home management and professionals; health system actors	Governance objects; collaborative governance; regionalization	(Non-)participant observations; semi-structured interviews	How do healthcare providers and national authorities shape the region as a governance object for organizing and delivering older person care? What does this teach us about constructing a governance object as a particular and purposeful strategy for collaborative governance?

The cases of networking cover the empirical domains of hospital and older person care in the Dutch healthcare sector. Chapters 2 and 4 elaborate on the case studies conducted in an urbanized hospital region. These cases draw on mostly semi-structured interviews, supplemented with (non-)participant observations and document analysis. The interviews conducted with hospital executives, managers, and medical specialists (among others) focused on their experiences and practices. I aimed to ask respondents for real-life examples to illustrate their role, position, and work in relation to networking. 'Hanging around' in this region for several years in different frequencies (e.g., data collection, in person and e-mail conversations) and on different locations (e.g., research presentations during management meetings, attending regional conferences) allowed me to complement the respective cases of networking with detailed insights.

The cases elaborated on in Chapters 3, 5, and 6 result from involvement in a national, action-oriented research project on regional collaboration in older person care (the 'RegioZ' project). The research team conducted ethnographic fieldwork in 10 predominantly non-urban regions in which healthcare organizations seek to invent regional forms of older person care in order to deal with growing care needs and a declining workforce. Examples of such 'regional care experiments' are telehealth, task reallocation among nurse practitioners and (specialized) physicians, regional schedules for care during out-of-office hours, and regional triage models (van Pijkeren et al., 2021). Central to our approach is that we 'worked with' regional actors, policymakers, consultants, and health insurers to learn from their experiences and strategies, acting at and moving between healthcare practice, management, and policymaking (cf. Ball, 2016). Our ethnographic methods consisted of (non-)participant observations during regional (project) meetings and on shop-floors, semi-structured interviews, document analysis, and informal conversations and other interactions. Several rounds of interviews were conducted with nursing home managers,

nurse practitioners, physicians, as well as representatives of the MoH, the Healthcare Inspectorate, and professional associations of nurse practitioners and (specialized) physicians. In the total RegioZ project, over 1000 hours of (non)participant observation, 290 interviews with healthcare professionals and management, and 200 hours of project participation (i.e. giving presentations, workshops) were conducted.

All interviews in the cases were audio-recorded with permission, anonymized, and transcribed verbatim in Dutch (quotes were translated into English). Field notes that were made during the interviews complemented the interview transcripts, sharpening interpretations. Observational notes were finalized, if possible, directly after an interview or meeting had taken place, and where possible verbatim statements and expressions were included (Emerson et al., 1995). The COVID-19 pandemic had a severe impact on processes in healthcare organizations and research practices. As a result, several interviews were done by phone or online, but most were conducted in-person. Over time, the COVID-19 pandemic became a subject during interviews and meetings, questioning the effects of actors' practices in relation to networking.

Being aware that underlying policy and organization texts give insight into how problems are perceived and framed (Sevenhuijsen, 2003), I included policy plans, regulatory statements, Parliamentary Letters, and organizational notes into my analysis. The policy orientation towards regionalization spurred not only policymakers to write down policy ambitions, but also resulted in a proliferation of documents published by regulatory agencies, advisory councils, and occupational bodies to position themselves vis-à-vis a networked policy discourse. Keeping track of these documents in a shared project folder, and discussing these with peers during my ethnographic work helped me make sense of a changing policy context. These documents were not analyzed systematically with coding software, but informed my eth-

nographic work. For instance, during informal conversations or meetings I used the documents as a reference point or as input for interviews.

Analyzing cases of networking

Central to this thesis is an abductive and interpretative logic of inquiry and analysis (Timmermans & Tavory, 2012; Yanow, 2015a). This means that I iteratively moved back and forth between empirical data and theoretical work about network and collaborative governance. Data consists of observational reports, interview transcripts, and policy and organizational documents as described above. Sensitizing concepts derived from the literature like 'managerial work', 'intermediation', or 'layered practices' guided the analysis (Bowen, 2006). Despite case study differences, the analytical focus was in general terms narrowed down to the relations and interactions among specific types of actors (e.g., healthcare managers, policymakers, policy advisors, physicians, nurse practitioners, and national authorities). Findings were categorized by searching for 'negative evidence'; empirical findings that refine data classifications. For this, Atlas.ti software served as the primary analytical tool.

Identifying cases of networking had a stepwise, pragmatic nature. For instance, while becoming familiar with a multi-network context in healthcare, I noticed that—somehow paradoxically—the emergence of networks led to new governance challenges for actors in terms of organization, coordination, and legitimacy. This became evident during the interviews and observations as part of the first case of networking (see Chapter 2). Subsequently, exploring how a network platform functions for actors involved, and how it is used in their work, became interesting in relation to networking as the network platform seemingly clustered a variety of

networks (see Chapter 3). Throughout the research process, the combination of ethnographic methods led to rich narratives about networking, bolstering an iterative process of triangulation to validate findings. For this, research group sessions led to a refinement of networking insights, or even led to new directions where to enter (or leave) the field. I attempted to create a social infrastructure to frequently reflect on preliminary findings. Project meetings and more informal 'doctoral clubs' helped me to make sense of my ethnographic work, and to validate the individual cases into a broader theorization of networking (Langley, 2021).

Outline of this thesis

The first set of empirical chapters (2 to 4) explore how to work in and with networks. *Chapter 2* explores from a management-organizational perspective how hospitals in a Dutch urbanized region navigate through a 'network of collaborations'. *Chapter 3* devotes attention to the workings and meanings of a network platform for the actors involved, and how it affects their work. Next, *Chapter 4* analyzes network-building in action within a specific regional setting as an attempt to cope with increasing and varied demands for older person care, studying everyday organizational and policy activities of actors. The second set of empirical chapters (5 and 6) are about the construction of a network logic. *Chapter 5* focuses on the role of policy advisors working for healthcare authorities and (national) knowledge platforms, and conceptualizes them as 'mediating policy figures' who mediate between macro-level policymaking and meso- and micro-level organizational and professional activities to promote network formation within a competitive healthcare system. *Chapter 6* analyzes how interrelated and interacting regional actors and national authorities shape and 'transform' the region as an administrative (geographical) place into the (legitimate) object of governance for organising and deliv-

ering older person care in the Netherlands. *Chapter 7* concludes this thesis by discussing the research findings, offering an answer to the central research question, and presenting the thesis' various scientific and societal implications.

Empirical theme 1

Working in and with networks

2

Managing (through) a network of collaborations: A case study on hospital executives' work in an urbanized region

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Abstract

Managing inter-organizational networks has been studied extensively, yet little attention has been paid to what it means for organizations and their management to participate in *multiple* networks simultaneously. This study therefore explores from a management-organizational perspective how hospitals in a Dutch urbanized region process and manage a 'network of collaborations'. We analyze the managerial strategies and activities performed to align organizational interests with the emergence of networks. While the network narrative has become dominant in public policy, this study adds empirical insights to the meaning and practice of governing in a networked environment.

Keywords: inter-organizational networks; network management; healthcare; hospital executives; qualitative research

Introduction

Inter-organizational networks are increasingly touted as suitable for managing wicked problems in public management (Isett et al., 2011; Kapucu et al., 2017; Lecy et al., 2014). Inter-organizational networks, referred to as 'whole networks' (Provan et al., 2007), 'goal-directed networks' (Saz-Carranza & Ospina, 2010), or, more recently, 'purpose-oriented networks' (Carboni et al., 2019), are narrowly defined as 'groups of three or more autonomous organizations that work together to achieve not only their own goals but also a collective goal' (Provan & Kenis, 2007, p. 231). Although inter-organizational networks are considered suitable for addressing complex societal problems, managing them, scholars observe, is rather difficult (McGuire, 2002). To learn more about how such networks are processed and managed effectively, we need to focus on how tensions are addressed by the involved actors in their respective context (Ospina & Saz-Carranza, 2010; Saz-Carranza & Ospina, 2010). The empirical question of how actors work and cope with emerging tensions in managing networks, however, has not been extensively explored (Berthod & Segato, 2019; Ospina & Saz-Carranza, 2010).

Especially in healthcare policy and research, inter-organizational networks (for short, henceforth referred to as 'care networks') are considered suitable for addressing a variety of problems: the fragmentation of services (Ferlie et al., 2011); the negative effects of competition (Westra et al., 2017); stringent paywalls (Provan et al., 2007); scarcity of workforce resources (Kuhlmann et al., 2018); the increasing demand for integrated care amongst ageing populations (Leijten et al., 2018); the centralization of highly complex care (Postma & Roos, 2016); the development of medical research across organizational boundaries (Waring et al., 2020); and, as shown recently, the nationwide distribution of patients in times of COVID-19 (Wallenburg et al., 2021). It is therefore unsurprising that hospitals, for instance, participate in both 'horizontal' (be-

tween hospitals) and 'vertical' (between primary and secondary care, and between payers and providers) collaborations (van der Schors et al., 2020). In all, hospital involvement in care networks is broad, ranging from platforms to share information and experiences to more tightly integrated forms of healthcare practice (De Pourcq et al., 2019).

Taking a management-organizational perspective, this study explores how hospitals and, more specifically, hospital executives, process and manage a 'network of collaborations.' Following Provan and Kenis' (2007) definition, a 'network of collaborations' is understood as the set of networks and two-party collaborations an organization is involved in. Analyzing the managerial strategies while networking offers fertile ground to explore how hospital executives govern or are governed by networks, and what this means in terms of their role and governing abilities (Bevir & Waring, 2020; Hajer & Versteeg, 2005). By doing so, we attempt to capture the work of hospitals and their management in governing the multiple nodes with other (healthcare) organizations, and how this affects hospital governability, understood as 'the overall capacity for governance of a hospital' (Scholten et al., 2019, p. 444). To this end, we pose the following research question:

> *How do hospital executives experience a network of collaborations, and how do they deal with perceived challenges for governability?*

To answer this, we conducted a case study in an urbanized region in the Netherlands in which nine hospitals are situated. By combining various data sources—heavily drawing on interviews—the analysis reveals that hospitals participate in a diverse set of care networks with different network origins. As a result, hospital executives are experiencing emerging challenges, and in response, develops pragmatic strategies. They work *through* the network of collaborations to prevent the organization experiencing undesired

effects related to financial performance, the hospitals' identity, and managerial and professional work intensification. They also question whether and when interference is needed (or not) to align organizational interests with the emergence of care networks. We argue that managerial work—that is, the ongoing management efforts within and between organizations and other parties of interest—is required to manage multiple networks.

The paper proceeds as follows. Informed by the above, we further elaborate on our management-organizational perspective in governing network involvement. Next, after describing the methodology and case study, we present the challenges experienced by hospital executives in managing multiple care networks simultaneously and reflect on how these challenges are handled. Lastly, we end with a discussion on how our analysis informs both research and networking practice and present management and policy implications.

Managing networks

In the network (Agranoff & McGuire, 2003; Kickert et al., 1997; Koppenjan & Klijn, 2004) and collaborative governance literature (Ansell & Gash, 2007; Emerson et al., 2011; Sørensen & Torfing, 2011), networks are characterized as patterns of relationships and interactions between diverse actors. The processes of interaction and decision-making are often complex (Klijn et al., 2015) because actors act strategically on the basis of different interests and perceptions of problems and desirable solutions. Networks can thus be seen as 'sites of multiple, shared, and contested meaning' (Bevir & Waring, 2020). For the involved actors, networks provide the social infrastructure to share and reinforce their meanings, values and identities (Crossley, 2010). Managing a network is considered necessary to connect the different perceptions and strategies (Klijn et

al., 2015), and to achieve legitimate outcomes that are supported by actors involved (Klijn, Steijn, et al., 2010).

Findings from different studies illustrate, however, that network management is cumbersome. For instance, the unequal distributions of power, clashes between organizational cultures, a lack of commitment from involved and diverse actors, possibly reduced accountability, loss of autonomy for individual organizations, a lack of suitable methods to support leadership, and the variety of governance structures available result in management tensions (Bianchi et al., 2021; O'Toole & Meier, 1999; O'Leary & Vij, 2012; Provan & Lemaire, 2012; Waring & Crompton, 2020). Managing networks is a continuous process, full of struggles, and dynamic as positions and network environments may change (Waring & Crompton, 2020). Furthermore, literature shows that how networks are managed is influenced by several contingencies. These entail, for instance, the wider regulatory and institutional context, such as competing organizational priorities (Ferlie et al., 2013), the clarity or ambiguity of policy (Klijn & Koppenjan, 2012), historical relationships and competition amongst actors (Martin et al., 2008), or network properties, such as goal consensus, resource distribution, and quality of relationships (McGuire, 2002). In addition, the many multi-actor collaborations surrounding the organization, led by different organizations, may complicate network management because an organization is only able to manage a *partial* account of the strategic resources required for 'community outcomes' (Bianchi et al., 2021; Osborne, 2006). Also, organizations are confronted with the downsides of network functioning in practice, such as passive cooperation among actors or negligible network results—also known as 'collaborative inertia' (Huxham & Vangen, 2004). The more organizations are involved, the more time-consuming and resource-intensive networking tends to be (Provan & Kenis, 2007). Managing networks could also result in intensive work demands (Hyde et al., 2020), because inter-organizational relations are formed by individuals who represent

their organization (Rethemeyer & Hatmaker, 2007). This is especially of risk in healthcare, as a sparse workforce is already burdened with increasing and varied demands from patients (Kroezen et al., 2018) and administrative demands from regulatory agencies (van de Bovenkamp et al., 2020). Organizational support and capacity are needed to manage networks. But these things cannot be easily expected given existing professional and organizational constraints.

For healthcare organizations and their management, the wider institutional context renders network involvement easier said than done. For instance, a recent study conducted in the Belgian hospital sector found that the complex legislative context—which has federal and regional government aspects—complicated collaboration (De Pourcq et al., 2018). In addition, the presence of various participants and institutional agents involved (Lorne et al., 2019), the strong influence of medical professionals (Barretta, 2008), regulatory pressure as a result of quality regulations, and complex financial structures (De Pourcq et al., 2018) are identified elsewhere in the literature as complicating factors. These contingencies illustrate that healthcare organizations operate in a 'layered' environment; that they are part of the interplay between local, regional and national agencies, 'coexisting, jostling and forging uneasy alliances' in governing healthcare (Lorne et al., 2019, p. 2). For healthcare organizations and their management, managing networks thus requires interactions with diverse actors at different organizational and policymaking layers in various overlapping spatial arrangements (Lorne et al., 2019; Oldenhof, Postma, et al., 2016).

Managerial activities in managing networks

Scholars have distinguished the specific managerial strategies, skills, competences and activities of 'network managers' in the process of managing networks (Edelenbos et al., 2013; Klijn, Steijn, et al., 2010; Klijn et al., 2015; Provan & Kenis, 2007).

McGuire (2002) distinguishes 'activation' (e.g., incorporating actors and resources), 'framing' (e.g., facilitating agreement amongst network partners), 'mobilizing' (e.g., developing commitment and coordinated action) and 'synthesizing' (e.g., enhancing the conditions for interactions amongst network actors) as four distinct managerial activities. In order to nurture and/or steer networks, Klijn, Steijn, et al. (2010) observe that facilitating the structure of interactions, using process rules to govern those interactions, and activating actors and exploring their perceptions are important in managing networks. In addition, formulating a vision, establishing network roles (Kickert et al., 1997), leveraging ideas to tackle policy and organizational problems (Klijn & Koppenjan, 2012), and developing appropriate leadership (Ospina & Saz-Carranza, 2010) play a role in this context. The managerial activities reflect that relational capabilities (i.e., in- and outward work), aimed-for coordination, and processes of meaning making co-exist in network management.

From managing single networks to managing multiple networks

Although managing networks has been studied extensively and the necessary managerial activities are well-documented, little attention has been paid to what it means for organizations and their management to participate in multiple networks at the same time. Literature on inter-organizational networks in public management largely focuses on how a single network can be governed or managed (Provan & Kenis, 2007), or how network properties lead to desirable outcomes (Provan et al., 2007; Provan & Milward, 1995). Furthermore, attention has been paid to competing policy networks (Klijn, 2002) rather than the perspective of an organization that has to deal with many different policy and organizational networks at the same time.

The literature tends to picture organizations and their management as being involved in only a few well demarcated networks, and that

it is rather easy to get an overview of organizational involvement in networks. However, today organizations increasingly operate within an environment that is full of different networks that possibly interact with one another (Nowell et al., 2019). The consequence is that a neglect of how a network of collaborations—including other organizations who are entangled in peripheral networks, and the environment in which these networks 'exist' (Rethemeyer & Hatmaker, 2007)—affects the role and position of organizations and their management. Organizations' involvement in multiple networks emphasizes the necessity of managing several possible interfering interactions amongst network participants as well as between networks. An understanding of this adds new dimensions to an already well-established literature. This could possibly require other strategies than we now assume as suitable to manage a single network (cf. Klijn, 2008; McGuire, 2002).

Following our relatively underexplored actor-level perspective in managing multiple networks, we are interested in how hospitals position themselves in a networked field; how they relate to external stakeholders; and, more specifically, which managerial strategies are developed by hospital executives in dealing with emerging challenges of operating in multiple networks at the same time. Based on the identified challenges and strategies, we reflect on how this affects the work and management of hospitals.

Materials and methods

Research context: The Dutch hospital sector

In the Netherlands, a small, densely populated country of 17 million people, there are around 65 general hospitals without training facilities, 26 teaching hospitals, and seven university medical centers. In 2006, a healthcare system of regulated competition was introduced to enhance competition between healthcare providers

and insurers in order to stimulate efficiency and quality of care (Helderman et al., 2005). Debates in the last decade about scale, quality of care, and competition have resulted in the distribution of medical services amongst hospitals (Postma & Roos, 2016). More recently, emphasis is placed on the organization of care closer to the patient's home, stimulating the network involvement of healthcare organizations within a layered institutional context, with regulated competition (van de Bovenkamp et al., 2016). As a result, hospitals increasingly form one part of an 'integrated' care service. In such settings, hospitals as well as primary and older person care facilities collaborate towards the optimization of care in the region. This intended 'regionalization' is understood as a more cooperative way of organizing care for the population in a specific geographical area (Schuurmans et al., 2021). While healthcare policy increasingly encourages hospitals' involvement in care networks on regional levels, the Dutch healthcare sector functions as an interesting study context to explore hospitals' positions within networked arrangements.

Case selection and description

We employed a case study in an urbanized and heavily populated region in the Netherlands (which we refer to as 'Region X' for anonymity reasons) in which nine public hospitals are situated: one academic medical center, two teaching hospitals, four general, and two specialized hospitals (i.e., focused on specific clinical specialties). These hospitals share the same geographic niche and are clustered in a regional partnership that aims to improve overall hospital care. Case selection was based on the relatively high number of (specialized) hospitals within the region, compared to other urbanized or more remote regions in the Netherlands. This stimulated us to explore hospital network involvement more precisely. The hospitals' characteristics in terms of size in 2020 are as follows:

Table 3. Characteristics of hospitals in Region X

Hospital	Type	Bed capacity
A	Academic medical center	1.320
B	Teaching hospital	600
C	Teaching hospital	750
D	General hospital	360
E	General hospital	332
F	General hospital	190
G	General hospital	40
H	Specialized hospital	12
I	Specialized hospital	116

Data collection

This research draws upon three data sources. Firstly, to get an idea of the number of care networks the hospitals in this case study participate in, we created an overview (primarily developed by the second author in September 2018) in which the involvement of each individual hospital in the network of collaborations is listed. The university medical center initiated the overview to develop an understanding of hospital network involvement, starting a debate with surrounding hospitals how this can be processed and managed. The overview is originated from a hospital perspective, and therefore predominantly includes ties amongst hospitals, rather than with primary and older person care facilities. Hospital representatives (executives and supporting staff) were asked to digitally fill in a list of the care networks and collaborations their hospital participated in, which was then merged in an Excel overview. This overview consists of the following elements: type of agreement, involved medical specialties, starting and ending date (if applicable) of the agreement, and intended goal(s). We used the overview to analyze the diversity of networks the hospitals in the region participate in. Given the explorative and agenda-setting nature of the overview, general inclusion criteria were applied. Care networks were included if they concern (the organization of) patient care;

geographically cover (a part of) Region X; and are operational during the study period. Both formal (e.g., through contractual agreements) and informal (e.g., partly or not formalized through agreements) collaborations were included. Though we were aware that networks cut across the region, we excluded these examples (e.g., international networks and research projects), because the primarily purpose was to explore hospital' network involvement in Region X.

Secondly, to further explore hospital network involvement, we draw on a group discussion with hospital executives and stakeholders in Dutch healthcare, with the aim of discussing how care networks affect the managerial role and changes healthcare (organizations). This group discussion was organized in June 2019 and was chaired by the third author. This role can be understood as facilitative, setting up an organized discussion of three hours to share networking experiences. In total, 31 hospital executives representing 28 hospitals spread across the Netherlands participated, among whom were the executives of the nine hospitals in this study. Stakeholders included two representatives of health insurers, three from the healthcare inspectorate, and eight employees of Dutch knowledge institutes related to healthcare policy and organization. The first two authors presented the insights from the overview in Region X as a starting point for discussion. They participated in the group discussion and asked if the presented insights were recognizable and representative for other hospital executives and how they overcome (or handle) the challenges that come with managing multiple networks. In addition, three hospital executives in different parts of the country (urban, non-urban and more remote) presented about which network(s) their hospital was involved in; how the networks came about (or not, if failed); and what challenges they experienced in the process. Their experiences led to much recognition amongst attendees and stimulated a lively discussion amongst hospital executives on how to manage hospitals in a networked environment. We took descriptive notes with ob-

servations and quotes, resulting in an observational report that was member-checked by presenting attendees. Clarifications were amended in our notes to check the statements and experiences of hospitals executives.

Lastly, central to our study, we conducted in-depth interviews with hospital executives (n=8) and supporting staff (n=4) in Region X to explore their experiences in managing multiple networks in more depth. The hospital executives were selected because they are formally in charge of a (specialized) hospital, and—together with supporting staff—were consulted during the overview creation. All agreed to conduct interviews to explore the managerial role in network involvement more precisely. The interviews were semi-structured, backed by a topic list based on literatures that address network management and inter-organizational networks, as well as data derived from the network overview and group discussion. The following topics were investigated: the different networks their hospital is involved in, challenges faced in managing the hospital in a networked environment, and managerial activities in processing the experienced challenges. We specifically asked for real-life examples to illustrate their managerial work in managing networks. The identified challenges in network involvement have been member checked with interviewees after data analysis. Most interviews with respondents were conducted in person and had a minimum duration of 50 minutes and a maximum of 75 minutes. All interviews were audio-recorded with permission, anonymized, and transcribed verbatim in Dutch (citations were translated into English). Field notes that were made during the interviews complemented the interview transcripts.

Data analysis

Based on the exploratory nature of our study, we analyzed our qualitative data using an abductive approach (Timmermans & Tavory, 2012). An ongoing iterative process of 'puzzling out' helped us to analyze how multiple networks are processed and

managed (Timmermans & Tavory, 2012, p. 167). Inspired by the group discussion—and informed by literatures that address network management and inter-organizational networks—we developed the notion of 'multiple network involvement' in healthcare, defined as the engagement of hospitals with different (and possibly overlapping and conflicting) care networks *simultaneously*. These preconceived ideas were leading in analyzing the observational report, transcripts, and field notes during interviews via Atlas.ti software. Triggered by the expressed challenges for hospital governability, we reexamined our data to explore how hospital executives manage multiple networks in various ways.

First, based on the group discussion, we broadly identified experiences of hospital executives in managing multiple networks as first order codes, leading to three themes: uncertainty about the added value and risks; the degree of managerial interference; and interfering interests of external stakeholders. Second, based on theoretical grounds, we made the clustered experiences more precise by identifying challenges as second order codes. These challenges were sent to interviewees as a basis for the interviews and discussed with the authors for data refinement. These challenges were then discussed in relation to how hospital executives dealt with them, leading to the following managerial strategies that structured the results accordingly: creating a strategic niche to remain distinctive; using network consultations for organizational interests; evaluation and prioritizing of and interference with networks; and developing governance platforms to coordinate network actions. These findings were then discussed against the backdrop of network management theory focused on managing an individual network. Besides careful coding, the quality of analysis was strengthened by iteratively comparing findings of the three data sources as well as extensive discussions between the authors during the research process.

Findings

The categories of network management primarily seem to be focused on managerial efforts to include professionals and other organizations in network actions (e.g., Klijn, Steijn, et al., 2010; McGuire, 2002), implying that managers are the only network initiators. The focus on *a* network manager is reflected in literature on inter-organizational relationships and management that describes 'alliance managers' as central in resource alignment and alliance performance (Das & Teng, 2000). Rethemeyer and Hatmaker (2007) state that network management activities are not bound to an individual network manager, and take place across 'the network system.' We have identified that managers, professionals and external stakeholders can *all* be network instigators. Hence the initiatives to network and the wish to steer them come 'from within' (professional and managerial induced networks) and 'from outside' (policy induced networks). Some actors look through the 'lenses' of organizations for network involvement (i.e., an inside-out view), while others seemingly centralize the needs and demands of the region where organizations are situated with the goal to stimulate the sharing of strategic resources (i.e., an outside-in view) (Bianchi, 2021; Bianchi et al., 2021).

Hospital executives networking' takes place within an empirical context of inadequate legislation and financial structures, regulatory pressures, and different procurement strategies of health insurers. They have to navigate through the interests and strategic aims of various professionals, organizations and authorities within the layered healthcare system while networking (van de Bovenkamp et al., 2016). Hence several challenges emerge while managing multiple networks. Organization-centered regulatory frameworks prompt hospital executives to negotiate demands with internal actors (e.g., physicians, supervisory board) and external stakeholders (e.g., network partners, financers, regulatory bodies) while networking. This sometimes induces a 'defensive' governing atti-

tude to networking to protect the organization from undesired effects, for instance related to the hospital identity, financial performance, and managerial and professional work intensification. Furthermore, the consequences of network actions for the hospital's position are unclear. Also, managers have to negotiate with multiple agents with different interests in many consultations.

Networking can also be a strategic activity of hospitals. The (potential) problems for hospital governability (Scholten et al., 2019) prompt executives to develop pragmatic strategies to align organizational interests with the emergence of networks: creating a strategic niche to remain distinctive; using network consultations for organizational interests; evaluation and prioritizing of and interference with networks; and developing governance platforms to coordinate network actions. Managing multiple networks requires managerial work in several directions and on various tasks, both inward (i.e., negotiating the interests of organizational parties) and outward (i.e., dealing with the interests and pressures of network partners and external stakeholders).

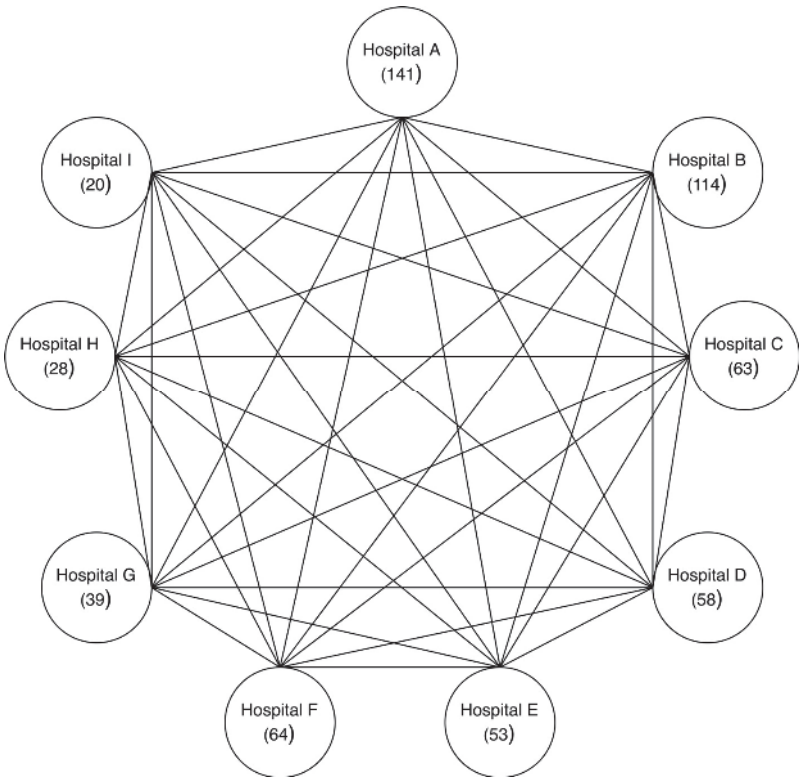
In the following sections, we elaborate on our case study findings in more detail. First, we present the diversity of care networks and collaborations in Region X to understand network involvement from a hospital perspective more precisely. Second, we elaborate on the emerging challenges, and subsequently analyze how these challenges are dealt with.

A network of collaborations

In Region X, individual hospitals participate in a varying number of care networks and collaborations (ranging from 20 up to 141) with other hospitals. These collaborations occur mostly between two hospitals, but also with three or more (healthcare) organizations. The academic medical center (A) is involved in 141 collaborations, followed respectively by 114 and 63 collaborations for both teaching hospitals (B and C). The four general hospitals (D, E,

F and G) participate in 64, 58, 53 and 39 collaborations respectively, and the specialized hospitals (H and I) in respectively 28 and 20 respectively. In total, hospitals in Region X participate in 237 collaborations (see *Figure 2*).

Figure 2. A hospital network of collaborations in Region X



In the overview, we noticed both variety and overlap in terms of goal-setting, scale, representation of participants, and degree of formalization. Hospitals participate in some cases in the same care networks, but take different positions (i.e., network partner or leading organization). Most hospitals are involved in collaborations to better align ('integrate') health practices between healthcare

providers (for example integrated stroke pathways). Hospitals also participate in disease-specific collaborations to optimize triage, consultation, and the development of scientific research (for example oncological care networks). In addition, collaborations are identified aimed at short-term and long-term efficiency improvement (for example sharing workforces, facilities and (digital) services). Other collaborations are innovation-oriented; they aim to foster healthcare entrepreneurship with (non-)governmental advisory bodies, universities, and other knowledge institutes. Lastly, collaborations for specific regional purposes are identified, for instance to attract and train higher qualified personnel. Some integrated care and disease-specific networks have a formal network governance structure, for example with a 'network administrative organization' (Provan & Kenis, 2007), while other collaborations are less formalized.

The care networks entail a mixture of voluntary initiatives between hospitals, but also initiatives that are either imposed or reactions to policy changes. In some cases, hospitals voluntarily reach out to other hospitals to create a network. An example of this is the building of a regional network to attract and train higher qualified personnel. Less-voluntarily initiated networks are a result of pressures from regulatory agencies or professional associations. An example of this are acute care networks to organize sufficient ICU capacity and develop a coherent hospital response in times of crises (see also Wallenburg et al., 2021). Acute care networks are a result of regulations from the Ministry of Health. Professional associations that prescribe volume standards for specific surgical operations to maintain high-quality care moreover urge hospitals to build, for instance, obstetrics and oncological care networks in which services and expertise are clustered. Hospital executives are thus constrained in evaluating in which network to participate as they have to comply with (quality) regulations.

We learn from the overview that hospitals operate in a networked environment, meaning the existence of a diverse set of care networks and collaborations, with different intended goals and governance arrangements. Networks originate at the professional level (e.g., professionals working across organizations to improve care processes), the organizational level (e.g., management searching for ways to improve efficiency and strengthen the organizations' strategic position) and the policy level (e.g., quality regulations that demand a certain volume or scale). While every purpose seems to have a separate network (i.e., creating integrated care pathways, compliance with (quality) regulations, managing scarce medical resources, etc.), this results in multiple network involvement, and possibly conflicts *between* networks.

The challenges of managing a network of collaborations

Organization-centered accountability structures

Managing networks requires attention to the institutional environment in which organizations operate. For instance, stringent regulations and institutional barriers complicate networks to take shape (Ferlie et al., 2013; Klijn & Koppenjan, 2012). Hospital executives find it challenging to simultaneously manage their respective organizations and their involvement in networks as they are confronted with different accountability structures that exist side-by-side, initiated by the internal supervisory board, and external stakeholders (e.g., health insurers, banks, the healthcare inspectorate, and other regulatory bodies). While these stakeholders mostly approach the hospital as a 'fixed' entity, responsible for its own functioning, hospital executives view their organization as being more fluid, increasingly tied to and dependent on the efforts of others. Despite the necessity of networks, they are nevertheless still held responsible for the overall functioning of the hospital:

> *"Although I'm in favor of care networks, it clashes with the responsibility I have for this organization. I have to maintain relations with the supervisory board and show my rati-*

> *os to banks, otherwise I will not receive finances for new buildings. I will never retain this position if the hospital is not doing well in financial terms as a result of multiple network involvement."*
> *(Executive of Hospital H, interview)*

When the healthcare practices of the involved healthcare organizations are subject to multiple legal frameworks, this raises questions when something goes wrong within the network, for example during patients' treatment, and especially in the case of informal networks (e.g., not formalized by a covenant or contract): who can be held accountable? This can instigate the formalization of agreements, which could weaken network relationships that thrive on trust and an informal collaborative atmosphere (Klijn, Edelenbos, et al., 2010).

(Unclear) consequences of network actions for the hospital's position

An important part of network formation are autonomous organizations that are willing to network based on trust and reciprocity (Provan & Kenis, 2007). Multiple network involvement, however, threatens an organization's existence as networks become superior to the organization, making the existence of autonomous organizations less obvious in network formation. While hospital executives state that networking is of strategic necessity as hospitals cannot do without the medical expertise of other hospitals, and thus need to network to exist, they acknowledge that this entails potential organizational threats. Although every network has a legitimate goal, the overall consequences for the hospital's strategic position are often unclear, or yet to be experienced. Financial consequences, the effect on patient flows and workforce, and potential competition between networks, cannot always be made clear beforehand. While executives have and express a need to obtain insights of networking results, they find it cumbersome to obtain an overview of network involvement as a whole. Hospital executives hence

experience uncertainty about the added value of the networks, wondering whether or not organizational goals are being achieved:

> *"Obviously, I'm hired with a primary assignment to strengthen the hospitals' position. There are situations, however, where this hospital needs help from other hospitals to share physicians and facilities. […] It is my responsibility to ensure a healthy organization, and that involvement in different networks doesn't lead to undesired effects."*
> *(Executive of Hospital E, interview)*

The willingness of executives to cooperate with other hospitals is limited, as the organization still needs to exist, and needs to be made visible ('branding') to protect the hospitals' respective identities (van der Scheer, 2007). Although goals can (partly) be aimed at the region (e.g., stimulating overall population health), the primary responsibility of executives is their organization. After all, too much involvement in networks could result in the dissolution of one's own organization, as the executive of Hospital H (interview) remarks: 'You don't want to lose your own brand. As the head of this hospital, no matter what, you do not step into that position and then sell it to someone else.' Executives of small-scale hospitals state especially that protecting their identity is challenging but necessary to maintain their uniqueness and added value as a potential network partner. Hospital executives have to manage different networks' conflicting accountability structures and institutional arrangements, but must also consider the consequences thereof, which could lead to questions concerning their own function and competence.

Balancing different interests

Developing enduring relationships between network partners and with external stakeholders is an important part of network management, reflected in the attention to relational capabilities

(Edelenbos et al., 2013; Ysa et al., 2014) and 'soft' forms of steering amongst network managers (Ayres, 2019). We observed that hospital executives have to negotiate with different agents—within the healthcare organization, between healthcare organizations, and between healthcare organizations and their stakeholders—over different goals. This requires many (possibly interfering) consultations, which is experienced a time-consuming responsibility. Hence inter-organizational relationships go beyond management levels, and also include professional objectives that may conflict with organizational interests in network involvement. Network actions within the hospital are moreover scattered across relatively small groups of physicians. Management needs to deal with professionals' expertise, ideas, and ambitions for networking. Hospital executives find it challenging to align their priorities in networking with those of physicians and to establish what actions this would require (and from whom). For instance, the managerial interests in exchanging 'care' in networks do not always align with the financial interests of physicians, rendering this a difficult process. Yet, hospital executives are dependent on physicians' problem-based knowledge while networking. Disease-specific networks, for instance, require the expertise and support of physicians, as they are specialized in medical content, but they also require an evaluation by hospital executives about how this affects the hospitals' strategic positions. Because hospital executives don't have in-depth expertise on specific diseases, they are seemingly inclined to follow the ideas of physicians on how to organize such networks, in which part of the network the hospital participates, and how this may make involvement in other networks redundant. Hence negotiating with physicians is increasingly part of managerial practice, while hospital executives are being held accountable for network involvement *in the end*.

Besides hospitals, physicians, and patients, external stakeholders also have an interest in which care networks the hospital participates in. Hospital network participation could reduce risks for

these stakeholders by maintaining revenue and accessibility for individual hospitals with the distribution of medical services and patient flows. However, health insurers fear less competition amongst networked hospitals, while banks fear that strong networks could result in lower revenues for individual hospitals due to the loss of production by distributing medical services:

> *Three hospitals created a joint venture for the distribution of oncological medical services to ensure accessibility to oncological care in [Region Z]. Although it was anticipated that this distribution would result in quality improvements, reducing overall costs, and attract professionals, the pre-proposed distribution was complicated because of financial difficulties faced by two involved hospitals. Banks hindered the distribution of oncological services, expecting production loss and consequently insufficient financial resources to pay off loans. As summarized by a hospital executive: 'A vision of care became a vision of distribution.'*
> *(Excerpt observational report, group discussion)*

The above excerpt illustrates that the shared goal for the region (i.e., accessible oncological care) was hindered by the short-term risk of financial instability in two hospitals, even though in the long term it was expected to diminish costs. This example confirms that external stakeholders act and interfere at the level of the individual organization, thereby also affecting the network. Health insurers, banks, and the healthcare inspectorate weigh the relevance of the network on consequences for the hospital, and for themselves as contract partner (health insurers, banks) or regulator (healthcare inspectorate) with their own remits. These external demands can, however, also be conflicting. For example, in the case of the oncology network in Region Z, whereas the bank saw a financial risk, the healthcare inspectorate was in fact very much in favor of network formation. This was because it allows specific hospitals to have a higher capacity, leading to better care, whereas

the competition authority might be wary about the creation of regional monopolies.

Dealing with emerging challenges

Creating a strategic niche to remain distinctive

First, hospital executives' work to manage multiple networks entails strategic (re)orientation, understood as the creation of a strategic niche for the organization to remain distinctive and autonomous while working together (cf. Provan & Kenis, 2007). Network involvement is used by hospital executives as a mechanism to coordinate medical care within the organization and to create (new) strategic positions in the networked context. They (re)examine the hospitals' strategic agenda and accordingly prioritize which networks are of added value for the organization. The executive of Hospital B exemplified this by making network involvement explicit in their strategic agenda, describing their hospital as a 'network organization.'

Constructing and communicating a narrative of the hospital's identity and ambition helps to position the hospital vis-à-vis network actors. Illustratively, the executive of Hospital E used the slogan 'from a white bunker to a campus' to communicate a shift from being a medical-oriented hospital to a 'place' in which also youth care and public health expertise are located. Similarly, the executive of Hospital F—situated in a less urbanized part of Region X—negotiated a strategy with physicians to become an all-round hospital that primarily serves its local population. Executives of general hospitals stated that becoming a periphery-oriented hospital that functions locally is feasible as these hospitals heavily depend on the expertise of physicians working in Hospital A to maintain medical care delivery. This illustrates that for these hospitals network involvement is not strictly voluntary as it allows the hospital to exist and function locally. Participating in multiple networks hence serves as a means for the hospitals' strategic agendas and allows hospitals to develop a niche to work from.

Using network consultations for organizational interests

Second and related, hospital executives purposely use soft relational leadership and governance while managing networks for organizational interests (Ayres, 2019). Network consultations (and personal connections with network partners) are considered a social infrastructure to share and reinforce the hospital's identity (Crossley, 2010). Most consultations take on an informal dynamic, meaning that information (for example, regarding ICU capacity during COVID-19 times) is regularly shared between executives. These consultations are used to explore ways to cooperate with hospitals that face similar challenges, to build trust, and to have access to potentially relevant strategic information from other network partners:

> *"I managed to position [Hospital I] in several meetings, for example, in [a regional acute care network] and [a regional non-acute care network], so that we could receive valuable information. We are part of many consultations as a result of network involvement and are a kind of spider in the web."*
> *(Executive of Hospital I, interview)*

Similarly, the executive of Hospital H stated that although the hospital has no ICU capacity and almost no medical patients, they attend acute care network consultations for relational purposes. During these meetings, the hospitals' respective identities and ambitions are communicated to others: e.g., providing specialized care in one location, yet open to provide care in other hospitals. Network consultations are used to legitimize the hospitals' existence to (potential) network partners. Hence an externally oriented strategic agenda to network with others stimulates thinking about a hospital's own identity and visibility, and creates internal unity (i.e., expanding a network logic amongst physicians).

Evaluation and prioritizing of and interference with networks

Besides nurturing and expanding network relations for network management (McGuire, 2002), hospital executives also tame further networking to prevent physicians, supporting staff, and executives from becoming overworked. We noticed an ongoing evaluation process in which professional perspectives and their network actions matter to decide in which networks the organization participates. Hospital executives hence prioritize certain networks over others, and set organizational boundaries to networking:

> *"The municipality asked for involvement in another network. It got as big as though we were going to make world peace. Then we said: no, stop for a moment, enough! I got people [physicians and nurse practitioners] here at my desk who said: 'I'm asked for a care network, but are we really going to do that, and with what effort?' Let's focus on what we have and keep it small."*
> *(Executive of Hospital C, interview)*

This quote shows that the need to prioritize networks is not only expressed by hospital executives, but also by employees (and external stakeholders as we saw earlier). The executive of Hospital C put a hold on networking to prevent professionals' work intensification, but also to develop better 'grip' on network involvement. Hospital executives evaluate what is needed on the one hand to mitigate risks and keep the network in line with strategic hospital interests, and on the other hand to establish what would aid and enhance the performance of the network and thereby prove its added value. As a response to many organizational parties whose networks are decentralized, hospital executives therefore question whether and when interference is needed (or not) to align organizational interests with the emergence of networks. Responding to the outlined network experiences of a hospital executive, the executive of Hospital A says:

> *"To manage networks, sometimes you need to let a network go, and don't interfere with the further development. Sometimes you need to consciously push into the right direction, facilitate bottom-up initiatives and, if needed, serve as the personification of the network self. […] Managing multiple network involvement requires different forms of managerial involvement."*
> *(Excerpt observational report, group discussion)*

This reaction seems to highlight specific capabilities in managing networks (e.g., knowing what the right direction is), despite uncertainties in dealing with multiple networks. Interference occurs both within the organization, and in networks. For instance, informal relationships amongst physicians raise questions as to what extent formalization is needed, in terms of covenants and contractual agreements, but they also require consultations with other executives in order to coordinate network actions in the broader network environment (Nowell et al., 2019).

Developing governance platforms to coordinate network actions

Third, hospital executives build and further develop existing governance platforms to manage multiple networks. In the literature, collaborative (governance) platforms are considered helpful to facilitate and coordinate 'multiple or ongoing collaborative projects or networks.' (Ansell & Gash, 2018, p. 20) In our case, hospital executives commit their organizations to such platforms for coordinated network actions on a more comprehensive regional level, to activate networking parties (i.e., organized support and resources for networking physicians), and to develop an overall strategy that prevents further network collision and overlap:

> *"With all that networking, you have to create a focus together. We therefore asked [the regional hospital platform] to make an overview, and they listed more than 80 initiatives in [Region X]. We are discussing how healthcare will*

> *look like in 2030 to align network actions. […] Hospital D and E will also become partners of [the regional hospital platform].”*
> *(Executive of Hospital C, interview)*

The regional hospital platform can be seen as a ‘network administrative organization (NAO)’ (Provan & Kenis, 2007); a separate entity that supports network initiatives amongst physicians, and accommodates hospital executives and physicians’ interactions. Though the NAO was primarily established in 2011 to accommodate for quality regulations (i.e., the clustering of care services for specific diseases), the platform has become increasingly relevant for hospital executives to coordinate physicians’ network initiatives on a regional level. Illustratively for this shift, several executives framed ‘caring for the region’ as a new common purpose to develop more regional coherence while networking (i.e., preventing unnecessary overlap), easing professional and managerial working pressures.

Discussion

Previous network management studies predominantly focused on establishing or managing an individual network (Provan & Kenis, 2007), or the establishment of policy networks by governments (Klijn, 2002; Milward & Provan, 2003). This article instead used a management-organizational perspective to analyze how hospitals and their management process and manage *multiple* network involvement. Our study is exploratory and inductive in nature as we considered the application of frameworks that focus on individual networks less suitable (e.g., McGuire, 2002; Provan & Kenis, 2007). The value of our study is that it relies on empirical findings, adding actor-level experiences to the current body of network management and governance literatures, as we foregrounded the complexities and peculiarities of the practice of governing an or-

ganization in a networked environment. In this section, we reflect on how our findings contribute to the ongoing, pragmatic and multi-layered understanding of network management (cf. Agranoff & McGuire, 2003; Klijn, Steijn, et al., 2010; McGuire, 2002), and how this affects the work of (healthcare) organizations and their management.

Managing multiple networks entails activities aimed at creating a strategic niche to remain distinctive; using network consultations for organizational interests; evaluation and prioritizing of and interference with networks; and developing governance platforms to coordinate network actions. With our focus on multiple network involvement, we further extend and reconsider previous work on traditional network management activities (see *Table 4*).

Table 4. Activities of managing multiple networks

Network management activities (McGuire, 2002)	Managing *a* network	Managing *multiple* networks
Activation	Incorporating actors and their resources for network goals	Developing governance platforms to coordinate network actions
Framing	Facilitating agreement amongst network partners	Redefining the organizations' and network managers' identity
Mobilizing	Developing commitment and coordinated action for network goals	Finding institutional support for networking on multi-layers
Synthesizing	Enhancing the conditions for interactions amongst network actors	Determining where to effectively interact between networks

The network management activities of activation, framing, mobilizing, and synthesizing (McGuire, 2002) are focused on how to manage *a* network, but take on a different meaning against the background of a highly networked environment, in our case a Dutch hospital region.

First, managing multiple networks has no clear end, but requires ongoing managerial efforts. Activation while managing multiple networks not only entails incorporating actors and their resources for *individual* network goals, but also requires managers to build and sustain governance structures like (regional) platforms that house multiple networks with a *variety* of goals. This may create governing flexibility for actors as they could use the platform for diverging networking purposes and strategies that moreover may change over time. The platforms' administrative support could activate actors as they might feel a necessity to network, but have limited time and expertise to do so. Related to this, deactivation while managing multiple networks not only entails breaking with actors because *a* network functions suboptimal, but also requires managers to interfere in many network formation processes to protect the organizations' governability and professionals work-life balance. The ongoing nature of network management is reflected in the framing activities while managing multiple networks. Framing goes beyond shaping the identity and culture of an individual network, hereby facilitating agreement amongst network partners. Instead, it also involves recurrent identity-making processes to position the organization and the manager as legitimate partner while networking. Several hospital executives, for instance, used slogans and adapted the organizations' strategic plans to reconfigure the organizations' identity in multiple network involvement. Managers must consider such framing techniques as a purposive activity for strategic (re)orientation, and to evaluate in which networks involvement is desirable.

Second, managing multiple networks is multi-layered. Mobilizing while managing multiple networks not only involves developing

commitment and coordinated action for network goals, but also involves finding institutional support from internal *and* external stakeholders for network actions. The different network origins urge managers to mobilize actors on organizational, network, and policymaking layers simultaneously. Mobilizing efforts are inwardly and outwardly oriented and moreover ongoing to adapt to (changes in) the regulatory environment with (potential) conflicting accountability structures. Managers must inform external stakeholders on a regular basis about network actions and how this affects organizational performance, as they may block or support network formation. Related to this, synthesizing while managing multiple networks not only involves enhancing the conditions for interactions amongst network actors, but also requires managers to govern processes *between* networks and with external stakeholders within the regulatory environment. Not only the patterns of relations and interactions within the boundaries of an individual network matter (cf. Klijn, Steijn, et al., 2010; Provan & Kenis, 2007), but also how networks possibly overlap or compete with each other. Managers must determine where network interactions converge to effectively interact with multiple agents, possibly breaking with meetings that are considered redundant.

We suggest that adopting a (regional) platforming logic could inspire and help managers to coordinate and steer network actions that are scattered across multiple agents on managerial, professional, and policymaking layers (Lorne et al., 2019; Schuurmans et al., 2021). This involves the (re)configuration of governance platforms for network coordination (Ansell & Gash, 2018) in a more or less defined geographical area, like Region X in our case. Such platforms do not function as a NAO for an individual network (Provan & Kenis, 2007), but house multiple networks with different governances (Iedema et al., 2017). As part of 'external networking'—the relationships that managers maintain with external actors (Hansen & Villadsen, 2017; Torenvlied et al., 2012)—managers may use platforms to 'get

things done' in the wider (health) system context, for instance by forming powerful coalitions to address institutional barriers for networking. Hence platforms may offer new governing possibilities for managers' 'relational work' as they facilitate and direct network actions (Feldman & Khademian, 2007). Clustering network actions may also help to identify overlap and conflict. Some networks might be considered redundant while negotiating regional purposes, while other (parts of) networks can be tied together because of similar professionals' ambitions. Such 'collaborative enquiry' (Mitterlechner, 2018) can serve as valuable input for network management as a neat and clear overview of network involvement cannot be assumed (cf. Provan & Kenis, 2007).

Our study offers implications for further network management research. An emerging problematic issue is to *actually* get a grip on the increasing number of networks managers are involved in. We experienced it quite challenging to collect the multiple networks hospitals are involved in as care networks have different origins and overlap in terms of network participants and goals. The case overview of hospital network involvement is probably not all-encompassing, and collaborations are likely missed. Iterative comparison with hospital representatives during data collection helped minimize missing elements, and helped us to understand the diversity of care networks hospitals are involved in, but the qualitative data also shows that hospital executives do not always have a complete overview of networks their hospital participates in.

A second difficulty is how to account for the different policymaking layers involved in managing multiple networks. Although we focused on hospitals, group discussion attendees reflected the multi-level nature of networks as they were more diverse in terms of organizational type (hospital, health insurer, healthcare inspectorate). Ethnographic work into the network actions that cut across work floor, organizational and policymaking layers may help to refine our understanding of how managers (and profes-

sionals and policymakers alike) work with *other* actors in managing multiple networks (cf. Bartelings et al., 2017; Waring & Crompton, 2020).

A third challenge is to remain sensitive to the adverse and less explored everyday consequences of network involvement for affected actors. Part of treating networks seriously (O'Toole, 1997) also involves attention to the 'dark sides' of networking as, in our case, networked healthcare is not merely attractive for organizations. We encourage researchers to take the consequences for everyday management as well as power dynamics in network formation (Heen, 2009; Maron & Benish, 2021) into account while studying network involvement.

A fourth related issue involves how to account for *where* networking takes place, and *how* place affects how networks take shape and are managed (Oldenhof, Postma, et al., 2016; Pollitt, 2011). This entails geographical characteristics, but also sociocultural dynamics. We found that multiple network involvement is not limited to urban regions, but is experienced across the country and forms a new reality for hospitals. Future work might focus on how managerial work in managing multiple networks is performed in different settings—urbanized and more remote—and other institutional and organizational fields, as well as how networks are built, extended or deteriorate over time in situated settings, which seems desirable to further unravel governance processes across traditional organizational boundaries.

These challenges may provide a basis to further unravel how increasingly networked environments like healthcare affect the work of organizations and their management.

Conclusion

Given the high expectations and prevalence of networks in many public domains, this study has shown how hospital executives manage (through) a network of collaborations. The case overview of hospital network involvement shows that the nine hospitals we examined participate in a large and diverse set of care networks and collaborations (ranging from 20 up to 141), established on different scales and in various governance forms. The qualitative results show that hospital executives create a strategic niche to remain distinctive, use network consultations for organizational interests, prioritize or interfere in certain networks, and develop governance platforms for network coordination. Managing multiple networks is an ongoing process of coordination that professionals at work floors (physicians), managers and staff of healthcare organizations (network partners) and external stakeholders (like banks, insurers and regulators) are all part of. Policymakers should reconsider to what extent encouraging organizations to network also leads to undesirable developments like quality risks and increasing work pressure for management and professionals involved. It moreover may result in winners and losers as large-scale organizations might benefit more from a networked environment as they possess more organizational capacity for networking compared to others. Our case study offers a real-life understanding of how multiple network involvement affects organizations and their management, and is intended to be a first step in providing an empirical grounding for future analysis of what it means for actors to govern within an increasingly networked and layered environment.

3

How does a network platform work for participating actors towards integrated care governance? A case study of a Dutch hospital region

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Abstract

Introduction
Network platforms are interesting for integrated care governance as they seek solutions for the problem of competition and tensions between networks. In this paper, we analyze how a network platform functions for the actors involved, and how it is used in their work.

Methods
We employed a case study in a Dutch urbanized hospital region, and conducted 17 interviews with hospital physicians, directors, and supporting staff who are involved in a network platform called 'BeterKeten' (BK).

Results
Actors assign different functions and purposes to BK: facilitating and legitimizing professional (learning) communities; adapting to a changing policy context; enlarging professionals' and the networks' circle of influence; and extending governing possibilities. Network platform' dynamics and frictions entail changing professional and managerial practices; embedding a BK network in a partner network; and alignment of (conflicting) network platforms.

Discussion
Network platforms are a promising strategy to govern, facilitate, and nurture network-building actions to enhance integrated care, offering new ways of working to cope with its multi-level nature.

Conclusion
BK is a dynamic actor with steering capacities that enables the co-existence of multiple purposes. Further research could pay attention to how network platforms are able to develop modalities of integrated care governance that suit healthcare system's networked character.

Key words: integrated care governance, network platforms, physicians, hospital directors, qualitative research

Introduction

Researchers and practitioners are increasingly addressing the networked and multi-level nature of integrated care to develop suitable governance within (fragmented) health and social care systems (Burns et al., 2022; Exworthy et al., 2017; Leijten et al., 2018; Looman et al., 2021). Collaborative governance—including engaging different stakeholders while building trust—is identified as a working mechanism for integrated care (Looman et al., 2021). Inter-organizational networks, understood as collaborations amongst multiple healthcare organizations and professionals (Sheaff & Schofield, 2016), are widely accepted and used for the coordination of health and care services to meet patients' needs (Burns et al., 2022).

Literature on integrated care governance predominantly focuses on governance structures and configurations within *individual* networks, and to what extent these conditions influence network effectiveness—understood as networks reaching their objectives (McInnes et al., 2015; Willem & Gemmel, 2013). Scholars have developed frameworks for the establishment, governance, and evaluation of individual networks (Cunningham et al., 2019; Provan & Kenis, 2007). Illustrative of this focus are the distinguished forms of integrated care governance (Minkman et al., 2021): *a* network coordinated by a separate entity; *a* network governed by a leading organization; or organizations that jointly govern *a* network. This, however, conflicts with the empirical realities of professionals and organizations who are increasingly enmeshed in a web of *multiple* inter-organizational networks (van der Woerd et al., 2021). Networks may overlap, interact, and possibly compete in terms of goal-setting (Iedema et al., 2017), leading to pressures on professionals' agendas or moral dilemmas about in which network to participate as time and financial resources are limited (Hyde et al., 2020). Though network variety in terms of characteristics is acknowledged (Willem & Gemmel, 2013), attention to-

wards the multiplicity of networks for integrated care governance remains scarce. The question becomes not necessarily how to effectively govern an individual network, but how to navigate multi-network dynamics to enhance integrated care.

Scholars of network governance describe network and collaborative platforms as a centralised and external form of governance to facilitate, enable, and regulate distributed network-building actions (Ansell & Gash, 2018; Iedema et al., 2017). Network platforms are interesting as they seek a solution for the problem of competition and tensions between networks. In this paper, we analyze a network platform called 'BeterKeten' (BK), operating in an urbanized southwestern region of the Netherlands, which houses multiple inter-organizational networks and has succeeded in establishing both 'horizontal' integration (i.e., coordination and shared clinical services amongst hospitals), and 'vertical' integration (i.e., hospital services with community and primary care) in the last decade (Shortell et al., 2000). We are interested in how this platform works 'from within' (O'Toole, 1997)—that is, how it is actually used in constituent actors' work practices. We aim to specify how a network platform can sustain network-building actions to enhance integrated care governance. In this, we apply an interpretative and dynamic approach to network platforms by focusing on the experiences and strategies of actors involved in BK (i.e., hospital directors, physicians and BK staff). Interpretative research into what a network platform means for participating actors, and how they make use of it, may foster a fine-grained understanding of how multiple networks are governed, and with what dynamics and frictions (van Duijn et al., 2021). This may challenge and reconsider rather general and abstract notions of network governance (Provan & Kenis, 2007). Being aware that it is a great challenge to capture the complexities of the multiplicity of networks for integrated care governance, we narrow down our focus to the perspectives of *participating* actors. The dynamics and frictions we unravel emerging through and within BK hence offers a partial yet important ac-

count of how a network platform works towards integrated care governance. The following research question guides our analysis:

> *How does a network platform work towards integrated care governance from the perceptions of participating actors, and which frictions and dynamics emerge through and within the network platform?*

To develop an understanding of the practices of and within the network platform, we conducted interviews with hospital physicians and directors who are involved in four (of the 21) clinical networks housed by BK. We used (non)participant observational notes of several BK gatherings to complement our data. Qualitative input about how a network platform functions for actors involved may offer valuable insights for those charged with shaping integrated care governance (Dickinson, 2014).

The enabling role of network platforms

A network platform is defined as "an organization or program with dedicated competences, institutions and resources for facilitating the creation, adaption and success of multiple or ongoing collaborative projects or networks" (Ansell & Gash, 2018, p. 20). 'Network administrative organizations' (NAOs)—a separate entity that coordinates network actions—are often described as a specific governance structure to govern *a* network (Provan & Kenis, 2007). A network platform may enable the (re)organization of network-building actions in response to a changing context (Ciborra, 1996). Also, platforms mediate between local networks and national authorities (Ansell & Gash, 2018), facilitating change beyond network boundaries, for example at health-system levels (Iedema et al., 2017). Furthermore, interactions among networks within the platform may create learning opportunities around how to net-

work or enlarge a network's focus in the wider healthcare context (Iedema et al., 2017).

With these enabling functions potentially leading to synergies between network-building actions, network platforms are seen as a specialized mode, strategy, or mechanism to cope with network-level tensions (Provan & Kenis, 2007; Saz-Carranza & Ospina, 2010). First, network platforms encourage inclusiveness by allowing actors to participate in governance processes, whilst focusing on achieving their networks' objectives. Second, collaborative processes strengthen internal legitimacy, whilst network actors may represent the network to others to obtain external legitimacy. Third, network platforms nurture a sense of unity amongst actors, whilst maintaining actors' diversity.

These tensions mainly relate to individual-network levels, thus overlooking how multi-network dynamics enable or constrain actors' work practices. Also, they seemingly assume a rather singular purpose in a network platform, restricted to governance matters. This may additionally overlook the diversity of platform functions, and the bottom-up dynamics and frictions between and within network platforms. For instance, the layering of multiple policy initiatives for integrated care may not only hinder actors' network-building on a day-to-day basis (Hyde et al., 2020), but could also cause confusion for a network platform regarding what to focus on. Furthermore, diverging interests and resources among network actors influence the evolution of a network platform (Mitterlechner, 2018). Others have shown that network actors use power strategies to deal with other members' opposing views, leading to less-inclusive platform types (Maron & Benish, 2021).

In this study, we conceptualize a network platform as a dynamic entity that may enable and fulfil *different* functions for *different* actors that moreover may *change* over time (Vangen & Huxham, 2012). To analyze how the central actors—hospital directors, phy-

sicians and BK staff—perceive the network platform and for which purposes and strategies, an interpretative perspective is needed, paying attention to actors' perceptions of how they use the platform in their work (Bevir, 2013). In doing so, our paper further builds on literature that critically analyzes collaborative forms of governance (in healthcare) by zooming in on emerging actor-level tensions, and how these inform our understanding of how a network platform 'works' (Glimmerveen et al., 2019; van Duijn et al., 2021; Vangen & Huxham, 2012). With network-building we refer to the intentional and ongoing efforts of participating actors to create, nurture and sustain networks (Feldman & Khademian, 2007; Stout & Keast, 2021). These include the development of relationships beyond organizational boundaries or efforts to integrate care delivery processes to shape a networked model of care. For the purpose of this study, we define integrated care as:

> […] a coherent set of methods and models on the funding, administrative, organizational, service delivery and clinical levels designed to create connectivity, alignment and collaboration within and between the cure and care sectors. The goal of these methods and models is to enhance quality of care and quality of life, consumer satisfaction and system efficiency for patients […] cutting across multiple services, providers and settings. [Where] the result of such multi-pronged efforts to promote integration [lead to] the benefit of patient groups [the outcome can be] called 'integrated care' (Kodner & Spreeuwenberg, 2002, p. 3).

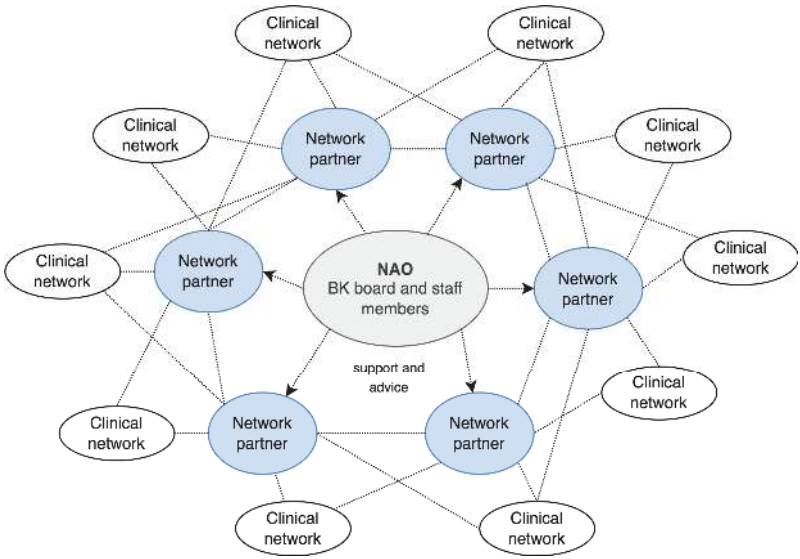
This definition fits with our scope as it highlights inter-organizational collaboration on various levels, including clinical ones, to enhance integrated care.

Methods

Research background: The BeterKeten network platform

In the last decade in the Netherlands, several hospital initiatives at regional and national levels have been initiated to cluster clinical expertise in order to develop clinical pathways for specific diseases like thyroid and oncology care (Postma & Roos, 2016). One of those initiatives is BK, established as a foundation (legal form) in 2011 by two hospitals in the Rijnmond region to enhance overall hospital care by initiating inter-organizational projects like aligning patient referral systems. *Figure 3* visualizes how BK is structured. BK is the name of the NAO that governs a network of clinical networks. These clinical networks have separate names, but are clustered in BK. The BK board consists of a selection of hospital directors and physicians who work for one of the by now six affiliated network partners (i.e., hospitals in the Rijnmond region). The chair rotates among the partners. Each clinical network has a separate board that supervises its day-to-day functioning, and organizes gatherings to discuss disease-specific matters. BK staff temporarily support the clinical networks with project and management expertise regarding network-building and the organization of clinical research, and organizes gatherings for network partners to discuss healthcare developments. BK staff hence does not initiate clinical networks by *themselves*, but nascent clinical networks can request support from BK. BK staff visits network partners to monitor or further develop network-building actions and ambitions, and consult them about network opportunities. Once a clinical network flourishes, BK staff intends to withdraw, leaving the network to its own functioning, unless organizational issues arise. To date, 35 clinical projects (including 21 clinical networks) and 11 PhD trajectories have been initiated involving approximately 500 hospital physicians. BK is interesting to study as a network platform because it houses multiple clinical networks (with most networks still actively supported), and has successfully operated in the healthcare sector for more than 10 years.

Figure 3. Simplified visualization of the BK network platform



Data collection

Following a case study methodology, we interviewed actors that work for BK (i.e., BK staff) and actors that are involved in the clinical networks supported by BK (i.e., hospital directors and physicians) to explore how BK functions and affects their work practices. Between April and September 2020, we conducted 17 semi-structured interviews: 12 interviews with hospital physicians, four interviews in pairs of hospital directors and medical staff directors working in the same hospital, and an interview with the former director of BK. These respondents were selected because they are involved in four clinical networks within BK: (1) *Obesity Center CGG*, (2) *Thyroid Network*, (3) *Pediatric Rheumatology Network*, and (4) *Partners Gynecology, Obstetrics and Reproductive Medicine*. We interviewed three associated physicians, the hospital director, and the medical staff director of each network. The representation of respondents reflected the variety of

included clinical networks, and helped to understand the development and working of BK more precisely. These networks were selected based on diversity in years of existence (i.e., initiated in the beginning years of BK or more recently); network scope and composition (i.e., different clinical specialties, and involvement of other healthcare organizations); and type of activities (e.g., specialized clinical services or integrated pathways with community services). During these in-depth interviews, we asked respondents to reflect on the network platform: Why and how does BK work? How does it affect (or not) their work practices? What future directions should the platform explore? We asked respondents for real-life examples that illustrate how specific dynamics or characteristics of the network they are involved in enabled how they made use of BK.

Interviews were conducted in-person or digitally due to COVID-19 measures limiting physical access to hospitals. The interviews each lasted 45 to 60 minutes. Audio recordings were transcribed shortly after the interviews had occurred, with permission from all respondents. To ensure that the interpretations reflected the understandings of respondents, the first and second author presented preliminary findings during two online BK board meetings (October 2020 and February 2021). We made observational notes in which we wrote down reflections of attendees. Nonparticipant observations were made during a BK network platform gathering mid-2020 to become familiar with BK's way of working. The discussions and notes helped refine the data, bolstering an iterative process of member-checking and triangulation to validate findings.

Data analysis

We abductively analyzed the interviews using Atlas.ti software (Timmermans & Tavory, 2012). We iteratively coded the inter-

views, going back and forth between data and theory about network platforms and governance. We first derived themes related to why and how BK works: shared ambitions for clinical excellence and research; possibilities to learn from peers; and reciprocity while collaborating. These themes helped us organise the data, and were then analyzed more precisely by zooming in on actors' experiences with BK. This led to the four themes presented in the first results section. Informed by theory on network platforms, we analyzed the interview transcripts again while paying attention to emerging dynamics and frictions between platform layers (i.e., physicians, directors, BK staff), and between BK and its context (i.e., surrounding platforms and stakeholders). This led to the three themes presented in the second result section.

Diverging functions of a network platform

Facilitating and legitimizing professional (learning) communities

BK enables physicians to develop (informal) professional communities that find common ambitions for clinical excellence. For them, BK is a learning platform for timely and informal access to other physicians, execution of clinical research, and development of expertise. For patients, these communities result in a widely supported assessment of their care needs as multiple opinions are discussed in a clinical network (van Dijk et al., 2022). Such professional communities are often led by renowned physicians who adopt a leading role in network-building. Professional relationships enable BK to exist, but formalising and 'labelling' these relationships as a BK initiative helps physicians to receive support for which they themselves do not have the expertise and time:

> *"The Thyroid Network would never have started without BK, because now we have a club that facilitates and thinks along professionally, and functions as a bridge between*

> *network participants. I don't think participants in our network could have done this on their own. We didn't have the workforce, time and expertise. BK has been and still is of vital importance to our network. The professionalism and cohesion will otherwise be lost."*
> *(Hospital physician, interview)*

BK's labelling and support acknowledges that physicians' network-building actions matter for (the organization of) clinical integration, legitimizing their role in network-building. Moreover, it facilitates and eases day-to-day learning beyond one's individual work practices.

Adapting to a changing policy context

BK also offers participating actors somewhere to process and adapt to a changing and increasingly complex healthcare policy context (van de Bovenkamp et al., 2016). BK was primarily initiated in response to quality criteria and volume standards imposed by professional associations, against the backdrop of national policy discussions about the role of academic centers and other specialized hospitals (Postma & Roos, 2016). This development spurred hospitals in Rijnmond to deliberately cluster surgical operations. BK staff guided physicians in building clinical pathways to follow quality regulations. The role and scope of BK, however, has incrementally changed in the last decade due to policy developments. Alongside a focus on quality regulations, cooperative strategies like 'regionalization' to handle capacity shortages (Schuurmans et al., 2021) are emphasised within a healthcare context of regulated competition (Helderman et al., 2005). BK has thus evolved into a platform that focuses on a broader set of questions involving peripheral hospitals and other healthcare organizations. This is illustrated in how the Obesity Clinic CGG evolved over time:

> *"In 2009, we [obesity care physicians] asked to the Board of Directors: 'Do we consider obesity an academic theme?' […] We thought it was, because it was a social problem. We*

> *wanted to offer a treatment trajectory for obesity patients. We, however, did not have an important treatment part, bariatrics, because of limited operating capacity. [...] BK played an important role in making obesity a legalized academic topic. Through collaboration with other hospitals, we learned how to recognize patient needs, and were able to link care to clinical research. BK allowed us to offer patients suitable treatments by dividing those amongst the academic and peripheral hospitals. [...] In our pathway, we now have debt counselling and neighbourhood coaches for light care needs, up to more specialized care."*
> *(Hospital physician, interview)*

Though the Obesity Clinic CGG started with physicians, it became an integrated care pathway with professionals working in healthcare and welfare domains. BK staff helped physicians to materialize their ideas on how to enhance integrated care for patients by successfully engaging other hospitals, primary care, and the municipality to align obesity care trajectories. For network actors, BK provides a foundation to work from, gradually expanding the networks' scope from clinical-orientation to integrated care.

Enlarging professionals' and the networks' circle of influence

BK enlarges professionals' and the clinical networks' circle of influence, thus it is used as a vehicle for cross-network interactions with national policy-making layers to enhance integrated care (van de Bovenkamp et al., 2016). Involvement with BK strengthens professionals' positions during negotiations with external stakeholders like the Ministry of Health (MoH) and health insurers to achieve goals beyond hospital boundaries:

> *"Our network is taken more seriously during negotiations with the MoH. [...] We have initiated the 'combined lifestyle intervention' [CLI], which is a strength of the Obesity*

> *Clinic CGG. I helped the MoH and the Care Institute [which advises the MoH on the insurance basket] to include the CLI in the basic insurance. […] We have presented patient narratives, quality of life effects and potential costs savings. Then the ball started rolling, and since January 2019 the CLI is reimbursed. This sounds like an easy story, but we have monthly meetings with the MoH about financial barriers and dysfunctional referral systems."*
> *(Hospital physician, interview)*

The MoH moreover considers the Obesity Clinic CGG a leading partner in developing a nation-wide integrated approach for obesity care, because the network included three hospitals with different diagnostic expertise. BK enables networks to work across hospital boundaries and the 'place' they were primarily intended for (the Rijnmond region), strengthening strategic positions in the healthcare system to overcome institutional obstacles regarding integrated care. Hence, BK functions for physicians as an intermediate between healthcare and policy (Iedema et al., 2017), allowing them to accomplish change on the system-level in order to enhance integrated care. This is referred to as "networking beyond the network" (Iedema et al., 2017).

Extending governing possibilities

Lastly, BK creates an 'outside' governance layer for network actors, which extends their governing repertoire beyond its normal intra-organizational scope. This governance layer accommodates interactions between directors and physicians who work in different hospitals, as well as with BK staff. BK creates a possibility to link the scope of clinical networks to organizational interests. For instance, through the work of BK staff, the bottom-up network initiatives amongst physicians are distilled and made 'visible' for hospital directors. This allows directors to consider network involvement, if desirable and possible, and to make organizational interests part of BK's still-undefined future directions. BK is also referred to during

national meetings by hospital directors to accomplish change within the organization:

> *"I'm going to the NVZ and the STZ [national hospital associations], so they can say: in our region [Rijnmond], they have organized a pathway together, and that's where you have to go as a patient. That also helps me within the hospital to say: if we can do that in the urology department, then we can also do that in other hospital departments." (Hospital director, interview)*

On the one hand, network actors see BK as a separate entity (i.e., a NAO) that allows cross-organizational and cross-network interactions. The examples above also indicate that BK provides a more fluid infrastructure to pragmatically pursue professional and organizational interests. This form of flexible governance cannot be acquired from intra-organizational governance positions alone.

Network platform frictions and dynamics

Changing professional and managerial practices

BK allows physicians and directors to involve themselves in each other's work practices. For instance, imposed quality criteria and volume standards make cooperation amongst gynaecology and thyroid physicians more-or-less inevitable. For hospital directors, BK is another route to stimulate physicians to network. Directors therefore promote BK within the organization as not all physicians realise what BK has to offer them: "BK is for many physicians one of the many logos. They do not know what is behind the logo" (physician, interview). BK staff deciding which projects will receive support can be seen as a means of steering *where* to network. Physicians are involved through BK in managerial practice: they use the multi-level nature of networks to accomplish

change outside the realm of intra-organizational positions. Integrating network-building in daily work is, however, cumbersome as it adds to an already heavy patient-related workload:

> *"Multidisciplinary consultations on regional level are central to our network. However, unlike other consultations within our hospital, we organize those regional consultations at the end of the working day. We then plan two hours to discuss complex patient cases. I think it's amazing that people put in this energy, but it also makes a working day extremely long."*
> *(Hospital physician, interview)*

Regional consultations allow for knowledge exchange opportunities, but also affect physicians' work-life balance. Physicians question how network-building can be classified as patient-related work, illustrating how existing work practices are subject to change.

Embedding BK networks within network partners

Though BK staff ease physicians' work pressure with project and management expertise, its support is temporal. This is because of limited BK staff, but also based on the conviction of BK board members that at some point networks must continue independently, hereby nurturing network-building as an integrated part of professional work in the long-term. Hospital directors and BK staff find it difficult to decide when and how to embed a clinical network established under the BK flag within a network partner (i.e., hospitals) that functions as leading actor. They suggest giving more responsibilities to physicians as they actually shape clinical networks in their everyday work, and could thus most likely contribute to network sustainability:

> *"How are we going to manage this [physicians' network-building actions], and how to keep it governable? We are*

> *now in many meetings, with a sandwich on the side, with 8 or 10 people. But do we dare to mandate a smaller group to get more things done? Because growing and doing more with the same board, I think that's utopian."*
> *(Hospital director, interview)*

Delegating far-reaching responsibilities for network sustainability to physicians is difficult as directors are responsible for overall hospital performance and thus also the organizations' involvement in networks. Organization-centered regulatory frameworks moreover prevent the undertaking of network-level responsibilities.

Aligning (conflicting) network platforms

While BK primarily focuses on clinical care and research, it has gradually broadened its scope in recent years to other care-related subjects requiring the involvement of peripheral hospitals. As a result, BK began to interfere with other regional and national platforms in the field of healthcare governance. These platforms exist side-by-side, and overlap in terms of scope (e.g., hospital care or closely related) and purpose (e.g., caring for regional populations). Hospital directors (among others) therefore question how competing platforms can be made productive:

> *"You want to achieve your goals as a hospital, but also as a region. I think that the cohesion of BK, SRZ, RotterdamseZorg, Regiovisie, Zorgdelta [all network platforms in the region] can be improved. We have to ensure that all those initiatives are aligned. For instance, within BK, we would like to guide patients during pregnancy for integrated gynecological care. We could use RotterdamseZorg to train professionals who work through administrative boundaries."*
> *(Hospital director, interview)*

Though BK coordinates network-building actions on a regional level, it also comes with the new challenge of aligning conflicting

platforms. This is cumbersome; each platform has its own governance structure and relates to different health and welfare domains with other laws and regulations. Moreover, ideas about the platform's future direction differ. Some participating actors would like to see that BK further extends its purpose to cooperate more intensively with primary care. Others are more conservative, arguing that BK should remain focused on clinical integration to prevent unmet ambitions. Hence, co-existing platforms with similar aims urge participating actors to rethink BK's identity and boundaries to remain distinctive in an increasing networked healthcare context.

Discussion

Forms of integrated care governance predominantly focus on how to effectively govern an individual network. However, how to navigate through multiple networks simultaneously receives relatively little attention. Network platforms are therefore interesting for integrated care governance as they seek solutions to the problem of competition and tensions between networks. Following an interpretative perspective (Bevir, 2013), this paper analyzed a network platform (BK) in a Dutch hospital sector that houses multiple clinical networks, exploring how a network platform works and affects constituent actors' work practices.

Our results show that a network platform is important for actors for a variety of reasons: it facilitates and legitimises professional (learning) communities; it helps to adapt to a changing policy context; it enlarges professionals' and the networks' circle of influence; and it extends governing possibilities. However, emphasis on and opportunities for network-building in the BK context change professional and managerial practices, for instance by putting pressure on their work-life balance. Embedding a BK network in a network partner primarily led by hospitals (and not by BK staff) is

moreover considered difficult as responsibilities primarily lie at the hospital organizational level. Furthermore, co-existing network platforms may conflict, and require alignment to prevent over-complicated integrated care governance.

BK provides a structure for governing increasing network-building actions that are scattered across the region (Provan & Kenis, 2007), but also dynamism, as it functions as a vehicle for a variety of purposes for multiple agents. This was for instance shown in how physicians use the network platform to shape professional learning communities, but also for cross-organizational and cross-network impact regarding integrated care. We distil several enabling capacities of a network platform.

First, it can reorder existing care delivery activities and priorities of network actors in a changing regulatory context (*purpose-rearrangement*). Our case illustrated that BK enabled hospital directors and physicians to develop clinical pathways to follow quality regulations. Second, it may turn away from old focuses of network actors or an individual network towards new strategic ones (*purpose-reorientation*). BK for example enabled hospital directors to give shape to regionally-oriented healthcare policy, and to reconfigure the organizations' position accordingly. Third, it allows for the exploration of new types of network-building actions, incrementally building on existing achievements generated from previous network-building actions (*purpose-extension*). BK enabled network actors to explore new organizational arrangements with professionals operating in *other* healthcare and welfare domains, and to bring about far-reaching policy changes to enhance integrated care. Besides context-driven (policy) reasons that call for more integration beyond clinical services, a network platform's rearrangement, reorientation, or extension is made possible through deliberate actor-level work. Network actors in our case recognised, created, and used the flexibility of BK in their work practices. This indicates 'function creep' of a network platform

that is purposive, understood as the gradual expansion of the networks' functions beyond what they were originally created for (Koops, 2021). BK started to focus on clinical integration, but gradually become a place for broader and underexplored questions regarding integrated care to accommodate complex patient needs (van Dijk et al., 2022). The platforms' function creep could be an explanation why BK interferes with other surrounding network platforms. This seems inherent to network platforms that function as an enabler for various purposes, making it more likely to overlap and collide with others.

Because our study aimed to develop a more precise understanding of what a network platform means for network actors, and how it is used in their work, we selected respondents who are strongly familiar with BK (i.e., involved in the four selected clinical networks). A limitation of our study is that we only analyzed an individual network platform in an urbanized region, with the possible consequence that we were unable to compare network platform functions and frictions in other healthcare and welfare domains or less-urbanized areas.

Our study provides several implications for the networked and multi-level nature of integrated care governance (Minkman, 2022). First, network platforms are a promising strategy to govern, facilitate, and nurture network-building actions to enhance integrated care. Our results may serve as input for practitioners and policymakers to build and further craft network platforms for integrated care governance (Dickinson, 2014), for instance how to utilise professionals' ambitions and expertise for (the organization of) clinical care and research. Though interfering network platforms could be made productive through alignment, this should warn policymakers and practitioners about the consequences and feasibility of network governance for everyday practice. Second and related, network-building as an integral part of professional work cannot be taken for granted; to be sustainable, it requires caring

for network actors by organising support when a network is established or considered operational. The identified network platform' dynamics and frictions should challenge our thinking as to what extent network-building is part of healthcare governance work, with what responsibilities, as well as how it can be extended beyond only a select group of renowned physicians. Working in networks may be useful, but also asks of network actors to develop strategies that make a networked healthcare context less complex. An example involves the mobilisation of policy actors to bring about institutional change. Third, network platforms' mediating role between shopfloor, organizational, and policy levels accommodates change for integrated care policies across individual network boundaries. Network platforms therefore offer new and unexpected ways of working to cope with the multi-level nature of integrated care.

Concluding remarks

We conclude that the functioning of a network platform cannot be reduced to primarily governance purposes. Our interpretative analysis of a network platform in a Dutch hospital region shows that different actors assign different, co-existing functions and purposes to BK. These are related to clinical integration, but also those that cut across intended platform aims like 'external' governing possibilities and health-system impact. BK is more than the sum of collaborating hospitals that together with their clinical networks form a 'network of networks' (Iedema et al., 2017) that aim for integrated care across hospital settings. More precisely—BK is a dynamic actor with steering capacities that enables the co-existence of multiple purposes, including those related to governance, coordination, and the fulfilment of professional and organizational interests. How a network platform works hence depends on which actor perspective is taken. This highlights to integrated care gov-

ernance studies the importance of including a variety of actors that operate on different policy-making layers to account for the multi-level nature of networks. Our study moreover informs integrated care governance studies by foregrounding how a network platform affects constituent actors' work practices, and how actors *work with* a governance structure to enhance integrated care. It seems therefore worthwhile to further investigate how governance structures are perceived in actors' work practices in other healthcare and welfare domains to shape suitably integrated care governance. Further research could especially study how network platforms are able to develop modalities of integrated care governance (e.g., supervision, accountability procedures, and leadership) that suits healthcare's networked universe.

4

Regional network-building for complexity: A region-oriented policy response to increasing and varied demands for older person care in the Netherlands

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Abstract

Networks are increasingly seen as promising generic solutions to complex public problems. This article analyzes network-building *in action* within a specific regional setting as an attempt to cope with increasing and varied demands for older person care, studying everyday organizational and policy activities of actors. Drawing on a qualitative in-depth case study of a regional network in Zeeland—the most aging region in the Netherlands—our findings illuminate how this network is created, nurtured, and sustained, and the particularities and complexities this involves. Our practice-based approach demonstrates that network-building requires the ongoing work of many agents within organizational contexts, as well as the outside interference of stakeholders to make the network 'work' within the wider population of networks, institutional context, and geographical place. This highlights to network literature the importance of place-based interventions that characterize how a network develops and pursues opportunities to come up with suitable responses to local needs.

Keywords: network governance, older person care, regionalization, non-urban regions, wicked problems

Introduction

Networked forms of governance are increasingly put forward in many fields of policy and practice as means of dealing with multifaceted challenges in society (e.g., Innes & Booher, 2016; Isett et al., 2011; Weber & Khademian, 2008). Scholars observe that the popularity of network governance reflects a broader set of interactive strategies like stakeholder involvement and frame-reflective policies to address complex policy issues (Bannink & Trommel, 2019; Bartels & Turnbull, 2020). Networks are understood as more-or-less stable patterns of social relations between interdependent actors, which take shape around a complex problem to invoke and foster collective action that no actor could achieve individually (Koppenjan & Klijn, 2004). Despite the widespread attention on networks as a policy promise to deal with 'wicked problems' like climate change, poverty, and aging societies (Ferlie et al., 2011; Rittel & Webber, 1973; van Bueren et al., 2003), relatively little is known about how networks are built, evolve, and are maintained (Provan et al., 2007).

Being aware that "there is no magic bullet to solve the problems" (Peters, 2017, p. 395), analyzing the process or evolution by which a network is built could help towards obtaining a better understanding of how emergent complex and collective problems can be processed and dealt with. In this paper, we examine how a networked response is carried out to search for feasible and sustainable solutions to contemporary and future shortages in older person care in a non-urban region, as well as the complexities that emerge from this. The case serves as an example to illuminate how networks unfold within and are impacted by underlying and broader governance arrangements and strategies, and that this layered policy context moreover has an interest in networks taking shape.

Aging populations and a declining workforce prompt great challenges for healthcare organizations to provide adequate care for older persons (Carson et al., 2015; Leijten et al., 2018). Western

countries increasingly emphasize the importance of healthcare policies that rely on regional networks to achieve a more integrated approach (e.g., Lorne et al., 2019). The Netherlands, the country central to this study, has adopted a regional approach to reorganize older person care. Here, organizations are supposed to collaborate in a regional network to bolster medical capacity. The promise of regionalizing older person care is to effectively distribute clinical capacity across organizational boundaries (Schuurmans et al., 2021).

In this paper, we apply a practice-based approach to study how regional network-building is carried out 'in action'—that is, we focus on the everyday activities and complexities experienced by actors in organising and delivering networked governance arrangements of organizing and providing care (Bevir & Waring, 2020). We focus both within and beyond the region, also uncovering the layered policy approach of network-building as a dynamic and rather contingent policy activity. As networks cannot simply be isolated from their environment (Nowell et al., 2019), analyzing network-building activities in a *particular* setting may add nuance and more compelling findings to generic ideas how networks take shape and are sustained (cf. Provan et al., 2007). In this paper, we build on an ethnographic study in the non-urban region of Zeeland, the region where the proportion of the population of retirement age is greatest in the Netherlands—both among residents and healthcare professionals, creating a double aging problem. Moreover, its geographical landscape of islands and peninsulas results in limited accessibility to public facilities, complicating cooperation among healthcare organizations. We analyze the particularities and complexities inherent to regional network-building in Zeeland, and how actors deal with these to create, nurture and sustain the regional network within a complex healthcare system (Helderman et al., 2005; van de Bovenkamp et al., 2016). The research is part of a larger research project in which we followed network-building activities in multiple cases of regionalization of predominantly

non-urban regions in the Netherlands in the period 2018-2021.

We argue that networks are particular and rather dynamic entities. They are place-based and embedded in overarching as well as underlying governance infrastructures, underscoring both the distinct entity of a network, as well as how the network ties into other governance infrastructures, and the challenges that come with this policy 'layeredness' for network-building. This challenges rather abstract notions of networks (Provan & Kenis, 2007) as network-building has no clear emplaced and policymaking boundaries. We show how the geographical and cultural particularities of a place (Ivanova et al., 2016), as well as efforts within and outside organizational contexts matter for network-building. The following research question guides this study:

> *How do actors in a non-urban region in the domain of older person care deal with situated problems to create, nurture and sustain a regional network to cope with increasing and varied care demands? What does this teach us about governing a complex policy issue through a networked response?*

In the following sections, we first elaborate on literature that describes networks as suitable for complex policy issues, then we present how a practice-based approach enables us to unravel how network-building is carried out in action and how these activities are tied into, and impacted by broader governance arrangements and strategies. After introducing the case and our ethnographic research approach, we elaborate on the identified network-building activities that emerge at different policymaking layers, and how these interact. In the discussion, we reflect on how our findings enrich current insights within network literatures on how network-building and network functioning ensue in the everyday practice of organizations and policymakers.

The promises and challenges of network-building for complexity

A common understanding in network literature is that most public problems cannot be easily solved by individual organizations or agencies but require working across traditional organizational boundaries to foster problem-solving capacity (Koppenjan & Klijn, 2004; Provan & Kenis, 2007). Network-building is considered suitable to cope with complex policy issues as it brings together a diverse set of actors with specific (knowledge) resources and capacities (Kickert et al., 1997). Complexity, in this case, refers to the dynamic set of governance and policymaking processes among diverse and interdependent actors for service delivery (Osborne, 2006), illustrative for a non-linear society (Lash, 2003). Cooperation among actors allows for the joint development of modes of workings that better consider the unstable and continuously evolving nature of wicked problems (Head & Alford, 2013; Rittel & Webber, 1973). For organizations, developing strategies for network-building is urgent as they increasingly experience the real-life consequences of 'great challenges' or 'wicked problems' (Ferraro et al., 2015), such as workforce shortage and climate change. Network strategies focus on the structures and rules of engagement among actors to interact, coordination among actors who have different ideas about the problem as well as possible solutions, and mutual learning throughout the building process (Ansell & Gash, 2007; Emerson et al., 2011; Ferraro et al., 2015).

Although networks seem harmonious and suggest inclusiveness, literature shows that they are often politically contested and rich with struggles. For instance, some actors could dominate others, resulting in the exclusion of other (non-dominant) actors and perspectives (Waring & Crompton, 2020). Furthermore, conflicting beliefs and divergent positions on problem definitions and possible solutions as well as institutional barriers can block collective action

(Ferlie et al., 2011; van Bueren et al., 2003). Additionally, accountability tensions can arise among network actors, also in relation to external stakeholders (Waardenburg et al., 2020). Network-building in everyday organizational practice may lead to time pressures, intensive work demands, and possibly create integrity challenges due to increasing (moral) commitments (Hyde et al., 2020). Studying network-building therefore also means having attention for the (power) imbalances between actors as these have consequences for and are influenced by how boundaries of the network are drawn; how problems the network seeks to solve are (re)framed; and how network-building is carried out in everyday life.

These challenges illustrate that actors who face the same problem cannot simply be expected to share understandings of the problem as they have their own preferences and perceptions (Bannink & Trommel, 2019). The requirement to bring different actor perspectives together furthermore complicates the *actual* integration of actor perspectives in a network. Network-building can thus only be an 'imperfect' response to a complex policy issue (Bannink & Trommel, 2019).

The place-based and layered policymaking nature of network-building

Contemporary research on networks mainly focuses on how actors position themselves in relation to others to explain why network functioning is cumbersome (Kickert et al., 1997; Koppenjan & Klijn, 2004). But *where* network-building takes place, and *how* place affects network-building, receives little attention. Networks are rather studied as if they are 'placeless' (Oldenhof, Postma, et al., 2016). Furthermore, frameworks of collaborative forms of governance seemingly assume that the place to network is more-or-less defined and agreed among actors (e.g., Ansell & Gash, 2007;

Emerson et al., 2011). Pollitt (2011, p. 46) signals an absence of the role of place in public policy and administration as we favor "universalistic management tools" that have led to "the diminution of academic concerns for national, regional and local particularities." Attention to the geographical particularities and deeper sociocultural aspects of a place may clarify how actors perceive network-oriented changes in the organization of care (Ivanova et al., 2016).

Networks are also embedded in an environment that consists of (conflicting) governance infrastructures that have been changed and placed on top of each other through policy reforms (Lorne et al., 2019; van de Bovenkamp et al., 2016). This means that network-building activities cannot be decoupled from sector specific governance logics in which it is aimed to have an effect, for instance regulations, professional autonomy, and accountability schemes (Helderman et al., 2005). *When* and *where* network-building is accomplished is thus difficult to define as it requires ongoing efforts to adapt to changing governance infrastructures, and is dependent on the efforts of actors at different policymaking layers (van de Bovenkamp et al., 2016). In our study, besides focusing on the regional level, we are aware of and consider the ways in which network-building in the complex environment of healthcare is dependent on shop-floor and managerial levels, as well as wider policy developments within the healthcare system. By this, we can critically assess if, and to what extent, network-building fosters collective action on a regional level.

Until now, little empirical attention has been paid to how actors deal with the complexities of network governance in practice (Bartels & Turnbull, 2020; Vandenbussche et al., 2020). In our study, we address this gap by centralizing the actions and strategies of actors involved in building a (regional) network, and how they deal with place-based and layered policy complexities that emerge from this. We elaborate on such a practice-based approach of networks in the next section.

A practice-based approach to regional network-building

A closer look on the practical and 'day-to-day' activities of how a network is created, nurtured, and sustained could facilitate a better understanding of how a networked response is carried out (Bevir & Waring, 2020). A practice view concentrates on how networks are built, and the everyday struggles actors—embedded in their own cultural-historical, strategic, and geographical environments—experience in network-building (Bevir & Rhodes, 2006). It offers fertile ground to explore the peculiarities 'on the ground' (Bevir & Rhodes, 2006)) of how actors (re)position themselves in relation to, in our case, policy-induced regionalization. It is furthermore argued that a practice view reveals strategies adopted by actors regarding how to position themselves vis-à-vis authorities, and how they negotiate governance and institutional arrangements (Overeem & Tholen, 2011). Such a bottom-up perspective leaves room to study possible interfering interactions with other networks surrounding actors' workplaces, opposite to focusing on how an *individual* network is governed (cf. McGuire, 2002; Provan & Kenis, 2007). However, how this is done, and with what consequences for network evolvement and success, is hardly addressed in the literature.

Being aware that network-building covers a wide and broad array of activities (e.g., Edelenbos & Klijn, 2009; Feldman & Khademian, 2007; McGuire, 2002), we narrow down our focus to network-building activities that are purposively undertaken on shop-floor, management and policy levels to create, nurture, and sustain network-building (Stout & Keast, 2021). These cover, for instance, activities that guide the collaborative process by "activating actors, managing interaction, and creating variety in content" (Edelenbos & Klijn, 2009, p. 319). It also entails activities related to relational work, meaning the creation of connections that allow actors to use

information rather than only disseminating information in the network (Feldman & Khademian, 2007). Whereas informational work helps to understand (conflicting) actor perspectives, relational work is necessary to overcome differences in interests to actually network (Feldman & Khademian, 2007).

In the remainder of this paper, we focus on the particularities and complexities of network-building in a non-urban region to search for feasible and sustainable solutions to contemporary and expected future shortages in older person care. We first outline our methodological approach in which we also provide a background account of the policy reform of the regionalization of older person care in the Netherlands.

Research design

Research background: Regionalization of older person care in The Netherlands

Over the past two decades, the Netherlands has developed a rather complex institutionalized healthcare system of both public and private governance arrangements, mixing up market-driven arrangements with state-led regulation (van de Bovenkamp et al., 2016). Following the regulated market paradigm, healthcare providers and insurers have to compete on quality and price in order to enhance the efficiency and quality of care (Helderman et al., 2005). In the past few years, the policy orientation has, however, shifted to regional collaboration to deal with emerging problems (e.g., the COVID-19 crisis and health workforce shortage), increasingly valuing collaboration over competition (Schuurmans et al., 2021). The Ministry of Health (MoH) has allocated budgets to Regional Care Offices (RCOs) to develop regional networks for long-term care delivery. These RCOs are linked to the largest health insurer in a particular geographical region, which functions

as a leading actor in executing the Long-term Care Act (*Wet Langdurige Zorg*).[1]

The 'RegioZ' research project: multiple cases of regionalization

This study is part of a larger and action-oriented research project ('RegioZ') in the Netherlands (2018-2021) focusing on 10 cases of regionalization. These cases are all non-urban regions with a growing healthcare demand and a declining workforce in which healthcare providers and policymakers seek to invent regional forms of older person care (so-called 'care experiments') in order to deal with problems in capacity and distribution of care services, or as an alternative way to organize and distribute scarce resources (Schuurmans et al., 2021). Care experiments are often practice-based and include (among others) triage models to develop regional routines of providing care, the reallocation of tasks among specialized physicians, general practitioners (GPs), and nurses, and inter-organizational collaboration during out-of-office hours (van Pijkeren et al., 2021). As researchers we were closely involved in those care experiments through a formative evaluation (Øvretveit, 1998) in which we participated in regional activities and provided feedback about the possibilities and difficulties of regional care provision, both at the organizational and policy level. In the total project, over 1,000 hours of (non)participant observation, 290 interviews with healthcare professionals and management, and 200 hours of project participation (i.e. giving presentations, workshops, feedback sessions) were conducted.

[1] The Long-term Care Act came into effect in 2015 to provide predominantly residential care for older persons that suffer severe physical or mental disabilities. It is designed as a statutory health insurance scheme, meaning that the Care Needs Assessment Center (CIZ) assesses whether an applicant is eligible for care under the Long-term Care Act according to national standards (Maarse & Jeurissen, 2016).

Case selection and description: The Zeeland case

In this paper, we particularly focus on one case of regional network-building: Zeeland. This region can be literally translated as 'Land in the Sea' due to its geographical composition; approximately one third of the region consists of (sea) water. Although the Netherlands is one of the most densely populated countries in the world, regions differ in accessibility to healthcare, which is particularly a problem in non-urban areas like Zeeland. Holiday homes and job opportunities for partners have been offered to attract physicians, yet without success. Furthermore, not all islands are easily accessible as there are only a few connecting bridges and tunnels, and sometimes a fee is required for using a tunnel. Healthcare organizations primarily cooperate with organizations on the same island and many of them employ local inhabitants.

We selected Zeeland as an exemplary case to study network-building because it is regarded by the national government as one of the regions in which immediate action is required to combat severe (especially medical) personnel shortages and related capacity issues. Illustratively, driven by an increasing awareness and urgency to develop a regional strategy to prevent a serious shortage of healthcare services in the near future, a covenant was signed at the end of 2018 by the directors of 10 nursing homes, the RCO, and the Provincial Board. The covenant entails regional initiatives like task reallocation among specialized physicians and nurse practitioners, telehealth, attracting higher qualified healthcare personnel, and creating network platforms for nursing home management and professionals. In this paper, we explore the particularities and complexities actors experienced in network-building in Zeeland and how this impacted on regional care delivery.

Data collection

The methods used in the Zeeland case are similar to those used in the other cases of regional collaboration in the RegioZ project.

Between May 2019 and March 2021, we conducted 42 semi-structured interviews, 72 hours of participant observations and a document review. We first analyzed reports and the websites of nursing homes and regional authorities like the RCO and Provincial Board to develop an understanding of regional problems in older person care. These insights were used for input during the series of interviews with nursing home management and professionals working across different islands and peninsulas (see *Table 5*). We also interviewed key stakeholders in older person care in the region to explore their role in network-building. Respondents were asked to reflect on their role and contribution to network-building, how they positioned themselves in relation to other organizations and professions, and the complexities they encountered. Themes were a sense of urgency for inter-organizational collaboration; dependencies of small-scale nursing homes on larger ones; difficulties to ensure professional commitment in care experiments due to high workloads; previous (failed) attempts for network-building; and the consequences of a fragmented landscape for professionals (e.g., long travel times). The interviews had a minimum duration of 45 minutes and a maximum of 90 minutes. All interviews were recorded with permission, and transcribed verbatim in Dutch (citations were translated into English by the authors). All respondents have been anonymized.

Table 5. Overview of interviews and observations

Interviews	
N = interviews	N
Nursing homes	
Directors	6
Managers	6
Physicians	4
Nurse practitioners	4
Policymakers	4
Others	
Project leaders	6
Policymakers RCO	4
Policymakers MoH	4
Policymaker Provincial Board	1
Director regional association of GPs	1
Patient representatives	2
Total	**42**
Observations	
N = hours	
Regional project meetings led by project leaders	62
Regional meetings between directors and RCO	10
Total	**72**

Participant observations were conducted during 54 regional (project) meetings charged with developing and monitoring regional initiatives, with a total duration of 72 hours (see Table 1). These meetings consisted of a mixed composition of nursing home management and professionals, project leaders, and authorities. Our observational focus was on how actors make sense of regional network-building, and how they relate to other organizations and authorities. Fieldnotes contain observations, thick descriptions, and verbatim excerpts of conversations. Fieldnotes were worked up into observational reports shortly after observations had taken place (within 24 hours) (Emerson et al., 1995). This enabled us to

build rich narratives of how network-building is carried out in Zeeland. Participating in person or digitally (during COVID times) on multiple locations in Zeeland allowed us to establish good field relationships (Hannerz, 2003), as well as to grasp cultural-historical traditions and geographical dynamics in terms of how regional network-building is carried out.

Data analysis

We abductively analyzed the data (i.e. documents, interview transcripts, and observational reports) thematically using Atlas.ti software, creating an iterative cycle between our empirical material and theoretical work (Timmermans & Tavory, 2012) about network-building. We took several analytical steps to explore the network-building activities of actors, and what complexities emerged from this (see *Table 6*). We first inductively identified developments in healthcare for older persons, resulting in network-building as a relevant concept to explore how actors attempt to cope with scarce clinical capacity. Then, informed by network governance theory that reports rather generically about network-building (e.g., Ansell & Gash, 2007; Provan & Kenis, 2007), we narrowed down our focus to network-building activities at different policymaking levels, i.e. shop-floor and management, as well as how stakeholders like the MoH and RCO relate to the network. This led to the following first order themes: crafting the place of networking; mobilizing actors to develop coordinated action; and network actors' interactions with external stakeholders.

As data analysis proceeded, we explicated how the first order themes are given a specific meaning and component against the background of a layered policy context. We carefully considered how different policymaking layers relate to network-building. This process of refining the initial themes led to second order themes for which we selected quotes and observations of actors' network-building activities. We specified the complexities emerging from network-building in a complex institutionalized healthcare system,

also by paying attention to how these can be explained by the particularities of the Zeeland case (e.g., geography, history, religion). The inherent imperfections of networks (Bannink & Trommel, 2019) informed our understanding that network-building requires ongoing efforts of actors at different policymaking layers (including external stakeholders' activities) to offer suitable and emplaced answers to the problems encountered, allowing for care delivery that fits with local cultural needs as well as available regional health workforce capacity.

Table 6. Analytical steps to network-building activities

First order themes	Complexities	Second order themes	Network-building activities
Crafting the place of the network	Uncertainty about where to start and monitor networked actions; disconnect between geographical-administrative and cultural boundaries	The proliferation of network platforms and accountabilities to shape a regional urgency to act	Building up and streamlining network platforms; demarcating network boundaries and accountabilities
Mobilizing actors to develop coordinated action	Dependencies and power imbalances within and between organizations; organizational-centered regulatory	Interacting management and shop-floor activities to develop coordinated action	Supporting interactions between management and shop-floors; ensuring professional and managerial commitment

	frameworks		
Network actors' interactions with external stakeholders	Overflow of coordinating actors; different spatial arrangements and accountability structures for authorities	External stakeholders' interventions to stimulate regional network-building	Feeding network actors with advice and expertise; breaking with vested routines to enforce network action and taking shared responsibility

Findings

The proliferation of network platforms and accountabilities to shape a regional urgency to act

It is often assumed that the place to network and its boundaries are more-or-less defined and agreed among actors (Provan & Kenis, 2007). We observed, however, that the boundaries of the network are not a given and 'the region' is not a natural identity, but rather a contested place for older person care (Schuurmans et al., 2021). In our case, regional actors and authorities struggle with the fragmented geographical area and cultural-religious aspects that influence who is working with whom (and with whom they are not working). Consequently, what the boundaries of the network are as well as who should engage in network-building activities entail a constant negotiation.

Illustratively, in Zeeland a myriad of network platforms has been set up by nursing home directors and other authorities—e.g., health insurer, RCO, Provincial Board, and MoH—to search for feasible solutions to combat problems related to personnel shortages and especially the (threatening) lack of specialized physicians and GPs in Zeeland. Uncertainty about shortage issues and related

consequences for quality of care prompts actors to engage in network platforms, shape regional interests that break with dominant island-oriented cultures, and enhance collaboration. One of these network platforms is the Zeeland Care Coalition (*'Zeeuwse Zorg Coalitie'*), in which directors of the largest healthcare organizations develop regional initiatives that strengthen healthcare provision. Parallel to this initiative is the covenant between nursing homes that includes campaigns to attract higher qualified personnel to the region, and telehealth (among others). Overseeing the many network activities and the efforts made, results can be disappointing for participants. Respondents experience fragmentation in the high number and partly overlapping network platforms originating from many action programs that exist side-by-side, which complicates prioritizing what to do first:

> *During a project meeting with nursing home managers and professionals, participants discuss the many and overlapping initiatives regarding triage models.*
> *[Project coordinator]: "Several [healthcare] professionals and [nursing home] directors take seat in different projects and initiatives, which is not convenient to take action.'*
> *[Nurse practitioner]: But we are in this meeting with several professionals, so we can discuss the scope of the triage experiment?*
> *[Project coordinator]: We should first discuss similar initiatives in the region, for instance by the Zeeland Care Coalition. Should we merge this project with other project structures because of overlap?*
> *[Director]: We already have the platform for all nursing homes in Zeeland, and the covenant with the RCO. We just have to go for it and not wait for others!"*
> *(Fieldnotes project meeting)*

As illustrated by the expert above, respondents doubt the practical effect of networks when similar initiatives are being discussed in

different network platforms. Illustratively, the RCO representative listed about 15 platforms in Zeeland in which similar topics were being discussed. The need for overview to streamline network platforms has paradoxically led to many more network consultations. Concerns are raised over how these participatory investments—which are time-consuming and costly—complicate the development of concrete plans as, for instance, physicians seldom take a seat in these platforms.

While the growth of network platforms is the result of a sense of urgency to act—most respondents understand change is urgently needed—*how* exactly to bring about change has not yet been fleshed out:

> *The small conference room slowly fills up with people. It is somewhat mundane as they seem to have encountered each other previously.*
> *[Director 1]: "It is already April, so something has to happen as we have been talking for long enough now.*
> *[Director 2]: 'A tsunami of older persons is coming our way, so it takes more than a few projects to cope with this. We have to move from paper to collective action."*
> *(Fieldnotes project meeting, 2020)*

This excerpt shows that talking about change in network platforms is not enough to make a network work. Covenants do not apply to all nursing homes, which renders it difficult to develop concrete plans, also because network actors do not fully cover the region. Organizational ties between healthcare organizations go beyond provincial (Noord-Brabant, Zuid-Holland) or even national (Belgium) boundaries, indicating that geographical-administrative and cultural boundaries are not the same. Inhabitants of the Tholen peninsula are even called 'zebras'—partly belonging to Zeeland, partly to the region of Noord-Brabant (which is situated next to Zeeland), but more closely connected to Noord-Brabant as no rivers have to

be crossed. Some nursing homes located in the southern area of Zeeland (Zeeuws-Vlaanderen) are more oriented towards Belgium, whereas some more northern peninsulas affiliate with the urban area of Rotterdam. Moreover, religious differences (i.e. Protestant, Catholic, or more liberal) make network-building cumbersome as some nursing homes traditionally hold on to their local identity. A nurse practitioner explained that "the waters are the borders" (interview), and a manager rhetorically questioned: "Can we even speak of 'one region' in Zeeland?" (fieldnotes project meeting). The emplaced reality of Zeeland, with its islands and peninsulas, results in a rather fluid perception of what is experienced as regional, challenging the idea that Zeeland is 'one' region with shared responsibilities. The understanding of the region as a geographical place hence matters for how networks evolve as it reveals the spatial and cultural complexities that come with and thus complicate network-building (Ivanova et al., 2016). Such complexities are reflected in the interactions between management and shop-floors within nursing homes, which we elaborate on below.

Interacting management and shop-floor activities to develop coordinated action

Finding the 'right' network partners and mobilizing them is considered an important part of network-building (Ansell & Gash, 2007; Provan & Kenis, 2007). Our data shows that network-building requires the involvement of many agents, and is influenced by the geographical, cultural and religious cleavages that run across Zeeland. Following the administrative approach of RCOs, Zeeland is a region, and network-building among healthcare organizations is strongly encouraged and subsidized by national policy programs. Participating in network-building, however, entails a tension between maintaining organizational continuity and protecting medical capacity in the short-term as well as fostering older person care in the long run. Importantly, collaboration with other nursing homes may threaten an individual nursing home's strategic position in the region:

> *Compared to nursing homes around us, we [a large-scale nursing home] train physicians and nurse practitioners, and yes, this is part of a regional discussion. Others say: 'Why don't we create an independent organization so [the whole of] Zeeland can profit from this?' These organizations didn't anticipate personnel shortages, probably because of time and financial arguments. I am not going to let this [a well-functioning organization] slip out of my hands, risking that a new [regional] organization will fail, and that we end up with less clinical capacity.*
> *(Nursing home director, interview)*

This nursing home director warns against the risk of losing even more clinical staff in the case of sharing workforce capacity among organizations. Some physicians and nurse practitioners are not in favor of working for different healthcare organizations and have even threatened to quit their jobs, worsening the problem (see also below). This tension is moreover due to existing regulatory frameworks in Dutch healthcare that mainly focus on individual organizations instead of collaboration in networks. Nursing homes are being held accountable for quality of care by regulatory agencies, and are expected to comply with formal quality frameworks (*Kwaliteitskader Verpleeghuiszorg*) that emphasize the importance of well-trained professionals (van de Bovenkamp et al., 2020). Hardly any formal responsibility is described at regional level, making nursing homes' involvement in network-building more voluntary and hence less obvious as it may even threaten organizational quality.

The uneven distribution of personnel shortages and power among regional nursing homes influences whether, and how, they contribute to network-building. If large-scale nursing homes tend to lose clinical capacity (e.g., physicians threatening to leave the organization), this might prevent them contributing to network-building activities. Small-scale nursing homes, on the other hand,

face more short-term urgency to interact, but experience difficulties to participate due to fewer available personnel. Zooming in on the interactions between specialized physicians and nursing home management, we noticed that their relationship is experienced as a continuous struggle:

> *During a project meeting with nursing home management, organizational struggles in maintaining clinical capacity are discussed.*
> *[Director 1]: "The time for negotiations with physicians is over. They simply get what they ask. We [Board of Directors] are forced to deal with their demands."*
> *[Manager 1]: "We offer diner coupons to show our gratitude and create some goodwill."*
> *(Fieldnotes project meeting)*

This excerpt highlights the powerful position of physicians vis-à-vis nursing home management, which can hinder network-building. Managers often feel too dependent on scarce physicians to take far-reaching measures. Illustratively, while the use of telehealth (i.e. 'smart glasses' to save travel time, and an often-mentioned solution for workforce shortage) was agreed upon in regional meetings, most physicians said they preferred face-to-face patient consultations and slowly disengaged from the initiative. As a result, the scope of the regional initiative remained limited to several nursing home departments rather than solidly embedded in the region as it was originally intended. While managers are urged to support physicians and meet their preferences to avoid losing them, they are also expected by authorities like the RCO to take far-reaching initiatives in developing networked arrangements that go beyond immediate needs to foster regional care provision.

Thus working on a regional network is contested; not all respondents consider regional networks as appropriate, as the fragmented geographical area with diverse cultures cannot be easily integrated

by building extra bridges or tunnels. A specialized physician expressed resistance:

> *"The first step to network is a willingness to work together, and that you are not going to point your fingers to each other. Nursing homes have common problems, but that doesn't mean we can solve them together. […] I don't think medical capacity will increase by working better together at the regional level."*
> *(Physician, interview)*

Other physicians, however, positioned themselves closely to nursing home management as a strategy of co-designing regional initiatives. This helped nursing home directors to gain more support within the region for a cooperative working method between a specialized physician, GP, and nurse practitioners. The physical or digital presence (especially during Covid times) of physicians during network consultations moreover helped other participants who were uncertain about the effects to support the initiative as physicians elaborated on possible results. Therefore interaction between management and shop floors ensures that professional perspectives and commitment to regional collaboration are preserved during network-building.

In sum, while a lack of support and effort from the shop floor complicates network development, mobilizing shop-floor workers, especially physicians, involves efforts from management and policy agents. The regulatory environment moreover urges management to emphasize organizational continuity rather than regional interests. This indicates that network-building does not only entail bringing management together, as they are formally in charge, but also requires interaction with shop-floor activities as well as external stakeholders to gain support and develop coordinated action. We elaborate on this below.

External stakeholders' interventions to stimulate regional network-building

Declining accessibility of older person care in Zeeland spurred actors outside the region or the healthcare field to step in. We observed how external stakeholders like the MoH and RCO intervened in the region and worked with regional actors as well as other authorities to facilitate network-building. National authorities, however, do not have the formal power within a decentered healthcare system (Helderman et al., 2005). They employed soft governance forms to enforce and sustain regional collaboration (Brandsen et al., 2006). For instance, policy advisors appointed by the MoH engage in network-building to advise organizations where to start care experiments and with whom. Moreover, it was hoped that the authoritative position of the MoH would put pressure on the nursing home directors to strengthen regional collaboration. In a similar vein, regional coaches who are part of a national policy program called 'Dignity and pride in the region' (*'Waardigheid en trots in de regio'*) that focused on quality improvements in nursing homes, were put in place to guide directors towards a networked model of care. They actively monitored progress and regularly contacted the regional project leader to offer help and advice. Furthermore, the RCO and Provincial Board appointed regional managers with the task of further fleshing out regional collaboration among healthcare providers (see the Zeeland Care Coalition example above). These examples demonstrate how outside authorities intervene to enforce and sustain network action. These activities helped to put a regional issue on the national policy agenda, creating more awareness among policymakers about the place-based complexities that inhibit collaborative action:

> *"At our [Provincial Board] request, [health insurer and RCO] presented a report entitled 'Breaking boundaries' on how to foster healthcare in the region and break with island-oriented cultures. Questions were asked in Parliament, followed by a visit of the Minister of Health to discuss re-*

> *gional collaboration with healthcare providers." (Policymaker Provincial Board, interview)*

Although the institutional role and impact of the provincial governments is limited regarding healthcare provision, the Provincial Board tried to intervene in and contribute to network-building as workforce shortages increasingly put pressure on Zeeland's' livability. They hence framed organizing older person care as a regional matter, and interfered in response to a lack of coordination caused by the different geographic and strategic orientations of Zeeland's many sub regions.

Policy advisors strategically intervene in network-building by 'feeding' network actors with advice and expertise about promising network initiatives in other regions. While dominant island-oriented cultures hindered network-building, the MoH policy advisor suggested to experiment with 'regional triage' as a way to align working routines that would facilitate inter-organizational collaboration especially during out of office hours (van Pijkeren et al., 2021). A coordinated care path among physicians and nurse practitioners during out-of-office hours was labelled a 'good example' of regionalization in other regions as it could help connect professionals working in different organizations scattered across sub-regions (van Pijkeren et al., 2021). While network actors conferred its feasibility in the Zeeland region, the policy advisor intervened in an attempt to obtain managerial and professional commitment:

> *[Policy advisor]: "In the Deltaplan [action program parallel to the covenant], there is no formal line with nursing home directors. We need to present the triage experiment at managerial platforms to obtain commitment from directors because they can pressure physicians to participate. Triage is inevitably linked to a regional schedule of care provision during out-of-office hours, so we cannot proceed without their sup-*

> *port. […] I can make a presentation, including the steps we should take in a concise plan." (Fieldnotes project meeting)*

Another related example of how the policy advisor intervened involves an attempt to break through a vested regional routine to enforce network-building. Nursing homes have made an agreement that within half an hour a specialized physician must be on site, but there is no legal basis for this. The policy advisor started a discussion with actors during a project meeting why such an agreement about arrival times has been made, and to what purpose. This provided regional actors with clarity about acute care regulations in older person care, which were previously regarded as unclear. The involvement of the policy advisor moreover provided project leaders with support to mobilize the shop floor for care experiments.

Other authorities like the health insurer and RCO use a combination of institutional schemes to enforce network action as tackling regional capacity issues also require the involvement of, for instance, hospitals. Nursing home management experience that nurses switch from nursing homes to hospitals, and that hospitals as a result do not have such large capacity issues. The RCO regional manager searched for institutional angles, including those outside older person care, to make hospitals co-responsible for network-building:

> *[RCO regional manager]: "During procurement negotiations with healthcare providers, regional collaboration becomes the starting point, especially with hospitals that fall under the Health Insurance Act [in Dutch: Zorgverzekeringswet]." […]*
> *[RCO regional manager] negotiates with hospitals which ask for long-term agreements for financial stability. The RCO aims for regional networks with nursing homes to maintain regional care provision, which is presented as a condition for hospitals. (Fieldnotes project meeting)*

Working towards a regional network thus involves reframing problems in older person care across administrative boundaries, requiring authorities to develop workarounds to enforce their programs.

The examples in this section illustrate that network-building entails effort from both participating organizations and outside actors that do not make part of the regional network but that are involved due to their formal and (assumed) responsibilities. This shows the dynamic character of a network entity as it needs to take shape within overarching governance infrastructures to have an effect for local problems. The outside interference from authorities can be seen as a temporal extension of the network, moving in and out through interfering work. This helps regional actors to find institutional support to pursue more far-reaching interventions and reforms, like the creation of network platforms or the start of a regional triage-system.

Discussion and conclusion

Networks are increasingly seen as promising generic solutions to deal with complex public issues (Ferlie et al., 2011). Based on a qualitative and in-depth case study in the Zeeland region, we explored how network-building is carried out as a strategy to cope with increased and varied demands for older person care against the backdrop of a declining workforce. We have shed a light on the particularities and complexities that play a role in network-building, and how actors deal with these problems to create, nurture, and sustain the regional network. By doing so, we offered an in-action and emplaced approach for network-building, focusing on the everyday activities and complexities experienced among affected actors (Bevir & Rhodes, 2006). In this final section, we reflect on how our findings enrich insights within network literatures on how network-building and network

functioning ensue in the everyday practice of organizations and policymakers.

Our findings show that networks are particular and dynamic entities that need to be crafted and cared for by (potential) network partners, as well as require (temporal) interference from the outside world to become a distinct network entity. We highlighted that network-building is embedded in underlying governance dynamics (i.e. professional-management relations), and that it ties into wider governance infrastructures (i.e. regulatory frameworks and a competitive system-logic), and that regional actors have to deal with the challenges that come with this policy layeredness. The regional network in Zeeland has characteristics that are particular (i.e. islands and peninsulas, religious differences) that make network-building difficult in other ways than our general understanding of network-building challenges. We consider what these specific insights add to network literature.

We found that place-making (Bishop, 2020) is enacted in the networked actions of actors involved. The research demonstrated how external stakeholders that intervened in network-building helped to make the Zeeland region a place to network. This was not the case beforehand but required active and continuous work. Crafting the place *where* to network helped to shape a regional interest and spurred organizations and policymakers to act on a regional level. Yet, building a regional network interferes with, and comes on top of, existing network initiatives. In our case, some organizations worked fruitfully together with organizations outside the wished-for network and even outside the country. The structures and boundaries of the regional network must be constantly negotiated among actors, who often hesitate about where to start and monitor network-building activities as they interfere with existing network-building activities. Besides the broadly felt need to cooperate on a regional level, 'the region' appeared to be a contested concept with no clear boundaries and governance logic of its own—even going

against the dominant policy paradigm of regulated competition. This illustrates that, in this case, the region is not only a contested place in the making but also a contested policy layer. The region had no clear governance structure of its own, nor a given accountability structure. Instead, it depended on the efforts of organizational and policy actors simultaneously. Network-building is therefore not only about constructing a network entity (Provan & Kenis, 2007), but also about constructing the region as a policy layer to combat problems in healthcare; a layer which does not yet have a clear status and logic of its own (except being a scale for RCOs to work on).

Although we illustrated that place matters for network-building in a specific case, this also informs our understanding that networks need a place to work from more generally (Oldenhof, Postma, et al., 2016). Networks are place-based interventions that have to land somewhere geographically, and have real-life implications for actors in local settings as well as specific (hidden) governance dynamics that can be explained by referring to broader governance infrastructures within which the network functions. Zooming in to such emplaced aspects in network literature may enlarge the explanatory potential of how networks as a general solution to complex problems can be cared for in specific local settings. Hence attention to the geographical-administrative and cultural-historical boundaries of a network (Lorne et al., 2019; Schuurmans et al., 2021) as well as to the symbolic and political dimensions of place (Pollitt, 2011) are important to better understand how network-building ensues in the mundanity of everyday practice.

Our findings also showed that network-building and functioning requires the efforts on different policymaking layers, both within organizational contexts and those from the policy layers outside the network. This does not mean that interactions among shop-floor, managerial, and policy layers harmoniously lead to a fixed, well-demarcated network. Their efforts do, however, show that

network-building requires the ongoing work of many agents within organizational contexts, as well as the outside interference of stakeholders to make a regional network 'work' within the wider population of networks, institutional context, and geographical place (Nowell et al., 2019; van de Bovenkamp et al., 2016). Hence network-building is not finished when key stakeholders are included, or a common purpose is defined, or a network structure is chosen that allows actors to interact, negotiate, and learn, or when (historical) tensions are (temporarily) eased (cf. Ansell & Gash, 2007; Ferraro et al., 2015; Provan & Kenis, 2007). Attention to the interaction between shop-floor, managerial and policy layers for network-building may reveal an adequate narrative of how actors 'muddle through' (Lindblom, 1959) towards regionalization in older person care. For instance, it reveals how network actors (re)frame problems across administrative boundaries (e.g., the health insurer enforcing hospitals to be involved). Furthermore, infrastructures required for network-building cannot be assumed or easily changed as they are institutionalized and hence resistant to change; they hinder and stagnate care experiments. In our case, regulatory frameworks are directed at individual organizations and not networks, which hinders collaborative efforts. Policy layeredness also creates opportunities for local actors to participate in network-building, (re)framing problems in such a way that their involvement seems legitimate, even if their role and impact is limited to care-related issues (see for example the role of the Provincial Board).

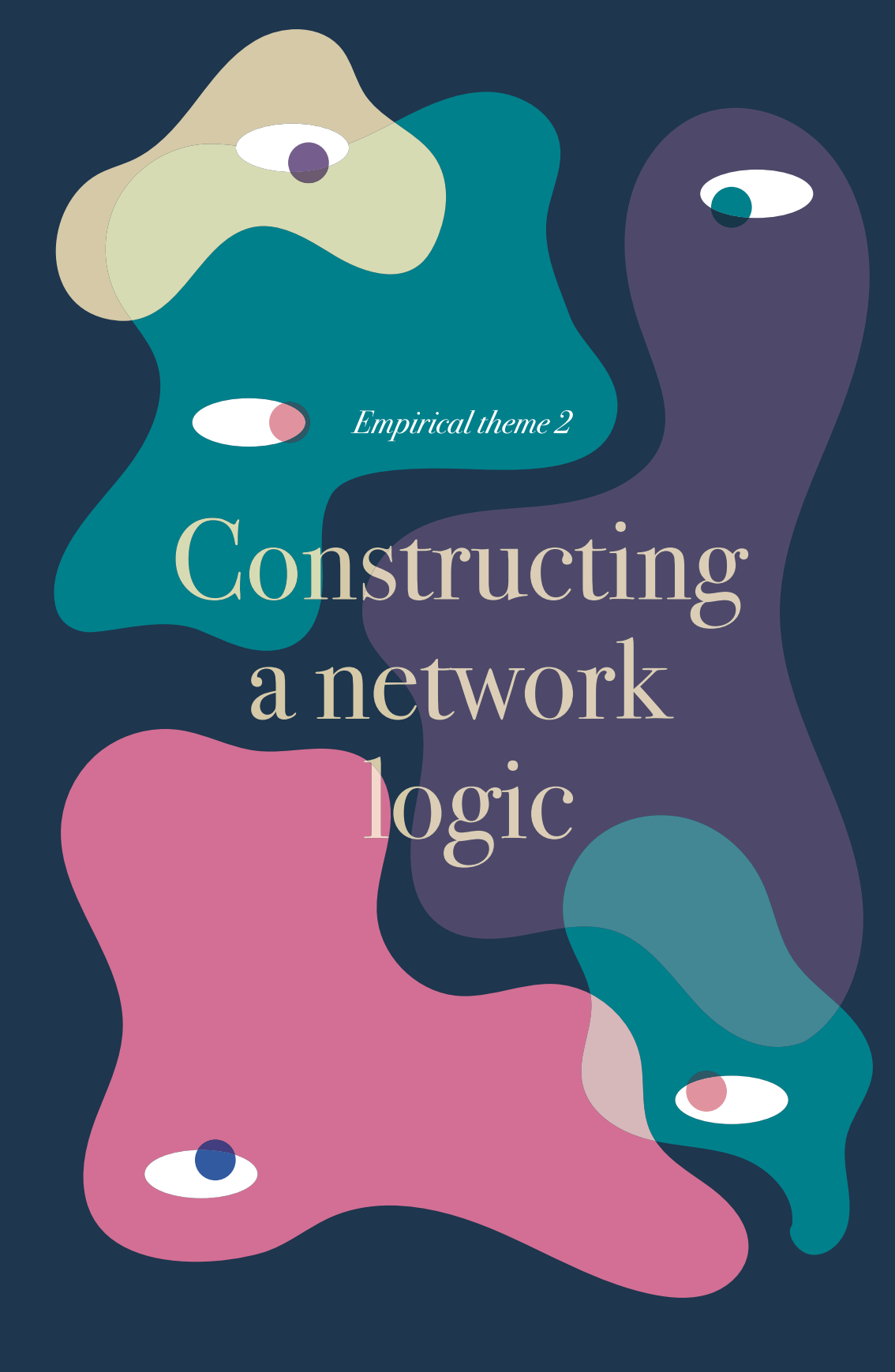
Though the pairing of expertise and resources are necessary for problem-solving (Huxham & Vangen, 2004; Koppenjan & Klijn, 2004), less attention is paid in the literature to the intricacies of mobilizing different policymaking layers of, in our case, a complex institutionalized healthcare system (van de Bovenkamp et al., 2016). Coordination skills and competencies are relevant, but mainly relate to intra- and interorganizational relations (McGuire, 2002). Yet our study has demonstrated that working across organi-

zations can be fostered through (temporal) involvement of external stakeholders, making this an important part of network-building. Future studies of network-building should take this alignment work into account, for instance by analyzing the work of mediating actors who operate at and in-between policymaking layers (Frankowski, 2019).

The emplaced nature of network-building and challenges of policy layeredness illustrate that network-building is no obvious and neat solution to a complex policy issue (cf. Ansell & Gash, 2007; Ferraro et al., 2015; Provan & Kenis, 2007). The Zeeland case shows that it is rather a highly contested and emplaced endeavour that encompasses vested routines, ongoing activities, and organizational, professional, and policy activities that must be (re)negotiated. Although network-building provides a far from perfect solution, it is no futile aspiration. It may uncover possibilities for local actors and regional and national authorities to develop 'regional intelligence' in making social problems—such as healthcare for aging populations—governable (Bannink & Trommel, 2019). This does not mean that social problems are pushed from national to regional levels but it involves place-based interventions that characterize how a network develops and pursues the opportunities to come up with suitable responses to local needs. This may also support the applicability of networks in specific settings. Being aware that complex problems cannot be easily solved (Peters, 2017), and paying attention to place-making and the ongoing efforts of many actors at different policymaking layers, could help develop an emplaced networked response. Although some would argue that the layered policy context is already reflected in networks as actors represent and symbolize a certain layer, we have highlighted that networks are particular and rather dynamic entities with no clear emplaced and policymaking boundaries. Policy layeredness reveals how networks require efforts of many actors that bring in different strategies and *other* networks to create a distinct network entity that must be tied into broader governance structures.

Our findings are possibly difficult to generalize to more urbanized regions, and moreover, to other countries that define, frame, or experience non-urbanity differently in terms of scale, density of populations, and expectations of accessible care (MacLeod & Jones, 2001). Despite a possible lack of case generalisability, this study is however theoretically generalizable as it applies to a wider debate on how network-building could help to process and live with complex issues (Peters, 2017). The addressed place-making and alignment work required for a networked response in healthcare can be applied to and analyzed in other contexts and settings to develop our understanding of emplaced interventions to complex policy issues. We therefore encourage ethnographic accounts that study how networks are made in action (Bevir & Rhodes, 2006) with attention to its placed and layered policymaking nature. Our practice-based approach and 'travelling' (Bal & Mastboom, 2007) between shop-floor, managerial, and policy layers illustrated the messiness of network-building, paying attention to actors' place-based rationales and social locations in a non-urban region. Further network studies then require a methodological approach that includes the many actors involved to draw lessons how to deal with governance challenges (Vandenbussche et al., 2020).

To conclude, our ethnographic approach has revealed place-making and the interactions between local, regional, and national agents for a networked response at the regional level. Network-building is messy and rich, with ongoing struggles. Although our case study shows that we do not yet know whether network-building in a non-urban region will develop into sustainable ways for older person care, it does challenge our thinking as to how to develop more suitable and emplaced interventions for complex policy issues.


Empirical theme 2
Constructing a network logic

5

Mediating policy figures and large-scale healthcare change: The case of regional networks in older person care

Abstract

This article analyzes how different state and non-state actors employ a collaborative policy strategy to foster regional collaboration among healthcare organizations in older person care in the Netherlands. We focus on the role of policy advisors working for healthcare authorities and (national) knowledge platforms, conceptualising them as 'mediating policy figures' between macro-level policymaking and meso- and micro-level organizational and professional activities who promote network formation within a competitive healthcare system. Drawing on ethnographic fieldwork and in-depth interviews, we show how policy advisors act as mediating figures through three repertoires of mediation: knowledge reformulation, administrative reconfiguration, and institutional workarounds. Policy advisors strategically connect actors, alluring them to take risks in developing ambitious initiatives with yet unknown results and seeking to organise support among healthcare authorities, reframing organizational to regional responsibilities whilst constructing 'the region' as a new administrative reality. The research adds to collaborative governance literature by showing the importance of mediating policy figures as they produce and connect both places and administrative levels in accomplishing organizational and policy change.

Key words: collaborative governance; regional networks; mediating figures; policy advisors; older person care

Introduction

Collaboration and the development of stable relationships between state and non-state actors is central to contemporary administrative practice in dealing with complex public problems like air pollution, technological development, and workforce shortages (Bannink & Trommel, 2019; Bartels & Turnbull, 2020). This is illustrated in the upsurge of interactive modes of organising like network governance, collaborative governance, and co-creation in the era of New Public Governance (NPG). These emphasise deliberative interactions among a broad range of stakeholders to shape public policy (Isett et al., 2011; Osborne, 2006; Sørensen & Torfing, 2016). These 'new' modes of governance share an enormous challenge—to "[...] engage people constructively across the boundaries of public agencies, levels of government, and/or the public, private and civic spheres in order to carry out a public purpose that could not be otherwise accomplished" (Emerson et al., 2011, p. 2). A prominent example, central to this paper, is the collaboration between healthcare organizations to make efficient use of available healthcare staff in light of increasing workforce shortages (Kroezen et al., 2018; Leijten et al., 2018).

Collaborative policy strategies seek to break with hierarchical and competitive forms of governance in favor of a more cooperative form (Torfing et al., 2020). Such strategies build on mutual interdependencies and shared responsibilities among stakeholders (Ansell & Gash, 2007) in order to enhance mutual learning and, ultimately, public innovation (Sørensen & Torfing, 2016; Torfing, 2019). To reach policy objectives like accessible healthcare or the reduction of pollution, scholars widely acknowledge that deliberate interactions can be best organised in heterogeneous governance networks (Cristofoli et al., 2017; Klijn & Koppenjan, 2015). These networks consist of formal (institutionalised) and informal linkages between interdependent but operationally autonomous actors that enable collaboration (Klijn, 2002). The formation of networks,

however, is more easily said than done. Policymakers often lack the power, capacities, or regulatory instruments to impose network participation on actors (Hajer, 2003; Rhodes, 2007); shared objectives and mutual trust cannot be assumed (Gray, 1989); problem and solution perceptions among stakeholders differ (Bannink & Trommel, 2019); and participating actors develop strategies that deviate from policy expectations (van Duijn et al., 2021). Hence, mobilising and engaging actors with different perspectives and interests in networks is not spontaneous but requires continuous effort and relational work (Feldman & Khademian, 2007).

Collaborative governance scholars have pointed to the importance of interlinking and coordinating the actions and strategies of system-level actors to the practices and experiences of local actors while shaping and implementing policy (Ansell & Gash, 2007; Sørensen & Torfing, 2016). This process requires intermediation of national authorities in a manner different to mainstream policy processes. It requires, for instance, the utilisation of mediating actors to interact with local actors in realising solutions for policy problems (Ansell & Gash, 2007). The collaborative governance literature, however, is unclear about the precise roles and activities that mediating actors play in collaborative governance (Frankowski, 2019). In this paper, we explore how a collaborative policy strategy is employed among different state and non-state actors to foster regional collaboration among healthcare organizations in older person care in the Netherlands (Schuurmans et al., 2021)—something deemed necessary in light of an aging population and decreasing health workforce (Kroezen et al., 2018; Leijten et al., 2018). We specifically focus on the role of appointed policy advisors and conceptualise them as 'mediating policy figures' to illuminate how they seek to encourage collaboration and foster network formation in a formally competitive healthcare system dominated by the policy paradigm of regulated competition next to professional self-regulation and decentralisation (Jeurissen & Maarse, 2021). Given this complex institutional setting, authorities like the

Ministry of Health (MoH) have limited institutional power over healthcare organizations, and healthcare purchasers (in the Dutch case: private health insurers). Network formation thus requires strategic engagement with existing institutional arrangements. In this paper, we show how policy advisors take up a role as mediating figures and how this impacts network formation. To this end, we ask ourselves the following research questions:

> *How do mediating policy figures interact with regional actors and national authorities to develop collaborative governance in regional older person care? What does this teach us about network formation as a contingent and purposeful policy strategy for institutional transition?*

To answer these questions, we draw on a large-scale action-oriented research program in Dutch older person care in which we conducted ethnographic fieldwork in 10 regions attempting to build regional networks (Schuurmans et al., 2021). We especially draw on (non-)participant observations and 9 interviews with policy advisors acting on both the national and the regional level—next to numerous informal conversations and other interactions—to explore how they interact with nursing home management, professionals, healthcare purchasers, and local politicians—thus giving an analysis 'from within'. We demonstrate how policy advisors move between and mediate across organizational and policy levels for network formation, hereby creating an alternative policy paradigm that enables regional collaboration.

We first elaborate on the need for mediating actors for collaborative governance. We then conceptualise policy advisors as mediating figures between macro-level policymaking and meso- and micro-level organizational and professional activities. After providing a background description of the Dutch healthcare system and introducing our interpretative approach, we elaborate on how mediating policy figures foster network formation in older person care.

Finally, we reflect on what our findings add to the study of (mediating policy figures in) collaborative governance theory.

Collaborative governance and the need for mediating actors

Connecting macro-level and micro-level collaborative efforts is considered an important mechanism for collaborative governance, often referred to as intermediation (Ansell & Gash, 2007; Emerson et al., 2011; Sørensen & Torfing, 2016). Studies about intermediation in collaborative governance focus, for instance, on structures like collaborative platforms (Ansell & Gash, 2018). Such platforms are supposed to help coordinate interactions among multiple actors, and have the resources and expertise to facilitate "[…] the creation, adaptation and success of multiple or ongoing collaborative projects or networks" (Ansell & Gash, 2018, p. 20). For such platforms to function they not only have to be created and cared for, but their functioning also requires connecting links to other platforms and often to national policy levels. The roles of such mediating work and the actors engaged in this work in collaborative governance is as of yet understudied (Frankowski, 2019).

Mediating actors are believed to connect policy levels and interests, but may also temporally withhold or exclude actors to enter collaborative processes (Frankowski, 2019). Conflicting interests and expectations among actors, as well as conflicting institutional logics make the role of mediating actors cumbersome (Nederhand et al., 2019). They have to navigate through conflicting perspectives to policy reforms (van Duijn et al., 2022). Mediating goes beyond neutrally 'passing on' knowledge to catalyse collaborative processes (Ansell & Gash, 2012; Frankowski, 2019). Instead, it also involves translating such knowledge to other situations, as well as back to policy levels. Mediating, in this regard, contrasts with facilitative

ideas about intermediation as it points to a 'process of assembling' (Latour, 2005), meaning the creation and adaptation of knowledge by utilising the relations and interactions among actors.

Attention to the actors engaged in mediating collaborative governance is vastly growing. The emphasis on building relationships is reflected in network management (Agranoff & McGuire, 2001), in which a process management style entails activating actors, and managing interaction (Edelenbos & Klijn, 2009). A commonality among these actors is to work on relationship building. For instance, individuals who act as boundary spanners seek to facilitate collaboration across organizational and sectoral boundaries (van Meerkerk & Edelenbos, 2014; Williams, 2002). They are supposed to build and sustain relationships among actors based on trust and reciprocity (Williams, 2002), and connect processes in networks with processes in their home organization (Blijleven & van Hulst, 2021). Furthermore, public entrepreneurs are supposed to bring actors together from different perspectives through informational and relational work (Feldman & Khademian, 2007). They can play the roles of broker (i.e., disseminating information across participants), translator (i.e., reformulating ways of knowing), and synthesiser (i.e., evaluating information) (Ansell & Torfing, 2022).

Ideas about collaborative leadership—similar to what the network literature calls 'metagovernance' (Sørensen & Torfing, 2016)—consider 'facilitative leaders' important to managing relationships, and promoting constructive dialogues among participants (Ansell & Gash, 2012). Mediation work then involves intervening in collaborative processes to bring them further (Ansell & Gash, 2012). Facilitators are considered legitimate to do so because of their apparent neutrality and independence (Crosby & Bryson, 2010).

Conceptualising mediating policy figures for large-scale healthcare change

In this study, we focus on how policy advisors act as mediating policy figures. Mediating figures operate 'in between worlds' (Star & Griesemer, 1989), at the intersection of policy and practice, and between different administrative levels. They are supposed to deliberately interact with national and local actors for network formation within their environment. The travelling between different administrative levels makes them 'vague' (Bal, 2006), with their rather fluid and mediating role. Mediating policy figures may also see their own role as ambiguous (i.e., multiple meanings). Such fluidity may allow them to take different positions and play with multiple identities whilst engaging with actors, like the joker in card games or the empty domino stone (Hetherington & Lee, 2000). Field parties may attach different meanings to mediating policy figures, providing them with leeway to act and negotiate between different worlds. Yet, this may also lead to actors being suspicious and hesitant in interactions with mediating policy figures.

Mediating policy figures may be entrepreneurial as they engage with the substantive aspects of negotiations with participating actors to change policy rather than only facilitate collaboration (Morse, 2010). This involves the creation of opportunities for actors (or themselves) to change policy from the bottom-up, for instance by negotiating new institutional rules (Hajer, 2003). Given their seemingly 'free' role and position in-between healthcare policy and practice, mediating policy figures are seemingly ideally positioned for involvement in processes that transgress the creation of new institutions or transform existing ones. Actors may use the expertise of mediating figures to make sense of various laws and accountability structures. Mediating figures may develop insights from certain fields and strategically utilise these to facilitate collaboration when interacting with healthcare authorities. Mediators

navigate through institutional plurality (Mair et al., 2015) as logics of the market, government, and civil society—as well as sector specific logics of regulation and service delivery—compete with and potentially complicate network formation. Alongside mediation, this requires mediating policy figures to make these multiple logics work in their own setting (Torfing et al., 2020).

Our study contributes to literatures on collaborative governance by providing insights in how policies that rely on regional networks are being mediated and take shape in the dynamics of everyday policymaking. We move beyond research into the conditions under which we can expect collaborative governance to work (Ansell & Gash, 2007). Instead, following an interpretative actor-oriented perspective (Bevir & Waring, 2020), we analyze what policy advisors as mediating figures actually *do* when interacting with regional actors and healthcare authorities, what their mediating role entails, and with what consequences for network formation. In healthcare, Frankowski (2019) observes, studies on collaborative governance tend to focus on collaborative processes at the micro-level, for instance regarding interorganizational change (Oldenhof, Stoopendaal, et al., 2016). Our study highlights the policy actions between macro-level policymaking and meso- and micro-level organizational and professional activities. This offers new insights for collaborative governance that increasingly play out within and between different administrative levels as places of policy strategy and institutional change. We next elaborate on our study background and methodology.

Methods

Study background: Regional networks in Dutch older person care

Governance networks are traditionally an important means for state actors to manage healthcare (among other domains) (Klijn,

2002). In the Dutch healthcare system, through various reforms of marketisation and decentralisation, these state-led networks became increasingly pluriform. Nowadays, the pluralist healthcare system entails many stakeholders (e.g., central and local government agencies, (not-)for-profit healthcare providers, insurers, professional and patient associations) with diverging interests and power relations (van de Bovenkamp et al., 2016; van der Woerd, Janssens, et al., 2023). Policy development and regulation are based on several foundations like self-steering, solidarity, and the privatisation of care provision through insurance schemes, leading to a distinction between policy and practice (i.e., care providers and health insurers) (Van der Grinten, 2007). Care providers are supervised by the Healthcare Authority to compete on quality and price, and by the Healthcare Inspectorate to comply with national quality standards and regulations that are set by the professional associations.

Over the last decade, several changes have been made in older person care delivery: the Long-term Care Act (*Wet Langdurige Zorg*) was introduced in 2015 (Maarse & Jeurissen, 2016). This reform rendered institutionalised care (i.e., care provided in nursing homes) only available to those with severe care needs, encouraging older persons to live at home as long as possible. Importantly, the Long-term Care Act shifted the responsibility for the provision of care from the national level to health insurers and Regional Care Offices (RCOs). RCOs are linked to the largest health insurer in a particular administrative region (of which there are 31), functioning as a leading actor in executing the Long-term Care Act.

Parallel to this administrative transition, quality issues in older person care delivery have been widely reported in the media in the past decade, causing heated public and political debates about decent care for older persons. Quality improvement in nursing homes has become a dominant policy focus, for example through change-oriented policy programs and establishing knowledge platforms to

support collective learning (Oldenhof et al., 2022). These initiatives are now accompanied with the challenge of increasing workforce shortages that play out in the aftermath of the COVID-19 crisis and an ageing population.

The Ministry of Health (MoH) posits in many policy documents that regional collaboration is most promising to deal with contemporary policy challenges. Regionalization of older person care aims to intensify regional-level collaboration among healthcare organizations (mostly nursing homes) to maintain quality of care for a growing group of citizens (Schuurmans et al., 2021; van der Woerd, Janssens, et al., 2023). This is especially problematic for non-urban regions in which workforce shortages require an immediate response as the region's liveability is under pressure (van de Bovenkamp et al., 2022). The MoH allocated budgets to RCOs to develop regional networks. Historically, regulatory frameworks in older person care are organization-centered instead of region-focused, making it less obvious for nursing homes to act at a regional level and be held accountable for doing so. It also leaves public regulators with few means to force organizations to network. Instead, funding for regional initiatives and research projects have been offered to encourage regional actors to invent and develop 'bottom-up' network actions to tackle quality problems and workforce shortages. In this paper, we draw on one such initiative in which 10 regions participated in action-research to develop regional older person care. We will tease out this initiative in more detail in the next section.

The 'RegioZ' project

This study is part of a larger action-oriented research project ('RegioZ') in the Netherlands (2018—2022) in which healthcare providers located in 10 non-urban regions sought to invent regional forms of older person care (so-called 'care experiments') in order to deal with workforce shortages (Schuurmans et al., 2021). Care experiments are often practice-based and include (among others)

triage models to develop regional routines of providing care to facilitate workforce exchange; the reallocation of tasks among (specialized) physicians and nurses; and inter-organizational collaboration during out-of-office hours (van Pijkeren et al., 2021). Central to the research project was the role of the knowledge platform (KP) in older person care that executed the policy program 'Dignity and pride in the region' (*'Waardigheid en trots in de regio'*). Although the care experiments focused on collaborating healthcare organizations (mostly nursing homes) and developing 'smart' collaborative arrangements to enhance care capacity in the region, national authorities like the MoH and the Healthcare Inspectorate also participated to learn from the initiatives for their regulatory policies.

We as researchers 'worked with' organizational and policy actors to learn from their experiences and strategies, acting at and moving between healthcare practice, management, and policymaking (Bal & Mastboom, 2007). We conducted interviews with nursing home management and professionals, as well as healthcare authorities, to develop an understanding of regional problems and the institutional healthcare context. Ethnographic observations were conducted for several months during care experiments, project meetings focused on developing and monitoring initiatives, and twice-yearly national gatherings in which regional actors shared their experiences during workshops to enhance collective learning. Through our frequent engagement with the studied regions, we could develop an understanding of how localities such as geographical or cultural-religious dynamics interacted with the development of care experiments. In the total project, over 1,000 hours of (non-)participant observation, 295 interviews, and 200 hours of project participation (i.e., giving presentations, workshops, feedback sessions) were conducted by a team of eight researchers.

Data collection

For this paper, we focus on the mediating role of policy figures

appointed by healthcare authorities like the MoH, RCO, and the KP to foster network formation among healthcare organizations at a regional level. Our data consists of formal and informal conversations with and observations of policy advisors during regional project meetings, as well as national gatherings in which healthcare authorities participate to learn about policy concerns for regional networks. Conducting (non-)participant observations allowed us to "investigate, experience and represent the social life and social processes […]" of policy advisors' doing their mediating work (Emerson et al., 1995, p. 352). Our observations uncover what happens at the scene (Ybema et al., 2009) of the network formation processes. Though not the case for all studied regions, in some regions (Region A), we followed policy advisors up close as they were part of the development of care experiments. We used frequent research team meetings to refine data, for instance about how wider institutional healthcare structures relate to policy advisors' mediating work. Fieldnotes contain observations and verbatim excerpts of how policy advisors interacted with regional actors and healthcare authorities. Our fieldnotes convey a sense of 'being there' in order to capture the subtle dimensions of policy advisors' doing their mediating work (Emerson et al., 1995). These narratives were rewritten into polished observational reports in which we added our interpretations.

To complement the observations, we conducted interviews with policy advisors (n=9) to develop a fine-grained view of their mediating role. These interviews took place between May and October 2021, both in person and digitally because of Covid measures, generally lasted 60-90 minutes. We selected policy advisors appointed by the authorities mentioned above (i.e., MoH, RCO, KP), and who were involved in network formation in older person care in the regions we studied. This selection covers policy advisors spread over 10 regions in order to grasp a variety of experiences. We asked them to reflect on their role; how they manage expectations from the organization they work for, and that of field parties;

and which strategies they employ to foster network formation, and with what successes and pitfalls. *Table 7* provides an overview of their background and the purpose of their engagement with regions. Although their job titles differ, we refer to them as policy advisors. All respondents were asked for and provided consent. The interviews were recorded and shortly afterwards transcribed verbatim. We have translated the interviews and observation excerpts originally reported in Dutch to English.

Table 7. Mediating policy figures' background

Number	Organization	Job title	Education	General aim
1	Ministry of Health	Policy advisor	Human resource management	Sustainable older person care at regional levels
2	Ministry of Health	Policy advisor	Management	
3	Ministry of Health	Policy advisor	Geography	
4	Knowledge Platform	Policy coach	Healthcare management	Knowledge sharing (i.e., care experiments) for collective learning
5	Knowledge Platform	Policy coach	Management	
6	Knowledge Platform	Policy coach	Economics	
7	Knowledge Platform	Policy coach	Management	
8	Regional Care Office	Policy manager	Economics	24-hour accessibility and financing of regional older person care
9	Regional Care Office	Policy manager	Management	

Data analysis

Following an abductive and interpretative logic of inquiry and analysis (Timmermans & Tavory, 2012; Yanow, 2015b), we iteratively moved back and forth between our data and collaborative governance theory to analyze policy advisors' mediating work. Informed by this theory—which speaks rather generically about intermediation but also calls for research into how it actually works (Gash et al., 2022)—we focused on how policy advisors made sense of a policy strategy that relies on regional networks within a *specific* complex healthcare system and how they actually mediate. We iteratively analyzed the data using Atlas.ti software. First, to make sense of the large amount of field-notes and interview transcripts, we searched for surprising findings like events in which policy advisors participated (Yanow, 2015b). We attuned our analysis to an actor level instead of the regional network as a governance entity.

We conceptualised policy advisors as mediating figures for collaborative governance and became sensible to their relations and interactions with regional actors and healthcare authorities. What does their mediating role entail, and how is this perceived by regional actors and healthcare authorities? During the second round of analysis, we used mediating work as a sensitising concept to analyze the activities of mediating policy figures in network formation (Bowen, 2006). We then moved back to collaborative governance theory to deepen the different mediating aspects, generating three repertoires of mediation—that is, in our case, a way of how mediation is put into practice—that structured our findings: knowledge reformulation, administrative reconfiguration, and institutional workarounds. The combination of observations and interviews led to rich narratives about policy advisors' mediation, bolstering an iterative process of triangulation to validate findings.

Results

Based on our analysis, we first elaborate on the ambiguous role and position of mediating policy figures vis-à-vis regional actors and healthcare authorities in a complex and decentered healthcare system with no decisive central authority (Jeurissen & Maarse, 2021). Then, we demonstrate how ambiguity is made productive by mediating policy figures.

The ambiguous role and position of mediating policy figures

In the Netherlands, the central government lacks the legitimacy and regulatory instruments to intervene directly in the quality and accessibility of care because power and responsibilities are scattered across organizational, regional, and national authorities. Soft forms of steering are required to stimulate organizational actors to collaborate on a regional level in which the central government cannot rely on command and control modes of interactions (Ewert et al., 2023). Mediating policy figures play an important yet rather informal role in reforming older person care. They encourage and facilitate healthcare organizations to shape regional networks within a healthcare system of regulated competition. In doing so, they recurrently address and become familiar with regional problems and with the actors whom they seek to make responsible for initiating policy reform. Yet, the role of mediating policy figures is ambiguous. Shifting regional actors' strategies from an organizational logic towards a regional one contradicts the broader institutional order, which promotes competition and (individual) organizational performance. Although policy advisors aim for regional change, they lack the formal power to govern such institutional transitions, despite having informal influence:

> *"I don't have any formal role, financial resources, or contractual relationship [with nursing homes], no power to push things through. I'm here to tell regions that they should work differently. I organise power by myself, be-*

cause people think: 'If you say so…' I'm nobody, and nursing homes can easily send me away. Yet, they give me the opportunity to say what should be done [for network formation]."
(KP policy advisor 4, interview)

KP policy advisors have no formal mandate to act upon. In contrast, similar to health insurers, RCO policy advisors do have formal power as they directly negotiate with healthcare organizations about care procurement (Maarse & Jeurissen, 2016). However, within the Long-term Care Act, there is little leverage to stimulate regional collaboration as this goes against competition law. Although working for the MoH comes with a certain level of authority which may deliberately be used (as we show in more detail below), MoH policy advisors have limited power as they struggle to blend in the organization because they are a less exposed and defined type of professional:

I: "Suddenly, the MoH had nine colleagues [recently appointed civil servants] walking around in regions, who shared input among policymakers different to what they were used to working with. We shared experiences that policy in practice doesn't develop as intended.
R: How did they [MoH] process that information?
I: It was considered valuable, but that does not mean that you have a structure to process it. Nobody really knew within the MoH what we were doing. We realised that we had to make ourselves known."
(MoH policy advisor 2, interview)

Moreover, as mentioned, the MoH has no formal authority over healthcare organizations. Moreover, their involvement in regional care overlaps with the institutional tasks of health insurers and RCOs, making their position ambiguous.

Mediating policy advisors aim to push regional actors into action for network formation, confronting them when progress needs to be made. For instance, a KP policy advisor worked with the RCO in Region B to pressure nursing home directors to participate. Becoming familiar with the region's cultural-religious dynamics and (lack of) support among directors, the KP policy advisor and RCO stepped in. They created urgency by presenting (expected) organizational consequences of workforce shortages during board meetings (KP policy advisor) and contractual negotiations (RCO). Another example involves Region A—a region where maintaining accessibility of older person care during out-of-office hours is a pressing problem as nursing homes heavily rely on a scarce number of specialized physicians who face long commutes. While many gatherings among regional actors did not lead to a coordinated response, the MoH policy advisor intervened with a plan to overcome inertia:

> *During a project meeting in [Region A], [the MoH policy advisor] proposes a 'regional schedule' for physicians' emergency visits during out-of-office hours, advocating for a coordinating role for nurses to decrease physicians' working pressure.*
> *[MoH policy advisor]: "We should prevent more talking without action. […] Commitment from nursing home directors is required as they can pressure physicians to participate. We need to present the plan during other regional gatherings to speed up the process."*
> *(Fieldnotes project meetings Region A, 2021)*

In this example, the MoH policy advisor struggled to contribute to network actions as project leaders found it difficult to decide which care experiment to start with, covering which area. This was complicated because most nursing homes participated in another regional initiative initiated by the RCO not linked to the program the MoH policy advisor was part of. While the RCO steered in

other directions for network formation, the MoH policy advisor urged participating actors to start with the care experiment in a sub-part of Region A as the budget deadline was nearing, and actions had to be organised urgently. Despite the MoH policy advisor's lack of formal authority, the directors felt they could not ignore their advice easily.

Next to regional activities, the KP policy advisors organised recurrent national gatherings in which regional actors were given the opportunity to present the situated problems they encountered and how they sought to tackle these through regional initiatives. During one of those meetings, a 'system analysis' was carried out in which project leaders expressed their obstacles for network formation within the current healthcare system. Their experiences were clustered in themes like laws and regulations and geographical barriers (see *Figure 4*).

Figure 4. The 'system analysis' initiated by KP policy advisors

The system analysis made project leaders aware of the ways that change was most likely to succeed, for example through coalition-

building to negotiate collaborative training opportunities for specialized physicians with educational institutions. In this way, non-urban regions without universities could attract and maintain physicians—usually a persistent challenge for such areas. The KP policy advisors offered solutions and possible 'ways out', in this case by conferring with regional actors on how to deal with organizations responsible for medical training and thus attract physicians.

These examples demonstrate how mediating policy figures dwell in-between regional actors and healthcare authorities to establish organizational and policy change without a clear script of their roles and legal tasks—nor without any guarantee of success. In the following, we present the three 'repertoires' of mediation our analysis unveiled.

Different repertoires of mediation for network formation

This section describes three repertoires of mediation that each reveal a partial yet interrelated account of how mediating policy figures probe, explore, and strategize towards network formation: *knowledge reformulation* (i.e., generating knowledge of how to network, and translating such knowledge into network actions); *administrative reconfiguration* (i.e., constructing the place for initiating network actions, and with whom to act); and *institutional workarounds* (i.e., finding and creatively using institutional angles to enforce network actions). For each repertoire we unravel how mediating policy figures assert power and influence in the process of network formation, and with what challenges.

Knowledge reformulation

Mediating policy figures played a key role in connecting the different actors and suggesting network actions based on their growing

knowledge of a changing healthcare system with various laws and regulations, financial schemes, and regulating authorities, sketching a new organizational image of regional care. In this repertoire, they generate knowledge of how to network during policy change, and translate such knowledge into specific situations where regional actors explore network actions in response to pressing workforce issues. Moving between and interacting with regional actors and healthcare authorities allows mediating policy figures to acquire knowledge about healthcare practice *and* policy that other actors do not possess or have easy access to. For this, mediating policy figures rely on the KP who oversees ongoing regional initiatives. Central to their role as knowledge brokers is labelling 'good examples' of network actions, and transferring these across regions:

> *I: "How did the MoH policy advisors' team start?*
>
> *R: We had the Working in Healthcare committee [Commissie Werken in de Zorg, a think tank and national program for workforce problems], and the program was evaluated. The sub-program 'Working differently' [Actielijn Anders Werken] went too slow. We needed an army that collects good examples, making connections in and between regions to scale up those examples.*
>
> *I: What can and can't the regional team offer the region?*
>
> *R: Connecting regional actors with The Hague [i.e., national government] and strategic advice, but no project management. The employer organizations can do that themselves."*
>
> *(MoH policy advisor 2, interview)*

An illustrative example of knowledge reformulation was observed in Region A. Here, the MoH policy advisor succeeded in getting regional actors involved in a self-proposed care experiment. The

MoH policy advisor deemed a care experiment in Region C—involving task reallocation among nurses and physicians working for various nursing homes during out-of-office hours—a good example of network actions. Feeling the pressure to come up with regional solutions, the policy advisor pointed out during project meetings the possibilities of carrying out a similar initiative in Region A. Here, the policy advisor used the (still paper-based) care experiment to steer regional actors into this *particular* type of network action, supporting a 'can-do' mentality because the experiment seemingly worked in another setting, though not yet actually a reality. Regional actors began exploring this, inviting representatives from Region C to present their experiences in Region A. The MoH policy advisor acted rather opportunistically as knowledge broker, here brokering premature ideas. Regional actors followed the ideas from this 'external' authority to acquire legitimacy for desired network actions.

While mediating policy figures stimulate regional actors to start exploring network actions, they must navigate overlapping policy programs and regional initiatives, each with a particular approach to responding to workforce shortages (i.e., e-health, ageing in place, integrated care). They experience overlap as cumbersome, and in response attempt to align such initiatives, as well as the efforts of *other* mediating policy figures:

> *I: "How do you deal with the many policy programs?*
> *R: I am like a skewer, without knowing everything in detail. I start from a regional initiative and connect this with another policy program. Take the 'Home in the Nursing Home' policy program, do you know that?*
> *I: Yes.*
> *R: That is also happening in the region! This focuses on nursing homes, but the employer organization in [Region A] is barely involved. The MoH should*

> *make that connection. It's okay that it exists parallel, but both need to know what's going on in the region, and whether it can be tied together."*
> *(MoH policy advisor 2, interview)*

In this quote, the MoH policy advisor points at the policy program 'Home in the Nursing Home' (*'Thuis in het Verpleeghuis'*) that seeks to improve the overall quality of older person care through collective learning among nursing homes. Participating actors are different from other related initiatives like 'RegionPlus' (*'Regio-Plus'*) in which employer organizations seek regional collaboration to tackle workforce shortages. Connecting the network actions initiated by the actors involved is considered important by the MoH policy advisor as, in this example, employer organizations can exert pressure on nursing homes to network for which the other program is less far-reaching. Mediating policy figures thus do not necessarily operate within or as part of *a* network, but relate to *multiple* initiatives that require alignment to create a basis to work from (van der Woerd, Janssens, et al., 2023).

Besides disseminating knowledge across regions, mediating policy figures strategically translate knowledge into network actions, empowering regional actors to explore regional care. This is difficult as mediating policy figures occupy an ambiguous position outside of the network—as this sub-section has shown—and must thus navigate co-existing initiatives.

Administrative reconfiguration

The region is not a given place of healthcare provision in the Netherlands; it must be actively constructed among a wide variety of actors not yet familiar with a region-based and collaborative arrangement of older person care (Schuurmans et al., 2021). Mediating policy figures play an important role in this second repertoire. They demarcate the boundaries of the region as they are confronted with conflicting perceptions of what *a* region is. RCO

regions are considered the place to network from a national policy perspective, but this may conflict with what regional actors experience as 'the region'. Regions are not fixed entities, but constructed spatial perceptions influenced by history and culture (Schuurmans et al., 2021). Mediating policy figures' engagement 'from outside' the region help craft the place of networking, as regional actors may not have the authority or feel the responsibility to do so:

> *"Almost all GPs in [Region D] created a regional plan for that specific area. This overlaps with the labour market regions where the employer organizations are leading, and with RCO regions. Then the hospital says: 'Let's organise care in the hospital area. That is partly a GP, RCO, and labour market region. We then discussed: 'What exactly is a region?' There are many different regions in a region. […] We identified the nodes where different networks and initiatives come together, and worked from there."*
> *(KP policy advisor 7, interview)*

This example shows how regional boundaries become part of mediating policy figures' discourse. They reconfigure the region as an administrative reality to realise policy ambitions (Fraser, 2010), and seek to connect this with the actions of actors operating at other administrative levels, like nursing homes and national authorities. For instance, the RCO policy advisor in Region A collaborated with the provincial government to form a coalition of healthcare organizations to overcome hesitance towards network actions. In the Netherlands, provincial governments do not usually deal with regional care provision, having limited institutional power. However, they were considered important for creating urgency among regional actors and authorities to network as the region faced challenges around liveability such as difficult-to-access care during out-of-office hours. The provincial government reached out to the MoH for support, which was followed by visits from the Minister to become more familiar with the challenges. As a result,

an MoH policy advisor was appointed to support Region A in network formation. This illustrates how actors acting at different administrative levels of the healthcare system are drawn into regions to contribute to network formation.

Mediating policy figures seek to recurrently challenge and organise support among authorities like RCOs, the MoH, the Healthcare Inspectorate, and professional organizations to develop the region as a new administrative layer. This goes beyond providing healthcare authorities with 'hands-on' information, whether or not upon request, about field-level barriers or promising examples of network actions. Instead, moving in-between administrative levels also involves deliberate actions to confront conservative policy actors:

> *During a national gathering with project leaders and KP policy advisors, attendees discuss how to break with conservative ideas about regional collaboration.*
> *[Nursing home director]: "Change for task reallocation among nurses and physicians is opposed by [the professional organization of specialized physicians]. Shouldn't we as directors take a position on this? Attendees nod in agreement. […]*
> *[KP policy advisor 5]: Find and explore the spaces for regional collaboration! Promising developments [for regional collaboration] emerge where institutional frameworks collide. Here lies an important task for the RCO to facilitate such developments."*
> *(Fieldnotes national project gathering, 2021)*

In this example, KP policy advisors point the RCO to their legal responsibility for 24-hour accessibility and financing of older person care, urging them to support task reallocation initiatives among nurses and physicians to maintain regional care provision. They often encounter opposition of professional associations for nurse-physician

collaborations, and as a result, current physician-led working routines are maintained. Mediating policy figures are not led away from such resistance. They seek to find policy support and mobilise authorities, in this case the RCO, to circumvent conservative actors and proceed with the administrative construction of the region.

Mediating policy figures' ambiguous position facilitates the creation of the region as a new administrative layer in a changing healthcare system. They use different administrative levels of the healthcare system to address regional problems, constructing the place where regional actors and healthcare authorities should initiate network actions, and with whom. Mediation in this sense helps to form 'the region' as a reality for healthcare actors.

Institutional workarounds

Mediating policy figures find and creatively use institutional angles (whether cultural, regulative, or historical) to enforce network actions among regional actors, shaping regional responsibilities that are not yet institutionalised. Region A exemplifies this repertoire in action. Here, RCO policy advisors worked with various institutional frameworks, including those outside older person care like hospital and primary care regulations, to enforce network actions among healthcare organizations:

> *During a project meeting, the RCO policy advisor states that the RCO is changing their procurement strategy focusing on price and quality to regional collaboration.*
> *[RCO policy advisor 8]: "During procurement negotiations with healthcare providers, regional collaboration now becomes the leading principle, especially with hospitals that fall under the Health Insurance Act [Zorgverzekeringswet]. This offers a better context to stimulate regional collaboration." […]*
> *[RCO policy advisor 8] negotiates with hospitals in [Region A] that want multi-year agreements for organizational stability. The RCO aims for regional collaboration with nurs-*

ing homes to maintain regional care provision. This is presented as a condition for hospitals.
(Fieldnotes project meeting Region A, 2020)

This example shows an institutional workaround to maintain regional care provision as within the Long-term Care Act the RCO has little means to steer other healthcare organizations besides nursing homes. The Health Insurance Act gives more leeway but is not focused on nursing homes; by forcing hospitals to collaborate with nursing homes, however, collaboration between nursing homes can still be stimulated.

Although RCO policy advisors carve out new pathways, organization-centered regulatory frameworks prompt nursing homes to focus on how network formation will affect their organizational performance and possible regulatory consequences. In Region A, large-scale nursing homes who possess clinical capacity are wary of developing far-reaching regional initiatives for sharing specialized physicians as this may lead to lower quality care, which such organizations are legally accountable for (van de Bovenkamp et al., 2020). Several nursing home managers and professionals point to a healthcare system that hinders network actions. Mediating policy figures seek to find the 'loose ends' in the healthcare system to evoke change as network actions do not neatly correspond with organizational and professional guidelines:

R: "The power to change [older person care] is regional, with the healthcare organizations.
I: How do you organise power to foster regional collaboration?
R: We must be disobedient. I don't let myself be led astray by what there currently is but focus on what is desirable. I advise regions to disobey and explore [regional collaboration], knowing we might go out-

> *side the box. This will lead to content-based action rather than action based on current guidelines and protocols."*
> *(KP policy advisor 5, interview)*

In their role as stewards, mediating policy figures empower and allure nursing homes to navigate institutional barriers, and to take risks in developing ambitious initiatives for network actions with yet unknown results. They legitimate the efforts of regional actors who network, which they might not otherwise be comfortable doing without institutional support. For instance, KP policy advisors negotiate with the Healthcare Authority to clarify how network actions relate to competition law, and how regulations can be stretched to facilitate network formation. In doing this, they also redefine the responsibilities of nursing homes; not only are they responsible for their own clients, but for the whole population they serve.

While mediating policy figures attempt to shape regional responsibilities, they must navigate historically established inter-organizational patterns and traditions that do not fit with current regional problems. They must develop an 'emplaced' understanding of the region and its problems—that is, how historically inter-organizational efforts have come about (or not), and with what tensions:

> *"[Region B] is a difficult region; there are strict Protestant-Christian, but also Catholic nursing homes. I found out that people nodded 'yes,' but thought 'no.' Then I asked: 'Why are you doing that?' I discovered that five years ago there was a clash between nursing home directors that was never made public. There was still unease about RCO procurement policies. I discussed this individually, also with the RCO. I started again and said: 'Forget everything we did so far. I made the wrong choice because I went too fast. I have*

also noticed that you have not been honest with me.'"
(KP policy advisor 4, interview)

This quote illustrates that intervening in relational patterns is necessary to address regional problems, building relationships based on trust between nursing homes (and with authorities) to shape regional responsibilities. Mediating relies on frequent contact with regional actors as it reveals poor relations. Mediating policy figures search for informal relational ways to enforce network actions as formal policy programs provide a limited institutional basis to work from.

Mediating policy figures use the region as a mechanism to call upon nursing homes and authorities to account for their authority and responsibilities to maintain regional care provision. They come up with institutional workarounds to create new institutional spaces for network formation, and empower regional actors and authorities to make use of these opportunities for organizational and policy change. Hence, mediating policy figures not only seek bottom-up policy change outside the realm of traditional authorities and institutional frameworks but also reframe organizational responsibilities.

Discussion and conclusion

Collaborative policy strategies in response to public problems like healthcare workforce shortages increasingly rely on (regional) networks that must be mediated across organizational and policy levels (Ansell & Gash, 2007; Sørensen & Torfing, 2016). Yet, how mediation is taking shape, and what a mediating role entails to foster network formation remains relatively abstract (Frankowski, 2019; Gash et al., 2022). In this study, following an ethnographic approach, we analyzed how policy advisors mediate a policy strat-

egy that relies on regional networks to cope with workforce shortages in Dutch older person care. We illuminated knowledge reformulation (i.e., generating knowledge of how to network, and translate such knowledge into network actions), administrative reconfiguration (i.e., constructing the place where to initiate network actions, and with whom), and institutional work arounds (i.e., finding and creatively using institutional angles to enforce network actions) as 'repertoires' of mediation. In this final section, we reflect on how our findings inform the understanding of mediating policy figures for collaborative governance.

Policy advisors have an ambiguous position vis-à-vis regional actors and healthcare authorities as they support collaboration which goes against the dominant policy paradigm of regulated competition (Jeurissen & Maarse, 2021). We have shown how policy advisors can act as mediating policy figures in strategically connecting actors, alluring them to take risks in developing ambitious initiatives with yet unknown results and seeking to organise support among healthcare authorities, reframing organizational to regional responsibilities and constructing 'the region' as a new administrative reality. Policy advisors have no clear position, no jurisdiction of their own, no clear task description, and are not bound to specific rules (not even by the organization that established them). Paradoxically, it is exactly their lack of formal position that puts them in the ideal position to intervene in network formation. This legitimises their actions. In network formation, mediating policy figures venture where other actors cannot, given their specific (legally bound) role in the healthcare system.

Our findings offer empirical insights for collaborative governance that increasingly play out at and in-between different administrative levels as places of policy strategy and institutional change (Jones et al., 2019). Mediating policy figures as a new type of policy actor that operate between macro-level policymaking and meso- and micro-level organizational and professional activities help

shape collaborative governance *while* mediating. Thus, in our case, doing what others cannot do given their position in the healthcare system and legal task. For instance, mediating policy figures reshape administrative practice. Their work thus contrasts with boundary spanners who facilitate collaboration across organizations or public domains (van Meerkerk & Edelenbos, 2014; Williams, 2002). Instead, mediating policy figures (re)shape domains—healthcare in this case—by constructing a new administrative layer that articulates a new organising principle (the region), which is not yet institutionalised within a competitive healthcare system. Rather than just neutrally passing on information (Crosby & Bryson, 2010), they actively construct knowledge, responsibilities, and administrative realities.

Mediating policy figures' apparent independent position, rather than historical link to healthcare organizations, helps them to be considered a legitimate network partner by regional actors. Their position furthermore allows for emplaced interventions in network formation. This was observed in Region A, in which policy advisors intervened to clarify the place of networking as a form of 'scalecraft' (Fraser, 2010), steering regional actors into network actions related to out-of-office care. However, mediating policy advisors' embeddedness in accountability structures (in healthcare) is limited as they operate within an 'unsettled space' where no clear rules and accountabilities yet exist or fit their mediating work, shaping regional networks (Hajer, 2003). They furthermore contribute to the 'blurring' of institutional boundaries (see how MoH policy advisors overlapped with the institutional tasks of health insurers and RCOs). Holding them accountable is rather difficult. Regulating mediating policy figures may reduce their institutional impact as their unregulated role enables them to adopt an entrepreneurial approach. How to process such a practice of ambiguity for collaborative governance should be an important issue for policymakers and practitioners. Although this results in unclarity about healthcare authorities' institutional roles, on the

one hand, it may reveal needs for policymaking to enable network formation. On the other hand, it is important to avoid negative consequences such as the exclusion of certain actors or perspectives.

These insights inform collaborative governance scholarship that network formation is a purposeful yet contingent policy strategy that enables mediating policy advisors to enter the field, and to probe, explore, and strategize how to bring about organizational *and* policy change. Mediating policy figures recurrently go back and forth between administrative levels to bring about organizational and policy change, which highlights their iterative yet strategic directions. This goes beyond facilitating *in* networks (Agranoff & McGuire, 2001). Instead, they operate in various places (i.e., generating and translating knowledge from one place to another), networks (i.e., tying organizational initiatives with formal policy programs), and different administrative levels (i.e., connecting field-level actors with national authorities). This informs the capabilities of mediating policy figures for collaborative governance (e.g., Ansell & Gash, 2012; O'Leary et al., 2012). They should develop the relational capacity to engage with day-to-day issues in network formation, while also strategically mobilising relevant authorities towards institutional change (Feldman & Khademian, 2007).

A limitation of our study entails that the repertoires of mediation we found might be particular to the settings we studied. Future research should explore if and how these repertoires are reflected in other contexts. Future research could also focus on the legitimisation strategies used by mediating policy figures, which seems particularly important given their ambiguous institutional position. We conclude that mediating policy figures are important for collaborative governance as they produce and connect both places and administrative levels in accomplishing organizational and policy change. Understanding how mediating policy figures operate 'in

the shadows' of policy reforms may help make sense of the iterative process of organizational and policy change that increasingly relies on (regional) networks.

6

Heading for health policy reform: The caring region as a governance object in-the-making

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Abstract

This article analyzes how interrelated and interacting regional actors and national authorities shape and transform 'the region' as an administrative unit and an object of governance for organising and delivering older person care. Drawing on an extensive ethnographic research project in the Netherlands, our findings show that actors in interaction constitute the region through three practices: creating recurrent urgency to foreground regional problems and solutions; renegotiating regulatory policies to facilitate regional care provision; and rearranging and building care infrastructures to materialize regional care provision. Actors use and obtain power from co-existing and interacting institutional arrangements to develop new regional care arrangements. This evokes new interdependencies that reconfigure existing organizational and administrative governing arrangements. Studying governance objects *in-the-making* reveals the required iterations, reconsiderations, and adjustments as processes within a given (ambiguous) institutional context, and which lead to institutional change.

Key words: governance objects; regionalization; decentered approach; older person care; collaborative governance

Introduction

Contemporary 'wicked' challenges like poverty and changing demographics challenge the sustainability of welfare state regimes (Peters et al., 2022; Sabel et al., 2023) including healthcare. Demographic changes like an increasing older person population with complex care needs (Leijten et al., 2018), unfolding crises like the COVID-19 pandemic (Ewert et al., 2023), and health workforce shortages (Kroezen et al., 2018), threaten the accessibility and quality of healthcare services. This is especially true in non-urban areas with a burgeoning population of fragile older persons and severe labour market shortages, especially among higher educated professionals like specialized nurses and physicians (van de Bovenkamp et al., 2022).

In an attempt to deal with these issues, policymakers seek solutions to organise care closer to citizens' homes, in close cooperation between health and social care providers and informal caregivers. They present 'the region' as a promising place to organise and provide a more networked model of care (Hammond et al., 2017; Lorne et al., 2019). For instance, the recent establishment of Integrated Care Boards (ICBs) in the UK, covering local government areas, is seen as a governance vehicle to establish and facilitate regional collaboration among health and social care providers (Gongora-Salazar et al., 2022). Long-term care policies in Scandinavian countries like Denmark strongly focus on regions as the administrative place to coordinate care for regional populations (Poškutė & Greve, 2017). Regional collaboration or 'regionalization' promises efficiency gains and adjustment of services to local needs and cultural habits (van de Bovenkamp et al., 2022).

In the Netherlands, where the case we present is set, the region as a place of care does not (yet) exist as an administrative or organizational entity; nor do appropriate regulations, laws, or financial instruments exist to govern the region as a place of care. Regional collaboration may even conflict with existing policy paradigms.

For instance, the policy aim of regional collaboration conflicts with the existing policy paradigm of regulated competition and decentralisation of health and social care (Jeurissen & Maarse, 2021; van de Bovenkamp et al., 2016), which encourages competition between healthcare providers as well as payers instead of sharing responsibilities and collaboration to serve the regional population. In this paper, we examine how the caring region as both an administrative and organizational domain to deliver networked care is constructed within this institutional environment.

We draw on collaborative governance literatures that stress a consensual mode of decision-making among public, private, and civic actors to achieve a common purpose that could not be otherwise fulfilled individually (Ansell & Gash, 2007; Emerson et al., 2011). An understanding of collaborative governance is that by building trust and formulating shared goals, tensions among actors can be eased to achieve coordinated action (Ansell & Gash, 2007; Emerson et al., 2011). The development of a more-or-less shared perspective is deemed necessary for 'community outcomes' (Bianchi et al., 2021). However, critical-interpretative accounts of collaborative governance address that 'commonality' cannot be simply assumed and expected, as actors hold different views on organizational and policy problems, as well as beliefs and preferences on how to respond to them (Bannink & Trommel, 2019; van Duijn et al., 2021). We argue in this paper that such contestations include the administrative and geographical bounding of an issue, taking 'the region' as an object of our analysis. We hence do not take the formation of the region as an administrative domain as a given, but focus on how actors in relation and in response to each other make up 'the region' as a new 'governance object' (de Kam, 2020). The following research question guides the analysis:

> *How do health and social care providers and national authorities shape the region as a governance object for organising and delivering older person care?*

Our empirical focus is on how 'the region' is made into a governance object through continuous interaction between regional (health and social care) actors and local and national authorities. Zooming in on the practices of actors on various policymaking layers in the making of the region exposes the underlying social processes of health policy reforms (Jones et al., 2019; Waring et al., 2022). To this end, we draw on a national, ethnographic research project on regional collaboration in older person care in the Netherlands (the so-called RegioZ project, 2018-2022). In this project, we closely follow and work with regional actors, consultants, health insurers, and national policymakers to introduce and consolidate regional collaboration between healthcare providers in response to scarce personnel in older person care (Schuurmans et al., 2021). Contemporary collaborative governance literature increasingly calls for such insights on the negotiation of governance arrangements as this study offers (Peters et al., 2022).

Our theoretical objective is to deepen our understanding of the construction of the region as a governance object and as a particular and purposeful strategy for collaborative governance. In this paper, we argue that 'the region' as a new governance object is constituted in the interactions between policymakers, policy entrepreneurs, and healthcare providers. These interactions do not only create innovative ideas to organise and provide care and new care arrangements, but also evoke new interdependencies between actors involved. We show how these interdependencies (re)configure existing organizational and administrative governing arrangements.

Below, we first discuss literature on collaborative governance and regulatory objects to clarify what is meant with the construction of a governance object as a particular strategy for collaborative governance, as well as what this 'making process' entails. We then use these insights to conceptualise the region as a governance object in-the-making, followed by a description of our decentered research ap-

proach that will guide the interpretation of our ethnographic data. We proceed with a description of our research project and methods. In our analysis, we untangle the various relational practices of actors on different policymaking layers in the making of the region as a governance object. We conclude with a reflection on what our findings add to collaborative governance theory and offer reflective handles for actors involved in the (re)making of the region.

Making up a governance object as a strategy for collaborative governance

Collaborative governance was introduced as an alternative to hierarchical command and control and to market-based competition as it aims to 'reduce rivalry and manage differences' (Gray, 1989, p. 37) based on normative principles such as trust and power-sharing (Emerson et al., 2011; Peters et al., 2022). Given the importance attached to making the interactions among a variety of actors productive for organizational and policy change (Ansell & Gash, 2007; Emerson et al., 2011), it is interesting how collaboration is made 'governable' during policy reform, by whom, with what mandate, and with which (legitimizing) efforts and power dynamics.

A strategy to make collaboration governable is to demarcate geographical areas in which organizational actors are expected to collaborate (Fraser, 2010). Making such a spatial demarcation determines which actors can participate, as well as the content of the collaboration. The process of, in our case, making the region as a governance object during policy reform, as well as with what consequences for policy, regulation, and service delivery, is currently overlooked (Jones et al., 2019; Lorne et al., 2019). It is thus these "[…] ongoing practices of assembling new actors, resources or policies and disassembling other […]" (Lorne et al., 2019, p. 1237) to constitute the region in the current institutional context that we focus on.

Literature on the creation of regulatory objects provides insight into the work required to make collaboration governable. The notion of the regulatory object was first developed in the sociology of risk to analyze the work that needs to go into the creation of a specific object that can be regulated (Boholm & Corvellec, 2011). Examples of this are CO_2 emissions in the case of global warming, or hygiene to monitor food safety. Hence, a regulatory object seeks to "[…] [transform] a particular quality issue into the (legitimate) object of regulation" (de Kam, 2020, p. 143). Later, the notion of regulatory objects was used in studies on quality regulation and regulation more generally (de Kam, 2020; Kok et al., 2019; Leistikow et al., 2017). For instance, Leistikow et al. (2017) describe how a regulatory agency is increasingly focusing on 'organizational learning' amongst healthcare providers to enable learning from safety incidents. In this study, a governance object is a term that captures the construction of a steering mechanism. A governance object shapes and 'transforms' an administrative (geographical) place into the (legitimate) object of governance that not only defines who the relevant actors are, but also has an effect on the social realities of affected actors during institutional transition (Butler, 2010). Making a governance object, in other words, constitutes the object.

We approach the making of a governance object not as a politically neutral, static, and well-demarcated administrative practice. Instead, it requires continuous effort and deliberate (relational) work (Feldman & Khademian, 2007) on the intersection of policy and practice to constitute (and preserve) the region within the current institutional context. This work may moreover be contested as it reconfigures power relations and traditional policy processes, as well as challenges prevailing ideas of place in relation to care (Fraser et al., 2019; Waring et al., 2022). Below, we show what making process of a governance object entails.

The making process of a governance object

Constituting a governance object is no standalone process that emerges within a vacuum; its construction is embedded in the cultural, regulative, and historical institutional context. This may ask for organizational and policy activities that are ambiguous; what the governance object articulates may interfere with (or goes against) current institutional logics (Nederhand et al., 2019). Furthermore, administrative categorisations in which actors are expected to collaborate may cut across (or break with) existing collaborative initiatives, crossing traditional social-cultural traditions (Schuurmans et al., 2021). Such ambiguities require pragmatic strategies like intervention or workarounds from organizational and policy actors for the region to be considered legitimate (Oldenhof et al., 2022). Bending institutional rules, as well as stretching current institutional roles beyond their original scope of interference, may enable actors to shape the governance object. Such courses of action might be infused and carried out by local actors as they strategically deal with tensions (van Duijn et al., 2021) or purposively use their discretionary space (Visser & Kruyen, 2021). This may contribute to collective (policy) learning as the knowledge required for making a governance object is not straightforward.

Second, besides constituting a governance object as a new steering mechanism, it may require the disassembling of existing configurations of actors, resources, knowledge, or policies (Lorne et al., 2019). Assembling and disassembling may co-exist. For instance, routinised roles and activities among affected actors might come under pressure, or organizational boundaries may become fluid and change organizational practice (Oldenhof, Stoopendaal, et al., 2016). This may impact regulatory activities as policymakers have to find new modes of interaction with other actors as they often lack the power, capacities, or regulatory instruments to construct a governance object (Hajer, 2003; Lascoumes & Galès, 2007). This is eminent in decentered healthcare systems with no decisive cen-

tral authority (van de Bovenkamp et al., 2016). A governance object creates boundaries as it recruits particular actors to engage with, making its construction political; dominant actors may exclude less dominant actors because of dependencies and power differences (Waring & Crompton, 2020). Therefore, it becomes central *who* can engage with the process of making a governance object (and who cannot), with which mandate and (performative) power, and at the expense of what or whom?

Third, making a governance object is not an obvious and serendipitous organizational and policy activity; it may be planned and deliberately initiated top-down from policy levels *and* bottom-up from shop floors or a combination thereof. For instance, its construction over time requires agenda-setting on organizational and policy agendas, and framing to address the necessity for policy change (van Hulst & Yanow, 2016). This may involve persuading (and enforcing) organizational actors to develop and experiment with new organizational arrangements that embody a new policy discourse like, in our case, regionalization of care. Here, specific appointed 'facilitating leaders' may provide (temporal) support (Crosby & Bryson, 2010). Such facilitators provide actors with opportunities to address situated problems on policy levels. The provision of (financial) resources and (specialized) knowledge by setting up change-oriented collaborative platforms may help generate coordinated support and long-term commitment (Frankowski, 2019; Oldenhof et al., 2022). From the bottom-up, organizational actors may use such platforms to accomplish change by addressing institutional barriers that prevent collaboration taking shape (van der Woerd et al., 2022). Policy actors may use such platforms to learn from policy concerns and needs for policymaking to make the governance object 'fit' better with reality (Ansell & Gash, 2018).

Making a governance object is thus a dynamic and politicised engagement; its construction is power-sensitive as it may involve

revisiting entrenched administrative and institutional boundaries, differences in underlying values, as well as calling on actors to change their practice. This may lead to local resistance (Waring et al., 2022). Actors may conceive the making of a governance object as a threat to their status or control over (scarce) resources. To others, it could enhance their influence and authority. In this paper, we focus on actors' enactment of power whilst making a governance object, as well as the deeper structural interests, tensions, and elite narratives that shape its constitutive practices (Bevir & Waring, 2020). By sticking with the struggles and processes of power of how a governance object is made in and across policymaking layers, we intend to add to critical-interpretative collaborative governance accounts (e.g., La Grouw et al., 2020; van Duijn et al., 2021). We use the literature as a conceptual framework to examine the practices of the shaping and translation work that accompanies the making of 'the region' into a governance object. We analyze deliberate actions, strategies and processes of (dis)assembling and power in how a governance object is made *in the interplay* between actors that act on and represent different policymaking levels. In doing so, we account for the cultural, regulative, and historical institutional context that constitute a governance object. Our analysis will facilitate a further theorization of how governance objects are enacted during institutional transition (in healthcare) (Jones et al., 2019). In the next section, we describe how we will examine the region as a governance object.

A decentered approach to studying the region as a governance object

In this paper, we use a decentered approach, focusing on how interacting actors create, sustain, and modify policy based on different belief systems that are impacted by the social-cultural and historical context in which they are situated (Bevir & Waring, 2020):

> […] decentered theory examines the ways in which patterns of rule, including both institutions and policies, are created, sustained, and modified by individuals through their meaningful social practices that arise from the beliefs individuals adopt against the background of traditions and in response to dilemmas. (Bevir & Waring, 2020, pp. 8-9)

We not only focus on how local actors deal with policy-induced regionalization 'bottom-up', but also analyze their relations and interactions with national (healthcare) authorities in making the region into a new administrative domain. 'Practices' refer to the bundle of (everyday) actions and interactions that actors undertake, and the dynamics between them (Nicolini, 2012). Practices are formed by the assumptions and beliefs that actors develop in relation to a new policy paradigm—in our case, the regionalization of care. Such practices are shaped by traditions and dilemmas that actors experience in their situated environment (Bevir, 2013). A 'tradition' refers to the bundle of agreements an actor receives during socialisation processes, for instance within professional groups. A 'dilemma' emerges when new policies propose routines that do not correspond with existing work patterns, and challenge actors to reconsider their beliefs and traditions. How the region is seen may differ among actors as they are grounded in traditions with (sometimes) conflicting perceptions (Bevir & Waring, 2020).

Methods

An institutional background of Dutch older person care

From a historical perspective, the Dutch healthcare system can be understood as a corporatist (public) system in which professional associations and social interest groups play an important role in policymaking and implementation (Helderman et al., 2005). Here, consultations amongst (professional) societal groups are seen as a

mechanism for democratic decision-making and to obtain support for institutional change. Service delivery heavily relies on private organizations, resulting in a high degree of dependency between state and non-state actors (Jeurissen & Maarse, 2021). Since 2006, a system of 'regulated competition' has been introduced. Healthcare providers are expected to compete for clients based on price and quality, whilst health insurers compete for the insured. Insurers are primarily responsible for general medical care and specialized hospital care. Older persons care is regulated by the Long-term Care Act (*Wet langdurige zorg*). It provides, amongst others, institutionalised care for the most vulnerable people who require 24-7 (medical) care. Although the system of regulated competition is less prevalent in long-term care, providers still bear private legal and financial responsibility, evoking a rather inward-looking perspective. Amongst others, and driven by increasing workforce and accessibility problems, organizations increasingly compete for scarce personnel.

Whilst workforce scarcity differs across places, solution strategies are mostly directed at regional collaboration among healthcare providers and across healthcare echelons (Ministerie van VWS, 2022). Policy calls for (regional) collaboration, however, conflicts with a competitive logic focused on organizational performance. Institutional boundaries between healthcare echelons (e.g., primary care, hospital care, nursing home care)—each with their own laws and regulations, financial schemes and professionals—complicate collaboration further. Collaboration within a fragmented institutional context comes with tensions and uncertainties about quality of care, financing, and regulatory consequences (Oldenhof, Postma, et al., 2016). There is moreover no clear organization that has the mandate to enforce regional collaboration (which is the case for the ICBs in the UK), nor are appropriate financial mechanisms in place. Policymakers are becoming increasingly aware of these problems, leading to discussions on how to establish regional responsibilities (RVS, 2023). Heated public and political debates

have also sprouted about responsibilities for caring for older persons (van Duijn et al., 2022), and the consequences of institutional fragmentation for healthcare professionals who are burdened with administrative pressure and the aftermath of the COVID-19 pandemic.

Data collection: The RegioZ research project

This study is part of a larger action-oriented research project ('RegioZ') in the Netherlands (2018-2022) in which healthcare providers (mostly nursing homes, but also GPs, home care organizations and hospitals) sought to invent new organizational arrangements of care delivery for growing older person populations in 10 predominantly non-urban regions. Examples of such 'regional care experiments' are task reallocation among nurse practitioners and (specialized) physicians, telehealth, regional schedules for care during out-of-office hours, and regional triage models (van Pijkeren et al., 2021). These experiments were financed by Regional Care Offices (RCOs): organizations that carry out the Long-term Care Act in an administrative RCO region (of which there are 31) and are connected to the largest health insurer in that particular region. Appointed process facilitators supported the experiments as part of the policy program 'Dignity and pride in the region' ('*Waardigheid en trots in de regio*'). This change-oriented policy program stresses a collaborative approach among practitioners, national authorities like the Ministry of Health (MoH) and Healthcare Inspectorate (HI), and researchers to learn from the care experiments for healthcare practice and regulatory policies.

As researchers, we followed the care experiments 'from within' and researched the experiences of and strategies for regional care among regional actors *and* national authorities in and across participating regions. We conducted (non-)participant observations and interviews to study care experiments up close for several months, developing an 'emplaced' understanding of how experiments came about (or not) (Ivanova et al., 2016). Central to our ethnographic

approach, we 'worked with' healthcare providers, practitioners, and policymakers to learn from the care experiments, moving back and forth between healthcare practice and the institutional context (Bal & Mastboom, 2007). Engaging with many actors across sites made us aware to constantly balance immersion with critical distance (Keith, 2008). Research team meetings helped to prevent 'tunnel vision', discussing the impact our interventions had on care experiments and to what extent our work reiterated policy frames.

Ethnographic observations took place during managerial and project-related gatherings in which care experiments were monitored or (re)adjusted, care practices, and national gatherings in which regional actors presented (preliminary) results. The places observed consist of lively shop-floors, intimate boardrooms, policy halls, clinics, and crowded conference rooms. Our observations focused on how actors made sense of regional problems; how subjects and perspectives were prioritised (and which not); how negotiation processes were shaped and developed over time; the socio-cultural dynamics of a place; and the role materialities like patient records played. Moving from place to place allowed us to 'follow' how a governance object is made in real life and from different angles (Ball, 2016).

Several rounds of interviews were conducted with nursing home managers, nurses, physicians, as well as representatives of RCOs, the MoH, the HI, and professional associations of nurse practitioners and (specialized) physicians. These actors were selected based on their involvement in care experiments or related policy discussions. During the interviews, we discussed the perceptions of what 'the region' is; which (in)action is employed for regional care; and how this relates to the broader institutional and geographical context. We asked for concrete examples that illustrate frictions and practices.

Preliminary results and observations were shared with participating

regions, and on national levels to support collaborative learning among regions. In total, over 1,000 hours of (non-)participant observation, 300 interviews, and 210 hours of project participation (i.e., giving presentations, feedback sessions) were conducted by a team of eight researchers.

Data analysis

We analyzed the large amount of field notes and interview transcripts using Atlas.ti software and following an abductive approach (Timmermans & Tavory, 2012), iteratively moving between scientific literature ('theory') and empirical data to develop a convincing and fine-grained understanding of how the region is made a governance object in the *interaction* between regional actors and national authorities. As a starting point for our abductive analysis, following a decentered approach (Bevir, 2013), we were triggered by surprising empirical findings that we analyzed against the background of collaborative governance theory. We noticed that the region is contested. Regional collaboration presupposes clarity about regional boundaries, but this cannot be expected. These findings are surprising as they show how actors struggle over what the region actually is, complicating the formulation of regional problems and solutions. Such findings empirically enrich model-based conceptualisations of how collaboration comes about (Ansell & Gash, 2007; Emerson et al., 2011), functioning as an empirical basis to analyze the making process of the region as a governance object.

During the second round of analysis, we focused on the different policymaking levels (e.g., shop-floors, management, and national authorities) of the healthcare system. We referred to this as the multi-level policy context. We zoomed in on the relations and interactions among actors that act on and represent different policymaking layers to analyze *how* the region is made a governance object. Here, we searched for "threads that can be woven together" (Emerson et al., 1995, p. 171) to narrate the interactions and

struggles among actors in light of theory on collaborative governance and regulatory objects. We categorised these findings by searching for 'negative evidence': empirical findings that sharpen and reconsider previous made data classifications (Timmermans & Tavory, 2012). This process of refining the initial findings against the background of a multi-level policy context led to three practices of how the region is made a governance object. These relational practices structured our result section, for which we selected illustrative quotes and observations. We presented the analysis during regional and national gatherings, and to an expert group which consists of a representation of healthcare providers and national authorities, supporting a recurrent process of member-checking to validate our findings. Frequent research team meetings helped to refine data as not all researchers were involved in all participating regions.

How the region is made a governance object

In this section, we untangle the various relational practices of actors on different policymaking layers in the making of the region as a governance object for organising older person care. We distinguish the following practices: *creating recurrent urgency to foreground regional problems and solutions; renegotiating regulatory policies to facilitate regional care provision;* and *rearranging and building care infrastructures to materialize regional care provision.*

Creating recurrent urgency to foreground regional problems and solutions

A first relational practice of how the region is made into a governance object is creating urgency for regional problems and solutions. 'The region' as a new and collaborative caring place is not a well-demarcated geographical place, nor an obvious policy focus or organizational priority. It can be seen, rather, as an assemblage that

consists of (partly) overlapping heterogeneous managerial and professional networks with different compositions and geographical scope (Lorne et al., 2019). While regional actors are urged to engage in regional initiatives to make the region a more embodied venue for responding to workforce shortages, they struggle over what the region *is*, and *who* the organizations are to collaborate with. RCOs steer towards regional collaboration within RCO regions, but these collaborations are not always obvious (historical) partners for nursing homes. Therefore, recurrent urgency must be deliberately created to make the region a new administrative layer and place in response to pressing workforce problems.

Creating urgency is done by constantly articulating and constructing the region against the background of specific problems. Most nursing home managers and professionals stress that regional collaboration is a promising strategy to cope with contemporary (and expected) workforce shortages in older person care:

> *"We are already experiencing severe workforce shortages, and should not be under the illusion that a well-functioning recruitment policy is sufficient. As individual nursing homes, we cannot tackle this issue; it requires a regional approach."*
> *(Nursing home manager, interview 2019)*

Small-scale nursing homes rely on the care capacity of larger homes, rendering it a daily challenge to organise care for increasingly complex client populations. For larger nursing homes, workforce shortages are less severe, making regional action less urgent. Such dependencies influence *what* is seen as urgent, and by whom, and may change over time. This urges regional actors and national authorities to circumvent prevailing power relations to foreground the region as promising. They seek to overcome unwilling managers who often act and reason from their own organizational perspective, focused on organizational ambitions and benefits that do

not always correspond with regional interests. Managers do not want to lose the scarce and often highly coveted specialized physicians to other nursing homes that may offer better working conditions. Despite resistance, this situation creates urgency for regional care, which cuts across regulative policies that centralise organizational performance (van der Woerd, Wallenburg, et al., 2023).

Creating urgency also happens through the entry of new (mediating) actors into regional care. The MoH and RCOs frame workforce shortages in older person care as a regional problem, calling regional actors to act whilst interfering in their response. Although authorities are mostly indirectly involved in regional matters, policymakers work *within* regions to keep collaboration as a promising solution on the agenda. These 'mediating efforts' show an interplay that is uncommon compared to conventional policymaking, as the MoH has little power over individual healthcare providers in this market-based system. The MoH-appointed regional advisors stimulate and empower actors to develop regional initiatives. Acting as knowledge brokers, they 'translate' knowledge about laws and regulations to regional settings, and help in spreading 'best practices' across regions. Together with RCO regional managers, they aim to formulate regional policies. Furthermore, regional advisors appointed as part of a policy-initiated knowledge platform in older person care urge managers to take up a more entrepreneurial role to shape the region:

> *"We cannot change the [healthcare] system, but what is our circle of influence? There is room to manoeuvre. […] I recently gave a presentation in [Region A] about the steps towards regional collaboration. Their reactions were: 'Yes, but the healthcare system is hindering, we should first expect change from the MoH." I replied: "What is then the point of organising this regional gathering? We're sitting here with 10 people who are willing to explore what we as the region can do.'"*
> *(Knowledge platform advisor, interview 2021)*

This quote shows how national actors probe and learn how to constitute the region *while* stimulating regional actors to break with the policy paradigm of regulated competition. At this stage of an institutional transition towards regions, such mediating efforts—moving in-between regional care and national policy perspectives—aim to allure regional actors to develop far-reaching regional initiatives with yet unknown organizational results.

Related, national authorities 'outside' the region are used by regional actors to create and maintain urgency *in* regions. An illustrative example was observed in a region where a managerial network ('coalition') has been created by regional actors with support from the RCO and provincial government (despite having no legal remit for regional care). Historically, collaboration among healthcare providers located on the islands and peninsulas of this region was not obvious. Some nursing home managers who work on a particular peninsula lean more towards neighbouring regions (or even across national borders). Therefore, it proved difficult to get regional initiatives off the ground. Managers in favor of regional collaboration invited policymakers and the RCO to convince unwilling managers to focus on the formalisation of a regional agenda through covenants and contracts. They presented worrying levels of workforce shortages and the (imagined) consequences for organizations. Numbers and figures proved to be a powerful rhetorical tool in appealing to actors to create (and maintain) a sense of urgency to act regionally.

Creating a sense of urgency requires continuous effort as it is volatile; when process facilitators of regional collaboration like project leaders drop out because of staff turnover or temporary contracts, regional initiatives are often no longer seen as an organizational priority. Also, facilitative support and interference from national authorities in regional care is often temporal. Here, urgency must be re-established to prevent initiatives falling apart. Referring to the COVID-19 pandemic helped in this regard as regional collaboration

proved necessary for ensuring sufficient care capacity (de Graaff et al., 2023).

This section showed how interacting and mediating regional actors and national actors create urgency for the region as a collaborative place for older person care that shapes regional interests. The formulation of regional interests is, however, contested, as it comes with the (re)negotiation of organizational boundaries. Creating urgency is not fixed in time and place, but requires the ongoing articulation of actors to perpetuate it. In doing so, the foregrounded region as a new administrative layer interacts with an institutional order that revolves around organizational responsibilities.

Renegotiating regulatory policies to facilitate regional care provision

A second relational practice of how the region is made into a governance object is that regional actors and national authorities start up experiments to renegotiate current regulatory policies in older person care to facilitate regional care provision. In doing so, they create a 'collaborative timespace' to tinker with the as yet non-existing region into a legitimate caring place. General ambitions and small-scale initiatives amongst managers, nurses, and (specialized) physicians to shape regional care provision are made concrete in regional experiments (financed by RCOs). These regional experiments allow regional actors 'on the ground' to develop and experiment with new and unconventional ways of working that do not fit with current laws and regulations (e.g., lacking reimbursement, norms and guidelines). They must obtain support from regulatory agencies to further shape regional experiments. Regional experiments hence function as an experimental environment enabling interacting actors to work on specific regional problems to organise care for regional populations.

The regional experiments led to regulatory change. An illustrative example concerns accessible regional care during out-of-office

hours. Current quality and supervisory regulations prescribe that a physician must be on site within 30 minutes, on a 24/7 basis. This is an obstacle for regional experiments, especially within sparsely populated areas that cannot adhere to the 30-minute rule due to a combination of long travel distances and sparse medical capacity (van de Bovenkamp et al., 2022). Project leaders, managers, and process facilitators address such complexities; they negotiate and obtain commitment from the HI to be evaluated on whether professionals other than (specialized) physicians can arrive in time to provide acute care. Here, regional actors deliberately seek and create regulatory discretion. Doing so requires managerial support, in-depth knowledge of the healthcare system, and the boldness to confront authorities. This gives national authorities information about what stands in the way of regional collaboration. Whilst regional actors are steered in policy directions (i.e., regional collaboration), those obstacles are mostly still unknown, but become visible in the regional experiments.

Another example showing negotiations over regulatory policies entails the regional training of specialized physicians. Specialized physicians often continue to live (and work) near where they were trained (i.e., specialized hospitals), creating an unbalanced distribution of medical capacity across regions. Understaffed regions therefore suggested establishing region training programs, offering internships and medical training. Professional guidelines, however, dictate that an in-house specialized physician with a long-term employment must function as a trainer. Regional actors seek to circumvent hindering regulations *in the interaction* with national authorities:

> *During a regional meeting set up by [project leader in Region A], policymakers were invited to think along how to cope with an unwilling training institute for regional training.*
> *[Project leader] wants to speed up regional training: "We*

> *need a legal entity for this." […] [MoH policymaker] questions if its obligatory for healthcare providers to employ a trainer for regional training: "These norms are set up by professional associations, not by us [the MoH]. We only finance training places." [MoH policymaker] urges [Region A] to proceed, although the experiment is not in line with these norms due to participating nursing homes without a trainer: "[Region A] doesn't have to cooperate with [training institute], they can cooperate with other training institutes in [cities in other regions]."*
> *(Fieldnotes regional meeting 2019)*

In this example, regulatory policies were not directly adjusted as the MoH is dependent on professional associations. Professional associations often do not feel the urgency of, or are already committed to, developing regional experiments, as this often goes against existing agreements about professionals' responsibilities for care. They enact their veto powers to block further initiatives. Yet, the example shows how regional experiments are used to work around vested lines of power and influence—in this case professions that set up training guidelines. National authorities hence prefer working with ambitious (and rebellious) regional actors over consulting traditional professional associations to shape regional care.

Negotiating regulatory policies also led to new financial provisions that allow for regional experimentation. Illustratively, several regions focused on a coordinating and more responsible role for nurse practitioners vis-à-vis (specialized) physicians (van Pijkeren et al., 2021). Here, regional actors' interpretation of care responsibilities clashed with task reallocation guidelines set up by affiliated (and national acting) professional associations. Despite this friction, and the risk that the regional experiment would fail, the affiliated RCO (and health insurer) took up a prominent role by creating budgets to facilitate nurse practitioners to provide care with a

higher financial rate, something that is not obvious at the national policy level (but for which individual RCOs do have the authority). Regional experiments are hence important to authorities as they offer opportunities to meet their institutional responsibilities like providing accessible and sufficient regional care capacity in case of the RCO.

Notably, we as researchers contributed to processes of negotiating regulatory policies through facilitative support. For instance, we reached out to the Healthcare Authority to discuss missing financial arrangements that could embed the work of specialized physicians and specialized nurses in primary care. Through both our involvement in regional experiments and policy discussions, we were able to put such emerging frictions on policy agendas. The MoH and HI often took up a mediating role, acting on policy-practice intersections, which is experimental as it differs from conventional top-down policy roles and practice.

In sum, this section showed how the region is made into a governance object through processes of experimenting, negotiating and adjusting regulatory policies to facilitate regional care provision. Regional experiments allow regional actors to explore and tinker with new forms of collaboration, and help national authorities to be informed about hindering regulations and act responsively. In doing so, regional care provision is made robust so that it can be regulated. In this regard, making the region involves working in an 'institutional void' where regional responsibilities are underdeveloped or even missing (Hajer, 2003).

Rearranging and building care infrastructures to materialize regional care provision

A third relational practice of how the region is made into a governance object is the building of new care infrastructures to materialize regional care provision, something which is far from developed (and with many uncertainties). In line with Bowker and Star

(1999), regional infrastructures can be seen as socio-technical systems and structures that connect actors and their caring practices. As regional care is often perceived as an abstract policy ambition, interacting managers, professionals, and regulators seek to rearrange and build care infrastructures that enable the distribution of knowledge and personnel. Their building efforts help demarcate what the region *is*, who should be involved in regional care, and what this entails (Fraser, 2010). In doing so, regional actors and national authorities work on the materialisation of the region, making it more robust and thus visible in caring practices and an object to govern upon (also enabling further institutional support).

An example of the materialisation of regional care from the bottom-up involves a regional triage model for medical care that includes a flow chart and professional agreements about care trajectories and accompanying tasks and responsibilities (van Pijkeren et al., 2021). A regional triage model connects the care needs of clients with healthcare professionals in a certain geographical area, enabling professionals to work remotely and thus serving a wider area—something which is especially valuable to sparsely populated regions where scarce (specialized) physicians experience large travel distances. Such initiatives institutionalise ambitions for regional care among professionals; this allows managers to build on professional ties on which they are dependent whilst seeking the organizations' involvement and continuity in regional collaboration. Building such a care infrastructure does not happen in a vacuum, but adds to existing institutionalised agreements and responsibilities. The development of a triage model is power-sensitive as it revises vested working routines among (specialized) physicians and nurses. In this regard, a triage model provides opportunities to rearrange professional responsibilities into regional ones, enabling the governance of regional care.

Another related example of how a care infrastructure perpetuates and institutionalises the region involves a regional structure for

out-of-office care. This was initiated in many regions by managers, professionals, and project leaders to maintain accessible regional care, expecting efficiency gains and more robust care provision for fragile clients. By linking together the working schedules of specialized physicians who work for different nursing homes, geriatricians at the hospital and GPs, caring practices during out-of-office hours are oriented towards a wider geographical scope and respective client populations. In this regard, regional actors' efforts to establish a regional structure enables them to maintain accessible care in alternative (regional) ways. Setting up such regional structures, however, requires attention to workload consequences. At times, regional structures resulted in a higher workload, while the expected benefits (e.g., fewer shifts) did not outweigh the costs.

Besides professional agreements like triage models and combining working schedules for accessible out-of-office care, building care infrastructures involves the material construction of care facilities. Such care infrastructures are aimed at linking the expertise of professionals with each other, as well as older person populations and professionals. This creates managerial and regulatory opportunities to govern regional care:

> *In [Region B], managers discuss the building of a 'hospital unit' aimed at older persons, linking hospital and nursing home practice (especially during out-of-office hours).*
> *[Hospital director]: "The hospital unit offers vulnerable older persons the opportunity for short-term treatment, and if necessary, they can be cared for on hospital wards."*
> *[Nursing home director]: "Precisely the expertise of geriatricians is needed for this group. The unit helps shaping a regional team of specialized support, for which other nursing homes should provide for a specialized physician. […] We will show to the RCO that this is the way forward [no clear reimbursement is arranged as the initiative relates to the*

Health Insurance Act and Long-term Care Act]."
(Fieldnotes regional project meeting, 2019)

In this example, the hospital unit as a care infrastructure connects professionals working in nursing homes (specialized physicians) and hospitals (geriatricians). This allows GPs to transfer clients who require (semi-)acute care, and thus to expect fewer consultations during out-of-office hours. The hospital unit hence enables caring for regional populations for which different healthcare providers are responsible, making regional care visible and appealing. It allows healthcare managers across echelons to explore regional caring forms. Although fragmented financial arrangements do not facilitate the building of the hospital unit, it allows the RCO to learn from bottom-up initiatives, what regional care looks like (and how to stimulate this).

This section showed how making the region as a governance object involves the translation of 'the region' as an abstract policy ambition into tangible (and material) care infrastructures. Rearranging and building new care infrastructures from the bottom-up enables the materialisation of the region. This requires new and yet underexplored governance roles that can learn from such ongoing building processes to enable regional care provision (and enact adjustments accordingly), and new interprofessional relations.

Discussion and conclusion

Place-based reorganization of care through regional collaboration is increasingly seen as important in response to severe and increasing workforce shortages (e.g., Fraser et al., 2019; Lorne et al., 2019). This article analyzed the construction of the region as a 'governance object'—that is, an object that shapes and transforms an administrative (geographical) place into the (legitimate) object

of governance. We focused on how regional actors and national authorities in Dutch older person care in relation and in response to each other constitute the region by following an interpretative decentered approach (Bevir & Waring, 2020).

Our findings show that to further enact collaboration within a given regulatory environment, the making of a governance object is an important yet underexplored part. In our case, the region as a distinct administrative and geographical space served this purpose. We showed how regional actors and national authorities in interaction constitute the region as a governance object for organising older person care against an institutional background that stimulates competition rather than collaboration. Regional actors, we showed, create recurrent urgency to foreground regional problems and solutions. They renegotiate regulatory policies to facilitate regional care provision, and rearrange and build care infrastructures to materialize regional care provision. These practices cannot be attributed to *a* specific actor, but are relational; they entail (often contingent) constellations of interacting organizational and policy actors. The making of the region as a governance object is not straightforward but a rather messy, experimental, and uncertain process as it conflicts at times with (and must unfold within) the existing institutional context. Actors navigate through pre-existing governance arrangements, collaborations, and power imbalances. Illustratively, nursing home managers and professionals struggle over policy-induced regionalization in their respective (cultural, historical, and regulative) context; they experience a lack of clarity regarding whom to collaborate with and within which boundaries. Ambiguous regional boundaries push actors to assess and search for collaborations that conform with policy ideas of what the region is. Furthermore, organization-centered regulatory frameworks predominantly focus on organizational performance, complicating the formation of the region.

Governance objects are hence not static governance entities, but instruments at work (Lascoumes & Galès, 2007) that steer actors

into policy directions with yet unknown results that require reconsiderations and adjustment as processes proceed. The relational practices show that in the making of a governance object, new and unconventional policy instruments are developed, current regulations are adjusted, and new care infrastructures are built. These are placed on top of (and start to interact with) existing organizational, and administrative governing arrangements (van de Bovenkamp et al., 2016). These interactions enable institutional change. Actors use and obtain power from such institutional layering to develop new regional care arrangements. This evokes new interdependencies between actors and reconfigures existing professional, organizational, and administrative governing arrangements. Regulatory agencies move along with regional actors and laws and regulations (and even change national standards), or provide leeway to deviate from these standards. Studying governance objects *in-the-making* hence contributes to an understanding of how practices of assembling and dissembling occur simultaneously during institutional transition (Lorne et al., 2019). It reveals the required iterations over time that are part and parcel of how a governance object is made within a given (ambiguous) institutional context, and to which institutional changes this may lead.

Our study adds to a pragmatic perspective of collaborative governance that foregrounds the everyday practices and devices through which strategizing occurs (Ansell, 2011; Oldenhof et al., 2022). Making a governance object unfolds as a layered process, crossing professional and managerial boundaries whilst creating new administrative and geographical territories. The region as a governance object is constituted in the interactions between policymakers, policy entrepreneurs, and healthcare providers. These actors act and interfere on various organizational and policy layers. Adding to existing literature on the enactments of health reforms (e.g., Fraser et al., 2019; van Duijn et al., 2021; Waring et al., 2022), our findings show that actors strategically use these layers and the accompanied dynamics. In our case, task reallocation initiatives

among nurse practitioners and (specialized) physicians require the (re)negotiation of professional boundaries and responsibilities within the organization, but also alignment with other healthcare providers, as well as the engagement of regulators to obtain institutional support. The making of the region as a layered process allows actors like healthcare providers or regulators to enter administrative practice—something which was not common before. Here, interacting actors (and their strategies) enable the construction and legitimation of governance objects in practice (Oldenhof et al., 2022).

Our analysis shows that governance objects are not neutral and uncontested, and come with (historical) resistance. There is a growing recognition that professional and organizational configurations during health policy reform are troublesome (Fraser et al., 2019; Waring et al., 2022). In our case, the making of the region comes with multiple conflicting meanings on what the region is (cf. Fraser, 2010). The region is not (yet) an existing administrative reality in Dutch healthcare. The socio-spatial formation of the region as a governance object, we have shown, is shaped by configurational forces both within and across regional boundaries (van Duijn et al., 2022). National authorities 'opt in' to the region to force action, whilst regional actors rework broad policy ideas into concrete action. Regions are thus not 'bounded' geographical spaces that are defined for administrative purposes (Fraser, 2010), but rather dynamic constellations of managerial and professional networks and care infrastructures which policymakers are part of (Schuurmans et al., 2021). This contributes to a contextual and processual understanding of the 'social embedding' of idealized collaborative governance strategies (Peters et al., 2022).

The struggles and processes of power of how a governance object is made in and across policymaking layers further builds on critical-interpretative collaborative governance accounts (e.g., La Grouw et al., 2020; van Duijn et al., 2021). In our case, problems of work-

force shortages are redefined in relation to place, i.e., from local and national to regional levels (Hammond et al., 2017). This is accompanied by authoritative claims that *regional* care is in the interest of citizen populations. Regional actors are 'responsibilized' to come up with innovative solutions, whereas national authorities facilitate as they have limited power to shape regional care. This calls for collaborative governance scholarship to take the normative boundaries of governance objects into account, scrutinizing the moral foundations and narratives in which they 'come into being' (Bevir & Waring, 2020). Further research might expand on how governance objects redistribute care responsibilities, how perceptions of 'good care' are changed, and what this means for caring practices (Oldenhof, Postma, et al., 2016; van Pijkeren et al., 2021).

Our findings resonate with the established literature on new forms of organization like cross-sector collaboration to create public value (e.g., Bryson et al., 2015; Crosby & Bryson, 2010). Cross-sector collaboration is both enabled and constrained by the institutional context in which it is embedded, and therefore must be studied as a 'dynamic system' (Bryson et al., 2015). Significantly, however, our study reveals that governance objects play a profound role in collaborative endeavours. They must be created and cared for to become legitimate. Whilst 'integrative' leadership at organizational and inter-organizational levels is important in achieving legitimate outcomes (Crosby & Bryson, 2010), our study showed the critical role that shaping and translation work plays (Feldman & Khademian, 2007). This encompasses working with policy and institutional ambiguities (Nederhand et al., 2019)and rearranging relational patterns (see the 'mediating' facilitators that operate at the policy-practice intersection).

Finally, our study offers reflection for those involved in the (re)making of governance objects. In our case, the region is a contested place and administrative domain of which policymakers are

part. Making the region asks for the involvement of policymakers in politics in and between regions (van de Bovenkamp et al., 2022). How can they ensure that less powerful regions with fewer available organizational resources and social and technical infrastructures do not fall behind? Critical reflection on the engagement of researchers is also warranted (Keith, 2008). How can researchers remain engaged with yet critical towards policy discourse and related governance objects? We therefore encourage further ethnographic research that pays attention to the various places where governance objects are (un)made, by whom (and whom not), with what consequences for care provision, policy, regulation, citizen representation, as well as the region's political and democratic legitimacy, while (re)organising welfare state regimes (Sabel et al., 2023). Such layered analyzes are multi-sited and dynamic (Marcus, 1995) as they focus on how actors like service providers, policymakers, and regulators in relation and in response to one another constitute a governance object, and how this may lead to (gradual) institutional change.

7

Caring networks: A critical-pragmatist understanding

Conclusions and contributions to theory and practice

> […] [a] lot of intellectual energy has been spent debating the finer points of big models and purportedly universalistic management tools, while a good proportion of the implementation problems have been not so much to do with the models and tools themselves as with the times and places where it has been attempted to insert them (Pollitt, 2011, p. 46).

A grounded image of networking

At its beginnings, this thesis signaled an empirical deficit within contemporary network scholarship. This was namely around everyday governance in a multi-network context, which is understood as the enactment of network governance by actors (and their relations and interactions) in specific situations and particular settings. By bringing down the grand narrative of networks for public problem-solving ('the heavens') to the specific, concrete, emplaced, and mundane ('the earth'), I aimed to develop a fine-grained understanding of the doings, workings, and meanings of caring networks 'from within' (Bevir, 2013). The sculpture *Sky Mirror (for Hendrik)* (2017) designed by Anish Kapoor, shown in *Figure 1* in the introductory chapter, exemplified this aspiration. The overall research question was as follows: *How does networking unfold in the everyday governance actions and interactions of affected actors, and with which consequences does this come for their role and work?* By adopting a multi-sited ethnography (Marcus, 1995) in the context of Dutch healthcare governance—particularly centered around actors involved in older person and hospital care, the ethnographic work conducted put forward the multiple, ongoing, place-based, multi-layered, and multi-purpose nature of networking in which many governing actors with their own strategic agendas interact with one another.

The *multiplicity* of networks refers to the empirical reality that networking is no standalone activity within the boundaries of *a* network, but is tied with and relates to many nodes of multiple networks. *Ongoing* entails that networking has no clear stop, but requires continuous work while navigating emerging organizational, epistemic, and normative complexities and ambiguities that cannot be imagined a priori, but have to be processed over and over again. *Place-based* points to the situatedness of networking; it cannot be decoupled from the sociocultural, institutional, and geographical context in which it is aimed to have an effect. *Multi-layered* means that networking is embedded in underlying governance dynamics like professional-management relations and interactions, but also ties into broader governance structures, illustrating the need to engage with and mobilize various organizational and policy levels. *Multi-purpose* encompasses the various ways that purposes come into being through networking, underscoring the sensemaking possibilities for governing actors, and the multiple (conflicting) purposes that are present at the same time. Networking is thus not static, but dynamic—full of ambiguities and relational processes in which interactions and structures are made and unmade.

This grounded image of networking is reflected in *The Depot* building in Rotterdam as shown in *Figure 5*. Wandering through the building, visitors see through large windows restorers at work and how artworks are prepared and packed for transport. The exterior with an eye-catching mirrored façade and ongoing round volume reflects the park, the sky, and buildings around the art depot in multiple ways. Each angle provides a different, partial, and incomplete perspective of its surroundings, each time blending in with the environment. The Depot is about lived and worked multiplicities, rather than static homogeneity. The exterior provides a perfect image, nicely round with mirrors neatly co-positioned (i.e. the network as a finished, romanticized object). The interior stands for the ongoing work of various govern-

ing actors. Only focusing on the mirroring exterior comes with the risk of overlooking such hard-fought work, or may even mislead a societal understanding of how network governance unfolds in practice.

As reflected in the quote from Pollitt (2011) above, the critique that scientific inquiry is overly aimed at universalism and the modeling of problem-solving strategies, and relatively less towards particularism and multiplicity, is not new. This thesis contrasts with romanticized and instrumental-technical conceptions of network governance that provide limited insights into lived experiences and perceptions, and that cease offering insights when these perceptions become unruly and messy.

Taking the research findings together, this chapter zooms out by reflecting on how the cases of networking expose the making process of a governance order that relies on a network logic. In doing so, I do not necessarily compare the individual cases in a systematic way, but seek to unveil which overall insights these cases lead to. I elaborate on how thinking of dimensions of caring networks informs a critical-pragmatist understanding for public problem-solving. In the end, I describe implications and recommendations for healthcare governance and beyond, set out a research agenda for the study of caring networks, and distil lessons for the positionality of the network researcher in fuzzy fields when studying caring networks.

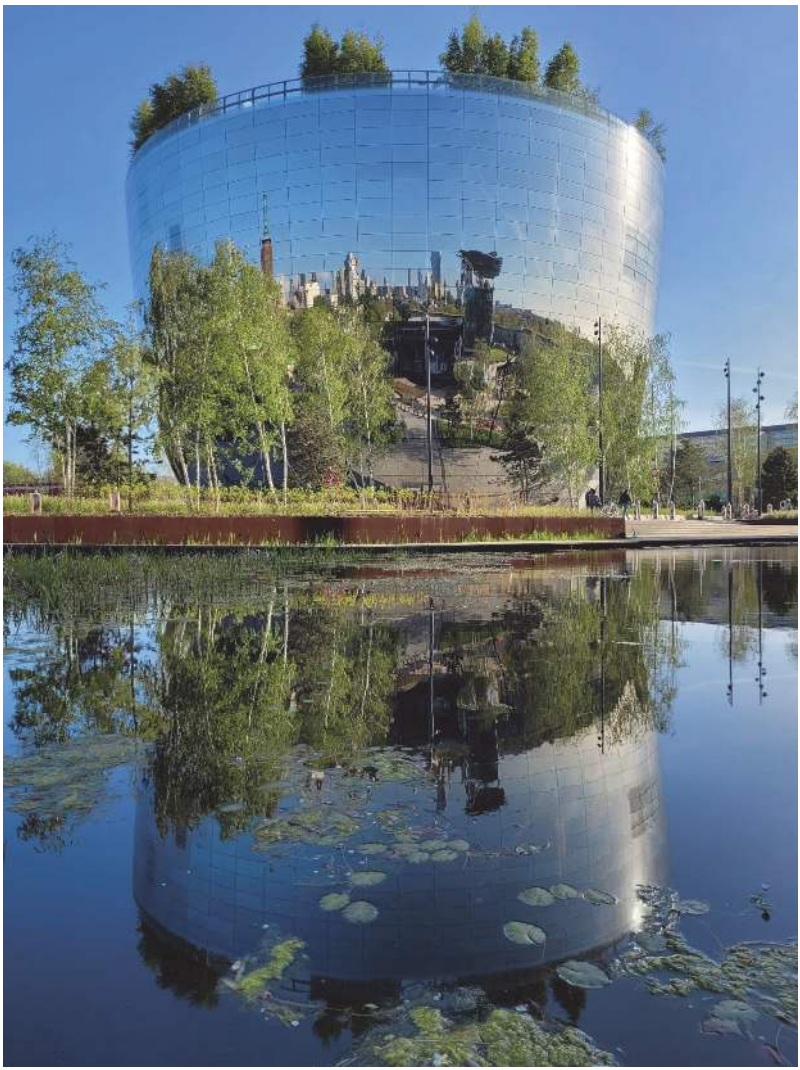

Figure 5. *'The Depot'* is a publicly accessible art depot, designed by architectural firm WVMDV, located next to museum Boijmans Van Beuningen in the Museumpark in Rotterdam. Banners throughout the city refer to The Depot as *'Not a museum, but a working place.'* Photo taken by Rick Bergwerff (2023).

The doings, workings, and meanings of caring networks: A critical-pragmatist understanding for public problem-solving

The grounded image of networking helps develop our understanding of the doings, workings, and meanings of caring networks in contemporary society. For this, I draw inspiration from the philosophy of pragmatism—a philosophy that emphasizes continuous inquiry, reflection, deliberation, and experimentation among actors to enhance problem-solving capacity (Ansell, 2011; Dewey, 1954; Oldenhof et al., 2022). It places value on the open-ended and probative process of knowledge development, aiming to develop useful knowledge about actions that arise in concrete governance situations (Greenhalgh et al., 2023). Pragmatism is thus practice-oriented (Wagenaar, 2011), which may help to develop possibilities for action beyond initially presuming impossibilities (Forester, 2012). This contributes to determining *how* the field of public administration and public policy can engage with societal experiences (Moynihan, 2022).

From a critical-pragmatist understanding, caring networks consist of the following non-exhaustive list of dimensions that may play a profound role during deliberative and democratic processes of reorganization in the field of healthcare governance: (1) caring *about* networks as a matter of societal concern to foster engaged learning; (2) caring *through* networks to harness governing actors' strategic values; (3) caring *for* network purposes and ambitions to enable diverse engagement; and (4) crafting *the place* to network to develop suitable responses to local needs. These dimensions are closely linked to actors' life-worlds; more infused with networking dynamics, and issues of multiplicity and not-knowing; less neat and infused with wishful thinking; and thus more pragmatic and intelligent for public problem-solving.

The dimensions of caring networks can best be understood as partial pieces of a broader and ongoing governance puzzle, not as clear-cut building blocks or an exclusive way that linearly will lead to increased problem-solving capacity in healthcare and beyond. While describing each dimension below, I make up the argument that multi-faceted infrastructures are necessary for facilitating pragmatic work, when it comes to network governance in healthcare. Informed by a critical-pragmatist understanding, caring networks are suitable places to fulfil such a relational infrastructural role. *Table 8* summarises how the networking findings relate to the dimensions of caring networks, and what these dimensions entail. This will guide the sections following.

Table 8. Dimensions of caring networks

Caring networks	Description	Networking findings
Caring *about* networks as a matter of societal concern to foster engaged learning	The recalibration and problematization of a network discourse to learn about the dark sides and how to navigate ambiguities and complexities	Managerial and professional pressure (Chapter 2 and 4); emplaced complexities (Chapter 3); institutional work arounds (Chapter 3, 5 and 6)
Caring *through* networks to harness governing actors' strategic values	The reconfiguration of actors' strategic positioning, making the in-between productive for organizational and policy change	Managerial work (Chapter 2); external network interventions (Chapter 3); mediating work (Chapter 5)
Caring *for* network purposes and ambitions to enable diverse engagement	The restructuration of a multi-network context, supporting and stimulating networking as a diverse and democratic practice	Governing possibilities through platforms (Chapter 3); managerial work (Chapter 2); mediating work (Chapter 5)

Crafting *the place* to network to develop suitable responses to local needs	The construction and legitimization of where networking must unfold and with whom, providing for populations' needs	Regional network-building (Chapter 3); mediating work (Chapter 5); the making of a governance object (Chapter 6)

Caring *about* networks as a matter of societal concern to foster engaged learning

Caring *about* networks stands for the recognition that networks are a matter of societal concern to foster engaged learning. It encompasses the recalibration and problematization of a network discourse to learn about the often-overlooked dark sides and opportunities networking brings, as well as how to process emerging ambiguities and complexities. Importantly, this goes beyond romanticizing networks as a problem-solving strategy by addressing and searching for 'best practices' of network successes. Since the need to network is rising, navigating through a multi-network context has become an empirical reality that actors must deal with. This thesis showed that the emergence of networks is policy-induced, but also accelerated by bottom-up initiatives from healthcare organizations because of increasing dependencies in terms of workforce and expertise. While networking opportunities are often framed in abstract terms and must prove themselves, threats can be real-time and require immediate action. Placing overt emphasis on networks as a generalized problem-solving strategy may lead to tunnel vision and a lack of sensitivity about the day-to-day consequences for actors. After all, as shown, networks have an impact on managerial, professional, and policy practice. It therefore becomes less an obligation to see networks as *a* well-bounded governance structure for healthcare governance. Moreover, constantly reiterating networks as a strategic solution to everything carries the risk of downplaying the hard-

fought work it actually requires, and the consequences for the role and work of affected actors. We therefore must acknowledge and reflect upon such implications generously.

The research findings indicate the need to approach networks as a deliberate societal concern, informing a critical turn in contemporary network thinking. Caring about networks from this stance entails a sensitivity to mechanisms of in- and exclusion, questioning which power relations are represented and reproduced in network governance and related decision-making processes. It pays attention to which knowledge resources and claims are valued, by whom, and which 'publics' are served with the proliferation of networks in contemporary society (Dewey, 1954). Caring about networks thus encompasses safeguarding the participation of non-elite actors with less network and social capital as a possible result of institutionalized inequalities (Paul et al., 2022). For instance, Chapter 3 showed that networking was mainly carried out by 'a happy few' of medical specialists. On the one hand, this illustrates their importance in creating networks bottom-up and outside the realm of traditional professional, managerial or policy practice. On the other hand, it also urges us to question their dominance and impact on *other* actors. In all, societal deliberation about these issues may foster engaged learning about actors' relations and interdependencies as these are subject to change during the making process of a new governance order. This may enrich our engagement, intervention, and sensemaking in a multi-network network full of ambiguities and uncertainties (Greenhalgh et al., 2023).

Caring *through* networks to harness governing actors' strategic values

Caring *through* networks points to the reconfiguration of actors' strategic positioning, making in-between land productive for or-

ganizational and policy change (Meurs, 2022). This entails the creativity at hand to refashion complex and uncertain circumstances in a multi-network context in such a way that it can be translated into new strategic paths. An important conclusion of this thesis is that working *in* and *with* caring networks comes with new and surprising opportunities for actors to explore and harness a variety of strategic values. Networking is thus not only a burden. For instance, Chapter 2 showed the strategies performed among hospital executives to align organizational interests with the emergence of networks. Caring through networks was, in this case, not just an escape to survive. It also helped less-dominant hospitals to obtain power and influence in the 'network of collaborations' as they became part of the strategic efforts and ambitions of *others* in light of a regional discourse of (medical) care provision. Power differences that are part and parcel of networking can thus also be made productive. This can be understood as a process of reconfiguring strategic positions that offer new possibilities—besides experiencing regulative uncertainties. Such strategic position-taking is, however, not fixed in time and place. Chapter 3, for example, showed that, at first, medical specialists used the network platform to facilitate and legitimize professional (learning) communities. Over time it helped them, besides healthcare managers, to have a cross-organizational and cross-network impact on (the organization of) care—far beyond the original network platforms' purpose, which was mainly a response to stringent quality regulations.

Thinking of caring through networks helps us to imagine how organizational, professional, or policy decisions are consequential for broader outcomes like regional care provision. This may lead to a felt perception of responsibility for such matters for which the current institutional context does not yet provide. Caring through networks is not only outward-oriented. Instead, it encompasses both inward and outward work (e.g. moving in and between networks and the organization). Chapter 2 and 3, for instance, showed how healthcare managers relate to many overlapping and

conflicting interests, purposes, ambitions, laws and regulations, and emotions simultaneously. Chapter 5 moreover showed the important mediating work carried out by mediating actors on the policy-practice intersection.

Illustrative for the Dutch context, this points us to the ongoing and layered nature of networking to adapt to (changes in) the regulatory environment with (potential) conflicting accountability schemes. Caring through networks is rather problematic as regulatory frameworks are often organization-centered instead of aimed at network levels. It can also be understood as a means of working with complexities, as well as different organizational and policy levels. In all, networking comes with a 'web of interests' (i.e. personal, organizational, regional, societal, external stakeholders) that requires recurrent alignment work. Emergent problems cannot be imagined before, but have to be recurrently processed and engaged with—exemplifying the pragmatic yet uncertain ways of caring through networks.

Caring *for* network purposes and ambitions to enable diverse engagement

Caring *for* network purposes and ambitions is about the restructuration of a multi-network context, supporting and stimulating networking to become a diverse and democratic practice. This thesis showed that networking is not always considered part of actors' professional work. For instance, Chapters 2 and 3 showed that networking cannot be taken for granted as an 'integral part' of professional work. These chapters moreover showed that network purposes are not fixed in time, but subject to change. Caring for actors and their network purposes and ambitions by organizing (prolonged) facilitative support is thus important. Enabling diverse engagement is necessary to prevent that networking becoming merely a practice for elite actors. Interesting in this regard is that

platforming is a promising strategy to govern, facilitate, and nurture networking as it offers new ways of working for actors to cope with the multi-layered nature of network governance. As shown in Chapter 3, such a platforming logic may help actors to coordinate network actions that are often scattered across different managerial, professional, and policymaking layers. The support provided could activate actors as they might feel a necessity to network, but have limited time, expertise, or social capital to do so. Yet, such support is often temporal as it cannot merely be attributed to facilitating support by supporting staff.

Caring for network purposes and ambitions is not an individual endeavor. It is rather about the ongoing work of many actors within organizational contexts, as well as the outside interference of actors to make networking a more common and legitimized activity within the wider population of networks, institutional context, and geographical place. This was, for instance, shown in Chapter 4 where policymakers interfered in regional processes of networking, asserting power and influence to overcome inertia that was already looming among regional actors. In this case, provincial governments became part of networking processes whilst having no institutional responsibility in healthcare. Furthermore, Chapter 5 showed how mediating policy figures searched for (and intervened through) creative ways to make networking a more common practice in a local setting.

In addition, caring for network purposes and ambitions entails the creation of new types of relations and interactions among actors that are less common. For instance, Chapter 4 showed how policymakers *used* the networked field to develop more close relationships with regional actors by actively intervening in local problem perceptions and intended solution strategies. Related to this, Chapter 5 showed how mediating policy figures produced and connected both places and administrative levels in accomplishing organizational and policy change. They made use of an institutional void as responsibility structures do not yet fit with networked healthcare

on a regional level (Hajer, 2003). We learn from this that not only support for field parties is required for network governance to work, but also the emergence of a *specific* type of mediating actor, operating *between* shop-floor, organizational, and policy levels to accommodate change for care policies across *individual* network boundaries. This clarifies the 'switching' between roles of governmental actors to connect field-level actors (Bryson et al., 2014). They are, in fact, *part of* networking. I therefore conclude that mediating spaces and places are important as these can be made productive. They provide support for actors, but also enable the caring for diverse and democratic engagement as this cannot be easily assumed from the start.

Crafting *the place* to network to develop suitable responses to local needs

Crafting *the place* to network entails the construction and legitimization of *where* networking must unfold and with whom, providing for the needs for citizen populations. Underlying such crafting work is the making of particular governance objects that steer actors into networking directions, making networked care a more 'responsibilized' activity (Fraser, 2010; Lascoumes & Galès, 2007). Governance objects must be created and cared for to become legitimate. Chapters 5 and 6 showed how interrelated and interacting regional actors and national authorities shape and 'transform' the region as an administrative (geographical) place into the (legitimate) object of governance for organizing care. Policymakers searched for policy instruments to make the region a more robust policy device. We learn from this that the spaces and places *at* and *in-between* networks matter during the making process of a new governance order. They should therefore be valued as important to develop suitable responses to local needs.

In addition, this thesis showed that crafting the place to network is a multi-layered and emplaced organizational and policy activity. It is embedded in underlying governance dynamics (i.e. professional-management relations and interdependencies), but also ties into wider governance infrastructures (i.e. regulatory frameworks and a competitive system-logic). The findings show that actors have to cope with the challenges that come with this policy layeredness. Reflecting on the central object of study in this thesis, caring networks are particular and rather dynamic entities with no clear emplaced and policymaking boundaries. For instance, Chapter 4 showed that networks need to be crafted and cared for by (potential) network actors, as well as requiring (temporal) interference 'from the outside' to become effective against particular local problems. Furthermore, Chapter 5 showed that, in using their ambiguous position within the healthcare system, mediating policy figures become important yet somehow hidden actors around the formation of networks. A central conclusion of this thesis is therefore that the practices and devices through which strategizing and legitimizing occurs in relation to caring networks encompasses more than constructing a well-demarcated network entity. This is often an illusion as this thesis showed that caring networks are moving objects that grow or shrink over time, with shifting purposes over time ('function creep') and co-existing in- and excluding mechanisms.

Instead, such processes also are about constructing the place determining where to network ('the region' as a policy layer), with whom ('regional actors'), and for which specific local needs and citizens ('regional populations'). Attention to the policy layeredness, as shown in this thesis, revealed how caring networks require efforts of many actors that develop and bring in different strategies (and *other* networks) to create a networked response to the needs of citizens populations. Such endeavors require new competencies and attitudes, as touched upon above and elaborated on below.

In all, the dimensions of caring networks form a provisional theory that is grounded in the networking findings. It aims to support a learning process that is based on real-life actions and interactions (Greenhalgh et al., 2023). These dimensions are provisional as they were uncovered in a particular context, i.e. a healthcare system with regulated competition that seeks for and relies on network governance. I therefore consider the dimensions not as generalized theory, but as conceptual opportunities that support further inquiry. My hope is that these insights would help us better grapple with networked healthcare. Notably, the conclusive dimensions highlight that studying networking requires a multi-sited ethnographic methodology to understand the networking practices of actors. This may help us to envision where the making process of a governance order that relies on networks may lead to, which is elaborated on next.

Pragmatism towards what? Caring networks as a multi-faceted infrastructure for a governance order in-the-making

A critical-pragmatist interpretation of caring networks informs our understanding of the making of a governance order. This thesis showed the ongoing dynamics of such a making process, with what new relations and interdependencies among actors this comes, and with which consequences for everyday governance. This section explores how the findings help us to imagine the contours of a governance order that relies on networks for healthcare governance.

This thesis observes that the lines between state and market governance arrangements are under pressure as networking constructs a communal order. Although networks are far from new, the healthcare system created an administrative fix of the single-

existing organization (Wallenburg et al., 2019). Networking comes with uncertainties and ambiguities in relation to current laws and regulations, accountability schemes, and institutionalized organizational and policy practices (Hajer, 2003). These are not yet focused on *the place* where networking should take shape ('the region'), but are mainly focused on organizations and professionals. Thinking of networking as a governance order hence requires other forms of regulation, responsibility, and financing structures. It requires the development of cultures of responsibility and responsiveness that fit with networked healthcare, reformulating quality of care responsibilities, and rethinking policy-practice relations and interactions. Such reformulation processes may go against traditional policy processes, and require actors to develop capabilities to work *on the intersection* and *in-between* organizational and policy levels to facilitate such institutional change. Although process facilitators like the mediating policy figures are aimed at providing temporal support, as shown, this also comes with the risk that they stay as policy-practice dependencies increase. In the midst of emerging complexities and ambiguities, a critical-pragmatist understanding of caring networks may function as a multi-faceted infrastructure while figuring out how to enact a network logic into everyday governance. Actors learn when they are able to critically reflect on their own beliefs and practices (Dewey, 1954).

This requires actors to live with and endure the imperfections of networking, yet it also creates unexpected opportunities for institutional change, as this thesis has demonstrated. Identifying and making use of such opportunities helps craft network governance during policy reforms. For this, acknowledging and making use of the in-between land contributes to engaged learning (Meurs, 2022), for instance about how to develop regulative practices that stimulate cultures of responsibility and responsiveness that are rooted in the communal. In the Dutch context, a possible direction for healthcare governance would be to make the region a more

robust and institutionalized governance layer, rendering networking a less complex endeavor (RVS, 2023). In this regard, discussing how the addition of a new governance layer to an already layered healthcare system comes at the cost of what or whom is important. However, this thesis showed that such organizational and policy ambitions come with a proliferation of network initiatives, persons, and gatherings, requiring coordination to avoid further competition between networks. Yet, this generates new problems in terms of the tasks, scale, democratic legitimacy, and functioning of national, regional, and local governments (ROB, 2021).

I therefore suggest exploring a more problem-based and situated approach that develops the craft of working and tinkering with scales (Minkman, 2020; Postma, 2015). Being aware that neither problems nor solutions fit neatly into scales (Tsing, 2012), understanding healthcare problems as *particular* situated problems for which different scales, actors, and ways of governing are required, would do justice to the networking findings presented in this thesis. After all, networking is not a neatly bounded practice that takes shape within a well-demarcated place, policy layer, scale, or strategic niche, or that can be reduced to a governance repertoire of specific actors. In reality, networking is much more fragmented and dispersed. In essence, this thesis calls for taking the making process of a governance order seriously to work toward new cultures of responsibility and responsiveness in healthcare governance. This entails critically reflecting on the making process and the potential of the multiple meanings of caring networks (Crossley, 2010). In this regard, the ethnography of caring networks is an important societal stimulus to discuss the possibilities and limitations of current accountability structures to shape 'collective' responsibilities.

Implications and recommendations for healthcare governance and beyond

The societal impact of this thesis can be found in providing insights into how networking unfolds in everyday governance, exposing the relations and interactions among actors that evoke new interdependencies, and reconfigure existing governing arrangements. This section distils implications and recommendations for healthcare governance and beyond, aimed at policy, practice, and research, in order to improve the overall capacity to govern healthcare (Kooiman, 2008).

Policy implications

This thesis shows that a multi-network context reconfigures the ways in which healthcare organizations, regulators, and governments develop their activities as it shifts the focus to building trustworthy relationships (Stoker, 2006). A looming danger for policymakers (and politicians) is to simplify or even downplay the everyday consequences of networking. Learning from field-level narratives of networking as presented in this thesis may enable policymakers to be aware of and evaluate the particularities and complexities of their policy activities, broadening the (political) value systems that are used in these networked policies.

A more specific implication is directed at the democratic accountability and legitimacy of networking. The exposed relationships and interactions among actors bring forward several questions about how to organize and account for (citizen) representation and participation. This seems less in scope compared to organizational and policy processes and preferences in relation to networking. As observed at the start, networks are often described as a means for horizontal, democratic, and legitimate decision-making. This thesis showed that networking is no power-free practice in which actor perspectives can be harmoniously woven

together into one (regional) perspective. This urges policymakers and politicians to ask the question: Who stays behind in networking? Who has access to networking, and who does not? Which differences in the quality of care among the places of networking are acceptable?

Notably, healthcare organizations legitimize, from their network positions, the scope of their care in terms of citizens. This might come with the risk that citizens fall in-between networks when they do not neatly fit *a* particular network scope. This thesis showed that patient representatives are rarely part of networking, or that they are considered participants in decision-making processes. An explanation for this is that an infrastructure to voice patient perspectives at the network level is is non-existent (cf. van de Bovenkamp et al., 2023). It is hence important for policymakers and politicians, citizens, practitioners, and researchers to be aware of processes of in- and exclusion that networking produces. In all, networking doesn't only 'integrate' things, but also comes with exclusion. Such an understanding may prevent that networking becoming primarily for elite societal or professional groups.

Another implication is about the structuration of networking, which comes with fragmentation, as shown. Networking asks for customized support over time; such support cannot be taken for granted. Yet, this also comes with a risk of 'over-coordination'. Supporting networking comes with a reflex of building and developing coordination vehicles like policy initiatives full of organized meetings, platforms, and appointed process facilitators.[2] This proliferation offers new governing possibilities, but also comes with 'projectification' (Penkler et al., 2019) with a plethora of temporal budgets and small-scale experiments that impact current working

[2] An illustrative example is the covenant *'Integraal Zorgakkoord (IZA)'* as a policy plan to reorganize care on a regional level, urging healthcare organizations to shape a networked model of care (Ministerie van VWS, 2022).

patterns. Policymakers should take this fragmentation seriously when further developing networking support, as well as the consequences of (conflicting) coordinating structures.[3]

This thesis also relates to the making of networking as an object of inspection for regulatory agencies (de Kam, 2020; Kok et al., 2019), i.e. how to develop and adapt regulating activities to a multi-network healthcare context. Current regulations are focused on existing, more-or-less visible, individual networks that can be identified as an entity so that 'the network' with respective healthcare professionals and managers can be addressed and held accountable. This thesis showed that *multiple* network involvement is an empirical reality that requires *other* forms of regulation that fit with networked healthcare. How can actors be held accountable for quality of care responsibilities that are focused on individual healthcare organizations? It would be wise for regulators and other system-level parties to closely interact with one another to learn from networking developments (Grit et al., 2022). This may help prevent regulatory activities from being counterproductive towards networked practice. Particularly informed by Chapter 3, exploring the opportunities that network platforms provide to come to grips with networked healthcare may offer fruitful opportunities for regulation. This furthermore may help us to understand the fuzziness of 'webs of goals', as these are not always clear and change over time.

Practice implications

This thesis showed how a multi-network context, particularly the region as the policy-induced place to network, has an impact on how healthcare managers, professionals, policymakers, and regulators do their work. Actors must work with and through networks

[3] Illustrative of this is that financial means are provided by funding agencies like ZonMw for healthcare organizations to make inventories of existing network initiatives for aligning purposes.

to 'get things done', shaping goals that are (politically) contested and moreover tangled with wider webs of goals (Lega et al., 2022; Vangen & Huxham, 2012). Administrators often lack the power, capacities, or regulatory instruments to steer (Hajer, 2003). It would be helpful to think over the idea that care responsibilities can and must be neatly distributed among healthcare organizations and their professionals. This is illustrated in how managers and professionals are educated, and how quality indicators are aimed at individual care responsibilities and performance. It would be valuable to discuss how healthcare organizations contribute through networking to the caring for citizen populations. An important implication for practice is therefore to reflect on what a networked, societal point of reference in care provision asks in terms of professionalization and related competencies and attitudes (van der Scheer, 2023). How can actors endure and tinker with the imperfections that come with networking? Being informed by the potential that imperfections bring for care provision may extend governing possibilities, for instance how to work with the layered healthcare system to accomplish institutional change (see Chapter 3 and 5). Furthermore, networking does not have to be successful to accomplish results (see Chapter 4), nor must it be focused on network structures (see Chapter 3). The imperfections of networking are thus an important yet unexplored resource for healthcare policy and practice.

To substantiate the practice implications, *Table 9* provides several reflective questions for each dimension of caring networks. These questions may guide actors to reflect on a multi-network context, and the ambiguities and complexities this brings for care provision. These questions may furthermore contribute to practice-informed education about caring networks for managers, professionals, policymakers, regulators, and students in the field of health sciences, public administration, and public policy.

Table 9. Reflective questions for the dimensions of caring networks

Dimensions of caring networks	Reflective questions
Caring *about* networks as a matter of societal concern to foster engaged learning	What or who is drawing network boundaries? How do network goals relate to wider 'webs of goals'? How do emerging ambiguities and complexities inform network functioning and conceptions of 'good care'?
Caring *through* networks to harness governing actors' strategic values	Which mechanisms do actors develop to navigate through a multi-network context? How are network goals enacted in actors' everyday work? How are working patterns reconfigured, and with what consequences for care?
Caring *for* network purposes and ambitions to enable diverse engagement	Which new relationships (internal and external colleagues) and interdependencies emerge through networking? Which in- and exclusion processes can be identified? How to organize facilitative support, and for whom? Which capabilities are required to network?
Crafting *the place* to network to develop suitable responses to local needs	How does networking relate to the geographical and institutional context? How can networking practice be legitimised and accounted for? How does this relate to caring for (regional) citizen populations?

Research implications and limitations

This thesis showed the relevance of ethnographically studying caring networks for public administration and public policy. In doing so, I focused not mainly on *one* administrative level or *a* type of actor, but included various organizational and policy levels, as well as the places in-between, in my analysis. Bussemaker et al. (2023) recently

called for a shift from system-level analysis ('the macro level') or attention to implementation dynamics on shop-floors ('the micro level') to *the coordination between* those analytical levels. An implication of this thesis is that such coordinating efforts do not merely relate to 'visible' organizational or policy levels, and the relations and interactions among actors. It also entails analytical exploration of what is emerging in-between administrative levels and between geographical places, and how such places reconfigure policy-practice relationships and interdependencies, and with what consequences for citizen populations. An example is the mediating work done by mediating policy figures in Chapter 5. Such analyzes inform a public administration that is attentive to societal experiences (Moynihan, 2022), prioritizing neglected or unfinished developments and actor dynamics. In doing so, a practice-informed understanding of caring networks may help to challenge and reconsider instrumental-technical thinking in public administration (Bussemaker et al., 2023). Engaging with and in-between various organizational and policy levels also has an impact on the role network researchers play, the frames they represent or seek to challenge, and how they interact with others. To substantiate this, I elaborate on the positionality of the network researcher in one of the sections below.

As recognized at the start, the particularities and complexities of the Dutch healthcare system make the research findings difficult to generalize to other settings. The question '*Where is this a case of?*' helped me to formulate more general theoretical contributions for the specific cases of networking (Langley, 2021). Although the cases are not systematically compared, I tried in this chapter to relate the case contributions to each other by searching for underlying mechanisms, i.e. a certain type of work. Furthermore, capturing what actors do might be seen as a flat ontology. What I tried in this thesis was to critically reflect upon the actions and interactions of different and many interacting actors, and with which consequences this comes. This provided more detail and analytical depth into our findings. I elaborate on the limitations of the multi-sited

ethnography methodology adopted in this thesis in one of the sections below. In the following, I first elaborate on the theoretical implications this thesis brings forward, and propose a research agenda on the study of caring networks.

The study of caring networks: A research agenda

A critical-pragmatist understanding of caring networks adds to and refines research agendas around networks (e.g. Hearld & Westra, 2022; Minkman et al., 2021; Peters et al., 2022). With the proposed suggestions I aim to provide, on the one hand, conceptual enrichment of networks as emerging social phenomena, and on the other hand, clarification of the doings, workings, and meanings of networks within contemporary society— particularly in relation to healthcare policy and practice.

A first research direction involves the further exploration and problematization of the dark sides of a multi-network context as touched upon in this thesis. These dark sides refer to overlooked and unfinished consequences of networking as this is not merely attractive for affected actors. For instance, emphasis on networking may reproduce certain differences in terms of network capital or dominant interests and perspectives, especially during large-scale policy reforms that aim to reconfigure certain institutionalized working patterns. Related research questions are, for instance: How to cope with structural disparities in terms of network capital between the places where networks should take shape? What does this mean for the organization and timespan of (policy) support? Which interactive forms between policy and practice are suitable for this, and which roles do citizens play in this regard? The 'boring things' such as policy reports and presentations during conferences in relation to caring networks may thus be important to reflect upon (Jones, 2023).

A second research direction entails exploring how networking changes and reconfigures institutionalized relationships and interdependencies among actors in contemporary welfare states. Networking may evoke the redistribution of professional tasks (Schuurmans et al., 2023; van Pijkeren et al., 2021), which may have an impact on how formal and informal caregivers, as well as citizens, clients, and patients construct and frame 'good care' (Heerings et al., 2022; van Bochove & Oldenhof, 2020). Studying the democratic accountability and legitimization of decision-making processes through networks seems desirable. Also, to what extent networking underpins citizens' needs and preferences, how healthcare agencies adapt their regulating work to this whilst increasingly interfering in policymaking around networks (van de Sande et al., 2021), and what this asks in terms of leadership and professionalization (van der Scheer, 2023) are important avenues of research. Research questions that may guide this quest are, for instance: How do formal and informal caregivers make sense of a networked policies while producing care, and with which power dynamics does this come? How do network interests relate to broader public interests, and how are these reconciled by actors ranging from citizens to politicians? What do leadership and professionalization in a multi-network context looks like, and how does this relate to the construction of 'collective' responsibilities?

A third research direction worth pursuing entails exploring methodological novelty within network scholarship. As I have elaborated on at the start, the scientific interest and fascination for networks in public administration and public policy ('science for *science*') seemingly results in a lack of attention to the lifeworld of actors, and implications that do not fully resonate with their empirical realities in a multi-network context. An understanding of the doings, workings, and meanings of caring networks would help in this regard ('science for *society*'), which was attempted in this thesis by analyzing how networking ensues in everyday governance. In order to achieve societal-driven research, I suggest putting

current network scholarship into dialogue with diverse methodological foundations, as well as other creative disciplines like social designers to prevent tunnel vision or institutional capture. This allows researchers to contribute to a democratized 'network science for society'. Further problematizing how to engage in a multi-network context, the partial knowledge this produces (Haraway, 1988), and how to value these perspectives from a critical-pragmatist perspective, could provide a modest start to such discussions. This may spur cross-fertilization among theoretical streams of literature and empirical domains.

These research suggestions are far from all-encompassing. They are a plea for further investigation into the network discourse in contemporary society from an engaged yet critical stance, unraveling its multiple facets. This requires reflection on the role and position of those researching caring networks, which I discuss in the next section.

Studying caring networks: Positionality of the network researcher

In this section, I outline several lessons learned about the positionality of the so-called 'network researcher' while studying caring networks by zooming in and out on the networking practices in which I was immersed (Nicolini, 2010). Adopting a multi-sited ethnography entailed, in this thesis, recurrent positioning processes across sites in the field of healthcare governance (Marcus, 1995), i.e. moving at the intersection and in-between organizational and policymaking processes. In doing so, I had to deal with 'fuzzy fields'—fields without clear boundaries (Nadai & Maeder, 2005). Informed by these experiences, supported with diary material, what methodological reflections and innovations can be formulated about ethnographic positionality?

First, positioning processes in relation to the study of caring networks comes with recurrent negotiation of the network researchers' identities (Bal & Mastboom, 2007). While interacting with different actors across sites, I was confronted with a plethora of actor perspectives and issues of power. What the exact role and position of myself as a network researcher was, and with what expectations and responsibilities, was often unclear. An illustrative example entails the ethnographic work in the context of the Zeeland region (see Chapter 4). While observing regional network-building processes, for some actors like nursing home managers and project coordinators I was seen as someone 'from the outside' who provides research evidence into 'what works' so that the regional network can become successful. This was not according to the role agreed upon in the broader project context, which was aimed at collective learning, working *with* regional actors, and providing them knowledge from other regions about how to network. This is rather opposite to giving clear-cut advice on which directions actors should take. Other actors like policy advisors reached out to me to learn about actor positioning dynamics as I gained valuable knowledge about local particularities and complexities. This informed them on how to create urgency for regional action, or how to enforce a breakthrough when inertia was looming. Presenting preliminary findings offered the opportunity to set such actions in motion. I learned from these experiences that it is important for the network researcher to plug-in frequent moments of reflection with peers *and* project participants to discuss identity-making processes in the field. How am I being framed by others, which roles and positions do I take, and for what purposes? How can uncertain and unsettling positions be navigated?

Second, engagement of the network researcher with many actors across sites requires being equipped with various strategies of interaction, constantly balancing immersion with critical distance (Keith, 2008; Van Duijn, 2020). Being part of and observing networking processes over a longer period of time required me care-

fully investing in and maintaining enduring relationships with a variety of actors. At the same time, I had to retain critical distance to prevent 'tunnel vision' as I was immersed in *and part of* a network discourse (Hannerz, 2003). Although this balancing act was far easier said than done, and rather complicated, the multi-layered nature of my ethnographic work allowed me to distance myself from policy frames, preventing too much attachment. While policymakers expressed their policy ambitions during interviews or regional meetings, closely interacting with nursing home professionals on shop-floors who challenged these ambitions informed and nuanced my perceptions. I intended to develop warm contacts with both organizational and policy actors to follow their work over time. What I had not expected were the instances in which policymakers reached out to me to come up with particular strategies about how to intervene in networking processes by *other* actors with whom I also had close contact. This made me at times uncertain. In response, I developed a form of interaction that was more thoughtful and reserved, seemingly considering plotting such an intervention as something out of my scope. It is thus important to be open about the unsettling 'betweenness' of the network researcher, but also to which unexpected opportunities this may lead to (Lorne, 2021). How to process power and powerful actors in order to prevent too much attachment? Discussing this not only at the start, but also during networking processes is important as these constantly change and develop (Vandenbussche et al., 2020).

Third, as shown, networking is no standalone, placeless, and power-free activity that emerges within a vacuum. It unfolds within a certain sociocultural and geographical place, as well as within a certain policy context like a healthcare system. I found it worthwhile to become familiar with such emplaced dynamics as it helped me to develop a historical understanding of networking in particular settings. Hanging around the places where networking (is attempted to) takes place helped me to understand local particularities and complexities. Conducting ethnographic work is time-

intensive and comes with practical constraints, requiring decisions about which paths to follow and unfollow (Van Duijn, 2020). For instance, I conducted participant observations during regional meetings in a specific region in which representatives of nursing homes, hospitals and GP associations discussed plans to network. This was exciting as GPs were often less involved in such discussions; often talked about, but not part of networking activities. While the regional initiative was put on a hold due to shifting strategic focuses (influenced by the COVID-19 pandemic), I had to unfollow these processes and started focusing on other regional initiatives in yet another region. Taking the places under study seriously also meant a sensitivity to surprising developments. For instance, being confronted with and increasingly aware of the mediating activities of policy advisors vis-à-vis regional actors in network formation (see Chapter 5), I deliberately started following them up-close. Ethnographic positionality is thus also about the development of an emplaced understanding, valuing the particular and surprising, while at the same time not being afraid to unfollow paths and explore alternative routes.

Fourth, moving at the intersection and in-between organizational and policymaking processes, I often felt the desire to generate relevant knowledge about networking. Looking back, I wanted to become influential, which was not surprising given the accelerated worlds of healthcare governance I was immersed in. Slowing down at times is not only important to balance and reflect upon immersion and critical distance (Kuus, 2015), but also to recognize and address 'blind spots'—especially within sensitive fields like healthcare. This, for instance, entails accessibility to knowledge. I often felt privileged to talk to and hang around with elite actors. For most actors under study like project coordinators, nurse practitioners, or small-scale nursing homes it is rather uncommon to have access to system-level actors like regulators or national policymakers to address issues. At times, the RegioZ project group addressed such issues on policy tables, in board rooms, during re-

gional meetings and national conferences. Such interventions are an important part of committed yet critical ethnographic research. How are network boundaries drawn, and by whom? Which processes of in- and exclusion are taken place? This underscores the emancipating value of the network researcher while studying caring networks. Positioning on the policy-practice intersection enables the translation of knowledge about networking to policy arenas, which cannot be assumed to be happening spontaneously.

Concluding remarks

This exploratory and empirically-grounded thesis originated with a fascination towards the value attributed to networks for public problem-solving, particularly eminent in the field of healthcare governance. This turned into an academic quest, conceptualizing networking as emerging social phenomena rather than merely instrumental-technical structures. The ethnography of caring networks contributes to our comprehension of how a grand narrative of network governance unfolds in specific situations and particular settings. This thesis calls for contemporary network scholarship to recalibrate network thinking, emphasizing the *multiple*, *ongoing*, *place-based*, *multi-layered*, and *multi-purpose* nature of networking in which many actors with their own strategic agendas interact with one another. It offers a lived view of networking, uncovering relations, interactions and dynamics among actors during healthcare policy reforms that rely on networks (Jones et al., 2019). I have intended to do so by analyzing various cases of networking.

In all, I believe that there is need for a critical-pragmatist understanding of caring networks, for which the dimensions provide conceptual enrichment into the hard-fought and relational work required during the making process of a new governance order.

Those entail: (1) caring *about* networks as a matter of societal concern to foster engaged learning; (2) caring *through* networks to harness governing actors' strategic values; (3) caring *for* network purposes and ambitions to enable diverse engagement; and (4) crafting *the place* to network to develop suitable responses to local needs. I hope these dimensions of caring networks will help stimulate deliberate reflection in this means of governance, involving discussion about how this making process reconfigures the relations and interdependencies in the continuum of healthcare governance: between policymakers, internal and external regulators, and healthcare practitioners; between the network of collaborations and healthcare organizations; and between shop-floor professionals, informal caregivers and citizens (cf. van der Scheer, 2023).

To conclude, the ethnography of caring networks is a plea to not overly romanticize network governance ('the heavens'), but to care from a critical-pragmatist perspective for a governance order in-the-making that relies on (regional) networks. This thesis is an invitation to stick with the wilderness of networking ('the earth'), moving beyond "debating the finer points of big models and purportedly universalistic management tools" (Pollitt, 2011, p. 46). It is therefore timely to acknowledge, explore, develop, and embark on romantic-realist representations of the practice and mundanity of network governance for healthcare policy and practice.

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List of tables and figures

Research data management, ethics and consent

The variety of cases of networking presented in this thesis in terms of geographical place, time span, and affected actors required careful data management, ethics, and consent. Each case required a deliberate process of data processing and data storage, as they related to different projects. Data sources like digitalized fieldnotes, observational reports, transcripts, audio files, policy reports and other documents, and Excel overviews were carefully stored in protected individual or project folders from Erasmus University Rotterdam. Atlas.ti software was used as a research tool to overview and analyze data. If needed, data was shared with project members, for instance before project meetings, to discuss (ongoing) findings.

The data obtained in Chapters 2 and 3 are in line with Dutch research law and regulations and did not have to be reviewed. All respondents were asked for consent, and this was received each time. More details about data collection can be found in the method section of each chapter. Chapter 2 did not receive any specific grant from funding agencies in the public, commercial, or not-for-profit sectors. Chapter 3 represents independent research partly funded by the BeterKeten network platform in the Netherlands.

The Medical Ethics Review Committee of Erasmus Medical Center (METC) granted ethical approval for studies carried out in the 'RegioZ' project (MEC-2019-0139). Those entail in this thesis Chapters 4, 5, and 6. The research presented in these chapters was supported by funds of several Regional Care Offices (CZ, VGZ, Menzis, De Friesland, and Zilveren Kruis).

The data that support the findings of this thesis are available on reasonable request from the author. The data are not publicly

available due to privacy restrictions. The research conducted was in accordance with the nationally and internationally accepted standards for scientific conduct as stated in the Netherlands Code of Conduct for Research Integrity (2018).

Summary: The Ethnography of Caring Networks

Creating, nurturing, and maintaining networks is increasingly seen as a solution to pressing healthcare issues like increasingly elder person populations and workforce shortages. Yet, networks require the reconfiguration of entrenched professional, organizational, administrative, geographical, and institutional boundaries, reconsidering current working patterns and cognitive frameworks. This thesis aims to disentangle a governance order *in-the-making* that relies on a network logic. Caring networks—as the central study object in this thesis—can be understood as more-or-less formalized or informal networked governance arrangements in the field of healthcare that consist of nodes and ties between multiple actors in attempts to (re)organize care provision for citizen populations, ranging from healthcare organizations and professionals, to policymakers and regulators. This thesis shifts attention from networks as well-demarcated governance structures to seeing networks as dynamic and emerging social phenomena.

Inspired by an interpretative and practice-based understanding of networks, this thesis signals an empirical deficit within network scholarship for 'everyday governance' in a multi-network context—that is, an approach that seeks to capture the enactment of grand narratives of governance by actors (and their relations and interactions) in specific situations and particular settings. This empirical deficit can be attributed to two main assumptions: (1) networks are more-or-less placeless and context-free, and (2) networks are given and bounded entities. Both assumptions seemingly focus on formal aspects of networks. This thesis covers social interaction in relation to formal *and* informal network dynamics. Through a multi-sited ethnography in older person and hospital care, I try to unravel how a policy discourse that relies on networks unfolds and is enacted through actors' actions and interac-

tions on the ground, and what consequences this brings for policy and practice. The theoretical exploration and conceptualization of networking leads to the formulation of the main research question: *How does networking unfold in the everyday governance actions and interactions of affected actors, and with what consequences does this come for their role and work?*

The cases of networking in older person and hospital care researched put forward the *multiple*, *ongoing*, *place-based*, *multi-layered*, and *multi-purpose* nature of networking.

The *multiplicity* of networks refers to the empirical reality that networking is no standalone activity within the boundaries of *a* network, but is tied with and relates to many nodes of multiple networks. The overuse of caring networks as a generic solution strategy hence ignores emerging problems like healthcare accessibility, administrative and professional pressure, and institutional fragmentation. Chapters 2 and 3 show that networking is not an 'integral part' of professional work. As a result, networking is not self-evident. This raises the question: should everyone network? Chapter 2 explores hospital executives' work towards aligning organizational interests with network actions. In this case, networking is not just a way to survive. It helps less dominant hospitals to enact power and influence in the 'network of collaborations', because they become part of the strategic ambitions of others around (medical) care provision. Chapter 3 discusses the role of a network platform as a strategy for governing a network of networks. A platform structure can help actors to coordinate network actions that are often spread across different administrative, professional and policy-making layers. The support provided activates and facilitates actors, because they may feel the need to network, but have limited time, expertise or social capital to do so.

Ongoing entails that networking has no clear stop, but requires continuous work while navigating emerging organizational, epis-

temic, and normative complexities, and ambiguities that cannot be imagined a priori, but must be processed over and over again. Strategy documents and neatly defined network structures are not a solution to the uncertainties that come with networking. Such artificial arrangements can only provide temporary relief; caring networks are dynamic objects that grow or shrink over time, with changing functions and purposes ('function creep'), and co-existing inclusion and exclusion mechanisms. Chapter 1 showed that working in and with a 'network of collaborations' can expand the steering repertoire of managers and professionals. But this requires relational capabilities that are not self-evident. Networking requires both internal and external work (i.e., moving within and between networks and the organization). Chapters 2 and 3, for example, show how managers simultaneously relate to overlapping and conflicting interests, goals, ambitions, laws and regulations and emotions. Chapter 5 shows the mediating work at the intersection of policy and practice. Caring networks are hence dynamic entities that require continuous commitment from those actors involved.

Place-based points to the situatedness of networking; it cannot be decoupled from the sociocultural, institutional, and geographical context in which it is intended to have an effect. Such processes are also about constructing the place determining where to network ('the region' as a policy layer), with whom ('regional actors'), and for which specific local needs and citizens ('regional populations'). Networking comes with uncertainties and ambiguities in relation to current laws and regulations, accountability schemes, and institutionalized organizational and policy practices. These are not yet focused on *the place* where networking should take shape ('the region'), but are mainly aimed at individual organizations and professionals. The practice of networking in this thesis shows that networking works despite rather than because of existing laws and regulations. Chapters 5 and 6 show how interrelated and interacting regional actors and national authorities shape and 'transform'

the region as an administrative (geographical) place into the (legitimate) object of governance for organizing care. Policymakers search for policy instruments to make the region a more robust policy device. Chapter 4 shows that networks need to be crafted and cared for by (potential) network actors, as well as requiring (temporal) interference 'from the outside' to become effective against particular local problems. Caring networks are particular and rather dynamic entities without predetermined, clear emplaced or policymaking boundaries, but they help shape them.

Multi-layered means that networking is embedded in underlying governance dynamics like relations and interactions between professionals and managers, between organizations and communities, between decentralized and central governments (or policy layers), and frameworks. Those who work on networks come into contact with different organizational and policy levels, and will have to mobilize and work with them. Networking is not a power-free activity, nor an individual endeavor, but is contested and entangled with different interest and policymaking layers. Networking as a layered practice requires work from both actors within organizational contexts, as well as the outside interference of actors to make networking a more common and legitimized activity within the wider population of networks, institutional context, and geographical place. Chapter 4 shows that policymakers intervene in regional processes of networking, asserting power and influence to overcome inertia that was already looming among regional actors. Chapter 5 shows how mediating policy figures search for (and intervene through) creative ways to make networking a more common practice in a local setting. They are hence more than a symptom of ambiguity. They help shape a governance order that relies on networks. Attention to the policy 'layeredness' reveals how caring networks require efforts of many actors who develop and bring in different strategies (and *other* networks) to create a networked response to the needs of citizen populations.

Multi-purpose encompasses the various ways that purposes come into being through networking, underscoring the sensemaking possibilities for governing actors, and the multiple (conflicting) purposes that are present at the same time. Networking is thus not static, but dynamic—full of ambiguities and relational processes in which interactions and structures are made and unmade. Strategic position-taking is not fixed in time and place. Chapter 3 shows that medical specialists and managers primarily use the network platform to facilitate and legitimize professional (learning) communities. Over time, it helps them to have a cross-organizational and cross-network impact on (the organization of) care—far beyond the original network platforms' purpose, which was mainly a response to stringent quality regulations. Chapter 4 shows how policymakers develop closer relationships with regional actors by intervening in local problem perceptions and intended solution strategies. Chapter 5 shows how mediating policy figures produce and connect both places and administrative levels in accomplishing organizational and policy change. They make use of an institutional void as responsibility structures do not yet fit with networked healthcare on a regional level. This shows the emergence of a type of mediating actor to shape network governance.

From a critical-pragmatist understanding of caring networks, I come to the following characterization of the type of work involved that may play a profound role during deliberative and democratic processes of reorganization in the field of healthcare governance:

(1) *Caring <u>about</u> networks as a matter of societal concern to foster engaged learning.* This includes the recognition that caring networks are an important societal resource to learn how to work in and with networks. It also encompasses the recalibration and problematization of a network discourse to learn about the often-overlooked dark sides and opportunities networking brings, as well as how to process emerging ambiguities and complexities.

(2) *Caring through networks to harness governing actors' strategic values.* This points to the reconfiguration of actors' strategic positioning, making in-between land productive for organizational and policy change. Networking is thus not only a burden, but comes with new and surprising opportunities for actors to explore and harness a variety of strategic values. This requires creativity to refashion complex and uncertain circumstances in a multi-network context in such a way that it can be translated into new strategic paths.

(3) *Caring for network purposes and ambitions to enable diverse engagement.* This is about the restructuration of a multi-network context, supporting and stimulating networking to become a diverse and democratic practice. Networking is not always considered part of actors' professional work. Caring for actors and their network purposes and ambitions by organizing (prolonged) facilitative support is thus important. Enabling diverse engagement is essential in preventing networking from becoming merely a practice for elite actors.

(4) *Crafting the place to network to develop suitable responses to local needs.* This entails the construction and legitimization of *where* networking must unfold and with whom, providing for the needs of citizen populations. Underlying such crafting work is the making of particular governance objects that steer actors into networking directions, making networked care a more 'responsibilized' activity. The construction of 'the region' as a governance object, for instance, is accompanied by authoritative claims about what (quality of) care includes and who is responsible for it.

The characterization of the type of work is closely linked to actors' life-worlds; more infused with networking dynamics, and issues of multiplicity and not-knowing; less neat and infused with wishful thinking; and thus more pragmatic and intelligent for public prob-

lem-solving. When it comes to network governance in healthcare, multi-faceted infrastructures are necessary for facilitating pragmatic work. A critical-pragmatist understanding sees caring networks as suitable places to fulfil such a relational infrastructural role, enabling engaged learning about networking. The ethnography of caring networks is a plea against overly romanticizing network governance, and a plea for care—from a critical-pragmatist perspective—for a governance order in-the-making that relies on (regional) networks. It is an invitation to acknowledge the practice and mundanity of network governance for healthcare policy and practice, leaving room for the *dark* and the *light* side of networking as a means of public problem-solving.

The societal impact of this thesis can be found in providing insights into how networking unfolds in everyday governance, exposing the relations and interactions among actors that evoke new interdependencies, and reconfigure existing governing arrangements. A looming danger for policymakers (and politicians) is to simplify or even downplay the everyday consequences of networking. Learning from field-level narratives of networking as presented in this thesis may enable policymakers to be aware of and evaluate the particularities and complexities of their policy activities, broadening the (political) value systems that are used in these networked policies.

The relationships and interactions among actors this thesis exposes generate several questions about how to organize and account for (citizen) representation and participation. This seems less in scope compared to organizational and policy processes and preferences in relation to networking. This thesis showed that networking is no power-free practice in which actor perspectives can be harmoniously woven together into one (regional) perspective. Networking does not only 'integrate' things, but also comes with exclusion. Such an understanding may prevent networking from becoming primarily a process for elite societal or professional groups. This calls for policymakers and politicians to ask the question: Who

stays behind in networking? Sensitivity towards this question is necessary to make networking a diverse and democratic practice of care in a changing welfare state.

Although this thesis shows that the structuration of networking results in alternative governing possibilities, networking also comes with managerial and professional working pressure, and 'projectification' with a plethora of temporal budgets and small-scale experiments that impact current working patterns. Networking asks for customized support over time. Yet, this also comes with a risk of 'over-coordination'. Policymakers should take this fragmentation seriously when further developing networking support, as well as the consequences of (conflicting) coordinating structures.

Another implication concerns the construction of networking as an object of inspection for regulatory agencies, i.e. how to develop and adapt regulating activities to a multi-network healthcare context. Current regulations are focused on existing, more-or-less visible, individual networks that can be identified as an entity so that 'the network' with respective healthcare professionals and managers can be addressed and held accountable. However, the ethnography of caring networks shows that new cultures of (democratic) accountability and responsiveness in healthcare governance are needed. This involves, on the one hand, reformulating quality of care responsibilities, and on the other hand, rethinking policy-practice relations and interactions. Such reformulation processes may go against traditional policy processes, and require actors to develop capabilities to work *on the intersection* and *in-between* organizational and policy levels to facilitate such institutional change.

The increasing emphasis on networking as a practice of care requires healthcare professionals and managers to live with and endure the imperfections of networking, but also to tinker with them further and become proficient in networking.

Network scholarship would benefit from further empirical exploration of what is emerging between administrative and professional levels, between geographical places, and how such 'in-between spaces' reconfigure policy-practice relationships and interdependencies, and with what consequences for citizen populations. Network scholarship goes further than system-level analysis, or attention to implementation dynamics on shop-floors. Coordinating efforts between those levels do not merely relate to 'visible' organizational or policy levels, but also include unexplored places and actors like mediating policy figures. Such analyses inform a public administration that is attentive to societal experiences, prioritizing neglected or unfinished developments and actor dynamics. Studying caring networks for public administration and public policy *ethnographically* is thus important because it provides insight into the social worlds of networking. A second research direction involves the further exploration and problematization of the dark sides of a multi-network context as touched upon in this thesis. These dark sides refer to overlooked and unfinished consequences of networking as this is not merely attractive for affected actors. Further research into what networking means for the redistribution of professional tasks and with what impact for formal and informal caregivers, and perceptions of 'good care', is desirable. Third, in order to achieve societal-driven research, I suggest putting current network scholarship into dialogue with diverse methodological foundations, as well as other creative disciplines like social designers to prevent tunnel vision or institutional capture. This allows researchers to contribute to a democratized 'network science for society' that embarks on actors' lifeworlds.

To end, the ethnography of caring networks provides insight into the positionality of the so-called 'network researcher' during large-scale policy changes that rely on (regional) networks. Network researchers operate between different

organizational and policy levels. This requires recurrent negotiation of the network researchers' identities; being equipped with various strategies of interaction, constantly balancing immersion with critical distance; becoming familiar with socio-cultural and geographical dynamics of the network locations under study; and temporizing engagement and network processes to recognize and address 'blind spots' in dominant network discourse.

Samenvatting: de etnografie van zorgende netwerken

Netwerkvorming wordt vaak als oplossing gepresenteerd voor de omgang met urgente vraagstukken in de zorg, zoals een groeiende zorgvraag door steeds ouder wordende populaties en toenemende arbeidsmarkttekorten. Tegelijkertijd vereist netwerken de herconfiguratie van diepgewortelde professionele, organisatorische, administratieve, geografische en institutionele grenzen. Dit proefschrift richt zich op zorgende netwerken als een sturingsorde in de maak. Met zorgende netwerken als object van studie wordt bedoeld: geformaliseerde of informele samenwerkingsverbanden in de zorg die bestaan uit knooppunten tussen meerdere actoren om zorg voor burgers te (re)organiseren. Dit proefschrift beschouwt netwerken als activiteit (werkwoord) en niet zozeer als ding (zelfstandig naamwoord).

In het huidige netwerkonderzoek valt een empirisch tekort voor alledaags bestuur op te merken. Dit kan worden toegeschreven aan twee dominante aannames: (1) samenwerkingsverbanden zijn min of meer plaatsloos en contextvrij, en (2) samenwerkingsverbanden zijn gegeven en begrensde entiteiten. Beide aannames lijken zich te concentreren op de formele aspecten van samenwerken. Dit proefschrift behandelt sociale interactie in relatie tot formele *en* informele dynamieken van zorgende netwerken. Door een zogenoemde 'gelaagde' etnografie in de Nederlandse ouderen- en ziekenhuiszorg wordt gepoogd om inzicht te krijgen in hoe netwerken zich ontvouwt, en met welke gevolgen voor beleid en praktijk. De volgende onderzoeksvraag staat centraal: *Hoe ontvouwt netwerken zich in de dagelijkse sturingsactiviteiten en interacties van betrokken actoren, en met welke gevolgen voor hun rol en werk?*

Op basis van verschillende empirische vindplaatsen in de ouderen- en ziekenhuiszorg kan worden geconcludeerd dat netwerken ge-

kenmerkt wordt door meervoudigheid, voortdurendheid, plaatselijkheid, gelaagdheid én de benodigde lenigheid.

De *meervoudigheid* van netwerken verwijst naar de empirische realiteit dat netwerken geen op zichzelf staande activiteit is binnen de grenzen van een samenwerking, maar betrekking heeft op knooppunten van meerdere samenwerkingsverbanden. Het overmatig gebruik van zorgende netwerken als generieke oplossingsstrategie miskent daarom opkomende problemen rondom toegankelijkheid van zorg, bestuurlijke en professionele drukte en institutionele fragmentatie. Uit hoofdstuk 2 en 3 blijkt dat netwerken geen 'integraal onderdeel' van professioneel werk is. Daardoor is netwerken niet vanzelfsprekend. Dit roept aanpalend de vraag op: moet iedereen netwerken? Hoofdstuk 2 gaat in op de ervaringen en strategieën van ziekenhuisbestuurders om de belangen van de organisatie op één lijn te brengen met de activiteit van netwerken. Zorgen via netwerken is in dit geval niet alleen een manier om te overleven. Het helpt minder dominante ziekenhuizen om macht en invloed te verwerven in het 'netwerk van samenwerkingen', omdat ze onderdeel worden van de strategische ambities van anderen rondom (medische) zorgverlening. Hoofdstuk 3 gaat in op de rol van een netwerkplatform als strategie om een netwerk van netwerken te besturen. Een platformstructuur kan actoren namelijk helpen bij het coördineren van netwerkactiviteiten die vaak verspreid zijn over verschillende bestuurlijke, professionele en beleidsvormende lagen. De geboden steun activeert en faciliteert actoren, omdat zij misschien de noodzaak wel voelen om te netwerken, maar daarvoor slechts beperkte tijd, expertise of sociaal kapitaal hebben.

Voortdurendheid houdt in dat netwerken geen duidelijk begin en einde heeft, maar voortdurend werk vereist. Hoe als professionals, bestuurders en beleidsmakers te navigeren door organisatorische, epistemische en normatieve ambiguïteiten is niet vanzelfsprekend, maar moet door hen steeds opnieuw worden ontdekt en ontwik-

keld. Strategiedocumenten en netjes afgebakende netwerkstructuren zijn geen oplossing voor de inherente beweeglijkheid en onduidelijkheid van netwerken. Dergelijke kunstmatige ordeningen kunnen slechts tijdelijk soelaas bieden. Aangezien zorgzame netwerken bewegende objecten zijn die in de loop van de tijd groeien of krimpen, met veranderende functies en doeleinden (*'function creep'*) en naast elkaar bestaande in- en uitsluitingsmechanismen. Hoofdstuk 1 liet zien dat het werken in en met een 'netwerk aan samenwerkingen' het sturingsrepertoire van bestuurders en professionals kan vergroten. Maar dit vraagt wel om relationele vaardigheden die niet vanzelfsprekend zijn. Netwerken vraagt zowel intern als extern werk (het verplaatsen in en tussen netwerken en de organisatie). Hoofdstuk 2 en 3 laten bijvoorbeeld zien hoe bestuurders zich tegelijkertijd verhouden tot overlappende en tegenstrijdige belangen, doeleinden, ambities, wet- en regelgeving en emoties. Hoofdstuk 5 laat het bemiddelende werk zien op het snijvlak van beleid en praktijk. Zorgende netwerken zijn, kortom, dynamische entiteiten die om voortdurende inzet vragen van betrokkenen.

Plaatselijkheid gaat over de lokale situering van netwerken. Netwerken staat niet los van de sociaal-culturele, institutionele en geografische context waarin het beoogd effect te hebben. Dergelijke processen gaan over het construeren van de plek die bepaalt waar te netwerken (bijvoorbeeld 'de regio' als beleidslaag), met wie en voor welke specifieke lokale behoeften en voor welke burgers. Huidige regulering is echter nog niet gericht op de plek waar netwerken vorm moet krijgen, maar is vooral gericht op individuele organisaties en professionals. De praktijk van netwerken in dit proefschrift laat zien dat netwerken eerder werkt ondanks dan dankzij bestaande wet- en regelgeving. Hoofdstukken 5 en 6 laten zien hoe regionale actoren en systeempartijen de regio proberen vorm te geven en 'transformeren' van een administratieve (geografische) plaats tot een (legitiem) sturingsobject voor het organiseren van zorg. Beleidsmakers zoeken naar beleidsinstrumenten om de

regio robuuster te maken. Hoofdstuk 4 laat zien dat samenwerkingsverbanden worden opgezet en onderhouden door diverse (potentiële) netwerkactoren, maar dat (tijdelijke) inmenging 'van buitenaf' nodig is om lokale problemen te slechten. Zorgende netwerken zijn dynamische entiteiten zonder vooraf bepaalde, eenduidige geografische of beleidsmatige grenzen, maar geven daar mede vorm aan.

Gelaagdheid omvat enerzijds dat netwerken ingebed is in onderliggende dynamieken, zoals relaties en interacties tussen professionals en managers, tussen organisaties en gemeenschappen, tussen decentrale en centrale overheden (of beleidslagen) en kaders. Wie werkt aan netwerken komt met verschillende organisatie- en beleidsniveaus in contact en zal deze moeten mobiliseren en bewerken. Netwerken is geen machtsvrije activiteit, maar is betwist en verknoopt met verschillende belangen en beleidslagen. Het vormgeven aan samenwerking als antwoord op de behoeften van burgers is geen solistische onderneming. Netwerken als gelaagde praktijk van bestuur en zorg vraagt namelijk voortdurend werk van actoren binnen organisaties, maar ook om de inmenging van buitenaf om van netwerken een gelegitimeerde activiteit te maken binnen het bredere palet aan samenwerkingsrelaties, de institutionele context en geografische plaats. Hoofdstuk 4 laat zien dat beleidsmakers zich bemoeien met regionale netwerken, waarbij ze macht en invloed uitoefenen om de lokale traagheid van netwerken te overwinnen. Hoofdstuk 5 laat zien hoe zogenoemde 'vage' beleidsfiguren zoeken naar (en interveniëren via) creatieve manieren om netwerken een gangbare praktijk te maken. Vage beleidsfiguren die mediëren tussen beleid en praktijk zijn meer dan een symptoom van ambiguïteit. Zij geven de sturingsorde mede vorm.

Lenigheid in doelvorming omvat de verschillende manieren waarop doelen tot stand komen door middel van het netwerken. Dit onderstreept de verschillende manieren waarop actoren betekenis geven aan samenwerken. Netwerken is namelijk niet statisch, maar

dynamisch, vol dubbelzinnigheden en relationele processen waarin interacties en structuren worden gemaakt en aangepast. Het strategisch positioneren is niet vastgelegd in tijd en plaats. Hoofdstuk 3 laat zien dat medisch specialisten en bestuurders een netwerkplatform in eerste instantie gebruiken om professionele (leer)gemeenschappen te faciliteren en te legitimeren. In de loop van de tijd helpt het hen om een organisatie- en netwerk overstijgende impact te hebben op (de organisatie van) de zorg. Dit reikt verder dan het doel van het oorspronkelijke netwerkplatform, namelijk het hanteren van vergaande kwaliteitsregels. Hoofdstuk 4 laat zien hoe beleidsmakers het veld gebruiken om nauwere relaties met regionale actoren te ontwikkelen door in te grijpen in lokale probleempercepties en beoogde oplossingsstrategieën. In hoofdstuk 5 maken de vage beleidsfiguren gebruik van de institutionele leegte die is ontstaan als gevolg van verantwoordelijkheidsstructuren die niet tot nauwelijks passen bij de totstandkoming van (regionale) samenwerkingsverbanden. Dit hoofdstuk toont de opkomst van een type bemiddelende actor die wordt ingezet om veranderingen in het veld te bewerkstelligen.

Vanuit een pragmatisch perspectief op netwerken kom ik tot de volgende typering van het soort werk dat hiermee is gemoeid:

(1) *Zorgen voor netwerken als een kwestie van maatschappelijke zorg om collectief leren te bevorderen*. Dit omvat de erkenning dat samenwerkingsverbanden een belangrijke maatschappelijke bron zijn om te leren over het werken in en met netwerken. Het omvat ook het herkalibreren en problematiseren van het huidige netwerkdiscours om zowel donkere kanten als kansen te verhelderen.

(2) *Zorgen door netwerken om uiting te geven aan strategische waarden*. Dit omvat het strategisch positioneren van actoren op een zodanige manier dat de spanningen die inherent zijn aan netwerken productief gemaakt worden. Netwerken gaat namelijk niet alleen gepaard

met onzekerheden en dubbelzinnigheden, maar biedt ook potentieel voor verandering in organisaties en in beleid. Dit vraagt creativiteit om onzekere omstandigheden zo te vervormen dat deze in nieuwe strategische paden vertaald kunnen worden.

(3) *Zorg dragen voor netwerkdoelen en ambities om diverse betrokkenheid mogelijk te maken.* Dit omvat het herstructureren van netwerken naar meer diverse en democratische praktijken van zorg. Dit vraagt om zorg dragen voor betrokkenheid van een brede groep actoren en doelvorming door (langdurige) ondersteuning. Diverse betrokkenheid is noodzakelijk om te voorkomen dat netwerken louter een praktijk wordt voor elite actoren.

(4) *Het maken van een plek om netwerken legitiem te maken als antwoord op lokale behoeften.* Hier gaat het over waar samenwerkingsverbanden zich moeten ontvouwen, met wie en voor welke behoeften van burgers. Hieraan ten grondslag liggen sturingsobjecten die netwerken een meer 'verantwoordelijke' praktijk van zorg maakt. De constructie van 'de regio' als sturingsobject om te netwerken gaat bijvoorbeeld gepaard met claims over wat (kwaliteit van) zorg omvat en wie daarvoor verantwoordelijk is.

De dimensies van een kritisch-pragmatisch begrip van zorgende netwerken komen voort uit de leefwereld van actoren, zijn minder netjes en doordrenkt met wensdenken, en dus—zo is een centrale conclusie van dit proefschrift—intelligenter en daarmee passender voor de omgang met publieke problemen. Een kritisch-pragmatisch begrip ziet zorgende netwerken als een veelzijdige (relationele) infrastructuur om collectief leren over netwerken als werkwoord mogelijk te maken, en als manier om 'professioneel aanmodderen' een plek te geven in het regionaal samenwerken aan zorg en productief te maken. De etnografie van zorgende netwerken is een

pleidooi om netwerken niet te romantiseren, maar om vanuit een kritisch-pragmatisch perspectief zorg te dragen voor een sturingsorde in de maak die leunt op (regionale) netwerken. De etnografie van zorgende netwerken is een uitnodiging om de rommeligheid van netwerken te erkennen en benutten voor het realiseren van passende antwoorden op urgente zorgvragen.

Dit proefschrift heeft implicaties en aanbevelingen voor beleid, praktijk en netwerkonderzoek. Een sluimerend gevaar voor beleidsmakers (en politici) is het vereenvoudigen of reduceren van de dagelijkse gevolgen van netwerken voor betrokkenen. Leren van verhalen over netwerken uit het veld is daarom belangrijk. Hiermee worden de bijzonderheden van netwerken concreet gemaakt, wat de (politieke) waardensystemen die centraal staan in het netwerkbeleid verrijken en verbreden.

De beschreven relaties en interacties in netwerk- en regiovorming in dit proefschrift roepen bovendien de vraag op hoe (burger)vertegenwoordiging georganiseerd kan worden en met welke verantwoording. Zorgende netwerken produceren namelijk vormen van in- *en* uitsluiting. Netwerkvorming 'integreert' niet alleen, maar sluit ook actoren, kennis en perspectieven uit. Bewustzijn is hiervoor nodig om netwerken een diverse en democratische praktijk van zorg te maken in een veranderende welvaartstaat.

Hoewel dit proefschrift laat zien dat het structureren netwerken in alternatieve sturingsmogelijkheden resulteert, gaat netwerken ook gepaard met de nodige bestuurlijke en professionele drukte en 'projectificatie' met tijdelijke budgetten en kleinschalige experimenten. Inzicht in de gevolgen van dergelijke (conflicterende) coordinatiestructuren kan beleidsmakers helpen om de proliferatie aan netwerkvormen in te dammen.

Een andere implicatie betreft de ontwikkeling van netwerken als object van inspectie. Huidige regelgeving richt zich veelal op be-

staande, min of meer zichtbare, *individuele* netwerken die als zodanig geïdentificeerd kunnen worden. De veronderstelling is dat 'het netwerk' aangesproken en ter verantwoording geroepen kan worden. De etnografie van zorgende netwerken laat echter zien dat nieuwe culturen van (democratische) verantwoording en responsiviteit in de (be)sturing van zorg nodig zijn. Dit omvat enerzijds het herformuleren van geïnstitutionaliseerde verantwoordelijkheden, en anderzijds het heroverwegen van de interacties tussen beleid en praktijk om over netwerken te leren voor toezicht en bestuur. Hoofdstuk 3 leert dat netwerkplatforms met lenigheid in doelvorming in alternatieve sturingsmogelijkheden resulteert om grip te krijgen op een vernetwerkte zorgcontext.

De toenemende nadruk op netwerken als praktijk van zorg vraagt van zorgprofessionals en bestuurders om opkomende onvolkomenheden te verdragen, maar óók om hieraan verder te sleutelen en zich in het netwerken te bekwamen.

Op basis van mijn onderzoek concludeer ik dat netwerkonderzoek gebaat is bij verdere empirische verkenning van wat zich afspeelt tussen bestuurlijke en professionele niveaus, tussen geografische plaatsen, en hoe dergelijke 'tussenruimten' de interacties en afhankelijkheden tussen beleid en praktijk herconfigureren, en met welke gevolgen voor burgers. Netwerkonderzoek gaat hiermee verder dan alleen analyse op systeemniveau óf implementatievraagstukken op werkvloeren. De coördinatie tussen die analytische niveaus omvat niet alleen 'zichtbare' organisatie- en beleidsniveaus, maar ook onontdekte ruimten, 'vage beleidsfiguren' en rommeligheid. Dergelijke analyses vormen de basis voor een maatschappelijke bestuurskunde die sensitief is voor sociale ervaringen aangaande zorgende netwerken. Etnografisch onderzoek is hierbij belangrijk omdat het zicht biedt op de beleefde werkelijkheid van actoren en praktijken van netwerken. Ten tweede is het problematiseren van de donkere kanten van netwerken noodzakelijk. Dit proefschrift laat zowel de sturingsmogelijkheden als de (on)verwachte onzekerheden zien.

Verder onderzoek naar wat netwerken betekent voor de herverdeling van professionele taken en met welke impact voor formele en informele zorgverleners en wat 'goede zorg' dan omvat is wenselijk. Ten derde kan netwerkonderzoek meer in dialoog gaan met diverse methodologische grondslagen, zoals sociale ontwerpers, om tunnelvisie te voorkomen. Het is tijd voor een gedemocratiseerde 'netwerkwetenschap voor de samenleving' die rijkelijk put uit de leefwereld van actoren.

Tot slot: de etnografie van zorgende netwerken geeft inzicht in hoe de 'netwerkonderzoeker' zich positioneert tijdens grootschalige beleidsveranderingen die zijn geënt op (regionale) netwerken. Netwerkonderzoekers begeven zich namelijk tussen verschillende organisatie- en beleidsniveaus. Dit vraagt om het steeds weer bespreekbaar maken van de identiteit; gevoel te ontwikkelen voor verschillende strategieën van interacties met actoren; vertrouwd te raken met sociaal-culturele dynamieken en de geografische plaats van de netwerklocaties, en te temporiseren om 'blinde vlekken' te herkennen in het dominante netwerkdiscours.

Dankwoord

'*Peace, love and understanding*'. Dat waren de woorden die jij, Roland Bal, als reactie gaf op een iets te harmonieuze notitie die ik schreef over bestuurskundige samenwerkingsliteratuur tijdens een van de eerste begeleidersbijeenkomsten met Wilma van der Scheer. Aan die uitspraak heb ik in de afronding van dit proefschrift vaak gedacht. Je scherpte, toegankelijkheid en persoonlijke betrokkenheid—zeker in de afgelopen maanden—heb ik enorm gewaardeerd. Mede daardoor kon ik oefenen in het lenig gebruiken van theoretische concepten—en, zo blijkt jaren later, veelal vanuit een kritische grondhouding. De gegeven ruimte om binnen en buiten de Healthcare Governance vakgroep verschillende paden te verkennen, zoals het coördinatorschap aan de Vrije Universiteit Amsterdam, zijn verrijkend geweest. En dat steeds met aanmoediging en een hoop gezelligheid. Ik wens je dit jaar mooie avonturen toe.

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Terugkijkend kan ik zeggen: het is prettig werken met jullie. En ik kijk ernaar uit om hier verder op voort te bouwen.

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Het fundament van dit proefschrift is de openheid van vele en verschillende actoren, variërend van verpleegkundigen tot bestuurders en van lokale en nationale beleidsmakers tot netwerk coördinatoren. Dank dat jullie—werkend op verschillende plekken in beleid, bestuur en praktijk en geografische plaatsen zoals Zeeland, Friesland en Groot-Rijnmond—jullie werkpraktijken openstelden. En bovendien bereid waren om hier met elkaar over in gesprek te blijven. Ik hoop dat dit proefschrift voor jullie herkenning oproept en dat het een waardevol middel is om verder te reflecteren op netwerk- en regiovorming tijdens grootschalige beleidsveranderingen. Dank aan Lizette Berkx en Marlise Schouten voor het fijn samenwerken in het BeterKeten evaluatieonderzoek. Jennie Janssens, onze verkenning van het 'netwerk aan samenwerkingen' in Groot-Rijnmond—en de thematische presentatie die we mochten geven—was terugkijkend een belangrijk startpunt van dit proefschrift.

Het schrijven van een proefschrift is groepswerk. Een belangrijke plek is daarom de 'RegioZ' projectgroep (en later 'Medisch-Generalistische Zorg in de Regio') geweest. Jitse Schuurmans, Iris Wallenburg, Roland, Nienke van Pijkeren, Hanna Stalenhoef, Dara Ivanova, Sander van Haperen en later Estella Posthuma en Laura Polfliet; dank voor het samen optrekken in het schrijven van regio-inventarisaties, veldnotities, rapportages en diverse artikelen, het uitvoeren van vele interviewrondes en observaties, het voorbereiden

en geven van presentaties, groepsanalyses tijdens projectoverleggen en het organiseren van focusgroepen en netwerkbijeenkomsten. Ook de prettige samenwerking met de projectcollega's bij Vilans zoals Joyce Theunissen en Marloes Berkelaar en later het Ministerie van Volksgezondheid, Welzijn en Sport benoem ik hier graag. Jitse, wat is het avontuurlijk en belangrijk om knelpunten in de praktijk te agenderen en te plotten op beleidsniveaus. Ook waardeer ik het meedenken en het vormen van een uitdagende rol in het vervolgonderzoek van RegioZ. Iris, dit proefschrift bevat veel sporen van onze gesprekken over literatuur en praktijk. Het kritisch meedenken tijdens de jaarlijkse evaluatiegesprekken hielp om richting te kiezen. Dat je mij uitnodigde om bij te dragen aan de bijeenkomst in het Kunstinstituut Melly over het boek *'Zusters uit Suriname'* van wijlen Annemarie Cottaar tekent je persoonlijke betrokkenheid en is een van de mooiste herinneringen uit mijn proefschrift periode. Nienke en Hanna, jullie collegialiteit heb ik zeer gewaardeerd. En wat was het leuk om samen de *'Caring geographies'* conferentie te organiseren en dit terug te horen tijdens de uitreiking van de Pauline Meurs award. We begonnen samen in het RegioZ project en hebben verschillende paden bewandeld. Ik blijf jullie graag volgen. Estella en Laura, wat is het een voorrecht om van dichtbij te zien hoe jullie je plek aan het vinden zijn. Ik kijk ernaar uit om verder samen op te trekken.

De vakgroep Healthcare Governance, van Amalia Hasnida tot Jan-Willem Weenink en van Nada Akrouh tot Leonoor Gräler; dank voor de inspirerende groep mensen die jullie zijn. Of het nu de belezenheid van Marcello Aspria betreft, het ongenuanceerd schoppen tegen de status quo met Martijn Felder, de ontnuchterende houding van Sabrina Rahmawan-Huizenga, het werkethos van Gijs Steinmann, de taligheid van Annemiek Stoopendaal, de open blik van student-assistenten zoals Raaba Thambithurai, de *smoothness* in voorkomen van Sander van Haperen, of de vrijdagmiddag anekdotes van Kim Putters, het is een plezier om van jullie te leren. Een plek die ruimte geeft om gedachten te delen. Die alle-

daagse onderzoeksmomenten doen ertoe. Dank, Lieke Oldenhof, voor het regelmatig delen van je scherpe ideeën. Jolien van der Sande, Tessa van Dijk en Koray Parmaksiz: wat is het gezellig en ontspannen om met jullie dit proces te doorlopen. En elkaar steeds weer te blijven herinneren: er is zoveel meer. Jolien, ik vind het eervol dat je als paranimf naast mij staat. Robert Borst, jouw aanwezigheid maakt een werkdag net wat leuker. Altijd valt er immers wel wat te bespreken, nietwaar? Ik kijk eveneens uit naar het verder optrekken samen. Susan Hoefnagel, veel dank voor hoe wij in meerdere opzichten als vak- en projectgroep op je kunnen bouwen. Ik kijk ernaar uit om verder te leren van jullie allen.

Tijdens dit proefschrift is het een voorrecht geweest om (steeds meer) te bewegen in de omgeving van het Erasmus Centrum voor Zorgbestuur, bijvoorbeeld in de Academische Werkplaats Zorgbestuur en in verschillende onderwijsprogramma's. In het bijzonder dank ik Petra Verweij, Bianca de Haan, Mies Mikx en Marielle Borst voor jullie werk om de vele onderzoeks- en onderwijsinitiatieven werkbaar en publiekelijk te maken. Dank, Relinde de Koeijer-Gorissen, dat je vertrouwen in mij uitsprak en uitdaagde tijdens de Academische Leergang Zorgmanagement om mijn rol in het onderwijs verder vorm te geven. En ook Maarten Janssen, Maaike Moen, Laura de Bruijn en Kees Ahaus; tof dat we samen de Master of Health Business Administration mogen vormgeven en de gegeven ruimte om hierin te leren van jullie. Ook is dit voor Frank Breemer van toepassing voor de leergang Regie in Zorgnetwerken en Zorgketens, en Richard Janssen en Pauline Meurs in vele informele gesprekken (over Suriname). Ik kijk ernaar uit om verder te bouwen op het snijvlak van onderzoek en onderwijs binnen het Centrum en het thema van gedeeld leiderschap (in netwerken) verder te verdiepen.

Het gave aan de afgelopen jaren is dat ik van scherpe denkers heb mogen leren, veelal via cursussen en bijeenkomsten georganiseerd door de Netherlands Institute of Governance (NIG) onderzoeks-

school en aanpalend het Critical Interpretative Public Administration (CIPA) research colloquium. Yvonne La Grouw, Lianne Visser en Wieke Blijleven: jullie werk vormt een belangrijke inspiratiebron en onze gesprekken in de afgelopen jaren hielpen om de bevindingen in dit proefschrift te overstijgen en breder te duiden. Vikas Soekhai, het samen optrekken in het onderzoeken van de Surinaamse zorgcontext heeft ons op onverwachte plekken gebracht en ik kijk uit naar wat komen gaat. Herman Meinhardt, Thomas Reindersma, Nick Zonneveld, Robin Peeters, Galina Léoné-van der Weert, Ferayed Hok, Sarah van Duijn, Erik-Jan van Dorp en Farzad Kananpour, onze doorlopende gesprekken waarin we onze verwondering deelden waren behulpzaam en fijn. Ook de vele interacties met studenten in werkgroep- en collegezalen vormen een inspiratiebron. Jullie doordachte vragen en reflecties hielpen om onderzoeksbevindingen scherp(er) te formuleren. Ik kijk er ook naar uit om verder te leren van jullie. Het speuren naar onderbelicht werk van studenten en het geven van begeleiding in het publicatieproces bij de Public Note redactie was hierom een verrijkende periode.

Tijdens dit proefschrift was de warme betrokkenheid van familie en vrienden voelbaar. Pa en ma, dit proefschrift draag ik aan jullie op. En dat was geen moeilijke keuze. Dat ik op jullie schouders verder mag bouwen en het leven mag ontdekken maakt mij trots en dankbaar. In het bijzonder waardeer ik jullie manier van geloven; een geloof vooral van *doen* door naast anderen te staan. En wat is het bijzonder om op te merken dat anderen ook ruimhartig om jullie heen staan in het revalidatieproces van jou, ma. De kwetsbaarheid van het leven werd letterlijk voelbaar afgelopen december; en dat bood ook ruimte om meer van hart tot hart te spreken. Wij zijn blij dat je bij ons bent. Pa, de jaarlijkse roadtrips kan ik hier natuurlijk niet onbenoemd laten; het zijn betekenisvolle momenten van ontspanning geweest.

Mijn *bhai's*, Jay en Marcus, we vormen een bijzonder stel samen—

althans, dat horen wij vaak anderen zeggen, maar wij hebben regelmatig lol over onze verschillen. Jay, dank voor je vele adviezen door de jaren heen. En Marcus, terwijl ik dacht dat het schrijven van een proefschrift een kunst is, ben ik tot de conclusie gekomen dat wat jij als allesklusser doet pas écht vakwerk is. Ik heb daar oprecht bewondering voor. Dank dat je naast mij staat als paranimf. Risha, Pushpa, en ook de warme familie Kars, dank voor de vele gezellige momenten en ontspanning tijdens familievakanties, verjaardagen of 'gewoon' tussendoor. Darshan, Roshan en Arjun, dat ik jullie *kaka* mag zijn is de titel die ertoe doet (en wat ben ik blij dat het *adja* en mij is gelukt om jullie supporters van Feyenoord te laten worden). Ik kan niet wachten om te zien wie jullie worden. Wanneer gaan we weer voetballen?

Mijn familie Ramkisoen in Suriname, wat voel ik mij thuis bij jullie, daar in het stadse van Blauwgrond of nabij de uitgestrekte rijstvelden in Nickerie. In het bijzonder noem ik graag Sara en Betie mausi, Stan, André, Alfred en Roy mamu. Jullie betrokkenheid van kleins af aan—zo ver weg maar toch dichtbij—koester ik. Ik kijk ernaar uit om jullie weer te zien en mijn eeuwig gebrekkige Sarnámi verder aan te scherpen. En toch mag ik met trots zeggen: ik ben een Hindoestaan. *Phir milenge*.

Yrith, Patrick, Rick, Regi, Gerlof en Arend; jullie vriendschap is mij veel waard. De gezellige filmavondjes uit, sportsessies, voetbalavonturen, rapconcerten, stedentrips, proeverijen, en beschouwingen over actualiteiten en het wel en wee van het leven zijn fijne momenten van ontspanning geweest. We bewandelen onze eigen paden en wat is het tof om elkaar daarin te ondersteunen. Rick en Arend, wat was het heerlijk om in het bruisende Oud-Charlois samen te wonen; een plek die ons elke keer weer bleef verwonderen en inspireren. Dank dat jullie mij stimuleerden en de ruimte gaven om dit proefschrift af te ronden (en een luisterend oor boden als ik plots weer op de praatstoel ging zitten na een stille schrijfsessie).

Lieve Roos, ik eindig dit dankwoord met jou. Tijdens de tweede helft van dit proefschrift leerden wij elkaar kennen en wandelden we de Kralingse Plas rond. Je werd daarmee óók onderdeel van een langdurig afrondend *proces*—al kon je dat woord op een gegeven moment niet meer horen. Nu, een tijd later, ben ik blij dat we zijn blijven wandelen en liefhebben en zeg ik met enthousiasme: ik kijk uit naar het toekomstproces met jou. Jij geeft zoveel glans.

PhD Portfolio

Author details

Name:	Oemar Sardjoe van der Woerd
Department:	Section Healthcare Governance and Erasmus Center for Healthcare Management
Institution:	Erasmus School of Health Policy & Management, Erasmus University Rotterdam
PhD period:	2018-2023
Promotors:	Prof. Wilma van der Scheer and Prof. Roland Bal

	Publications	Article type
2020	**van der Woerd, O.**, & Soekhai, V. (2020). Surinam's Response to the Coronavirus Pandemic. *Cambridge Core HEPL blog series*. Retrieved from https://www.cambridge.org/core/blog/2020/04/18/surinams-response-to-the-coronavirus-pandemic/	Viewpoint
2020	Kruse, F., van Tol, L., Vrinzen, C., **van der Woerd, O.**, & Jeurissen, P. (2020). The impact of COVID-19 on long-term care in the Netherlands: the second wave. *International Long Term Care Policy Network, 9*. https://ltccovid.org/wp-content/uploads/2020/11/COVID-19-Long-Term-Care-situation-in-the-Netherlands-_-the-second-wave-25-November-2020-2.pdf	Research report
2021	**van der Woerd, O.**, van Veen-Berkx, L., Schouten, M., van der Scheer, W., & Boonstra, J. (2021). Zorgnetwerken vergen bestuurlijke lenigheid. *Skipr 14*(3), 72–79. https://doi.org/10.1007/s12654-021-0782-7	Essay
2021	Kruse, F., Jeurissen, P., Abma, T., Bendien, E., Wallenburg, I., van de Bovenkamp, H., Peeters, H., Stalenhoef, H., Steinmann, G., & **van der Woerd, O.** (2021). *Houdbare ouderenzorg – Ervaringen en lessen uit andere landen*. Wetenschappelijke Raad voor het Regeringsbeleid (WRR), Working paper 42. https://www.wrr.nl/adviesprojecten/houdbare-zorg/documenten/working-papers/2021/02/08/houdbare-ouderenzorg-–-ervaringen-en-lessen-uit-andere-landen	Working paper
2021	Schuurmans, J., Wallenburg, I., van Pijkeren, N., **van der Woerd, O.**, Stalenhoef, H., Ivanova, D., van Haperen,	Research report

	S., & Bal, R. (2021). *Duurzame Medische Zorg in de Regio. Een actieonderzoek naar initiatieven om de medisch-generalistische zorg voor ouderen toekomstbestendig te maken.* Erasmus School of Health Policy & Management, Erasmus Universiteit Rotterdam.	
2021	van Veen-Berkx, E., Schouten, M. S., & **van der Woerd, O.** (2021). *BeterKeten: Samen voor betere zorg. Evaluatieonderzoek 2020.* Erasmus Centrum voor Zorgbestuur.	Research report
2021	**van der Woerd, O.,** & Soekhai, V. (2021). Rethinking Suriname-Dutch ties in uncertain times. *Public Note,* 8. https://www.public-note.com/suriname-netherlands-ties-678103-695421.html	Viewpoint
2022	**van der Woerd, O.**, van Veen-Berkx, E., van der Scheer, W., & Bal, R. (2022). How does a Network Platform Work for Participating Actors Towards Integrated Care Governance? A Case Study of a Dutch Hospital Region. *International Journal of Integrated Care*, *22*(4). https://doi.org/10.5334/ijic.6736	Original research
2022	Schuurmans, J., v**an der Woerd, O.**, Bal, R., & Wallenburg, I. (2022). Regionalisering in de ouderenzorg. *Beleid en Maatschappij*, *49*(3), 220-239. doi: 10.5553/BenM/138900692022005001	Original research
2023	**van der Woerd, O.**, Janssens, J., van der Scheer, W., & Bal, R. (2023). Managing (through) a network of collaborations: A case study on hospital executives' work in a Dutch urbanized region. *Public Management Review*, 1-23. https://doi.org/10.1080/14719037.2023.2171093	Original research
2023	**van der Woerd, O.**, Wallenburg, I., van der Scheer, W., & Bal, R. (2023). Regional network-building for complexity: A region-oriented policy response to increasing and varied demands for older person care in the Netherlands. *Public Administration*, 1–18. https://doi.org/10.1111/padm.12931	Original research
2023	van der Weert, G. E., **van der Woerd, O.**, & Zonneveld, N. (2023). Normatieve afwegingen in onderzoek naar zorgnetwerken. De meerwaarde van inzicht in structuren én praktijken. *Bestuurskunde, 32*(2), 67-76. doi: https://doi.org/10.5553/Bk/092733872023032002009	Viewpoint
2023	Schuurmans, J., **van der Woerd, O.**, van Pijkeren, N., Polfliet, E., Posthuma, E., Bal, R., & Wallenburg, I. (2023). *MGZ in de regio. Een inventarisatie van formatieproblemen, knelpunten en oplossingsrichtingen in de medisch-generalistische zorg in Wlz-regio's.* Vilans en Erasmus Universiteit Rotterdam.	Research report

2024	**van der Woerd, O.**, Schuurmans, J., Wallenburg, I., van der Scheer, W., & Bal, R. (2024). Heading for health policy reform: transforming regions of care from geographical place into governance object. *Policy & Politics* (published online ahead of print). doi: https://doi.org/10.1332/03055736Y2024D000000030	Original research
2024	**van der Woerd, O.**, & Soekhai, V. (2024). Healthcare policy reforms in postcolonial countries: Putting Surinamese developments in context. *Developmental Medicine & Child Neurology* (published online ahead of print). https://doi.org/https://doi.org/10.1111/dmcn.15929	Viewpoint

	Training courses	**Organization**
2019	Formulating and answering research questions	Netherlands Institute of Governance (NIG)
2019	Doing the (systematic) literature review	Erasmus Graduate School of Social Sciences and the Humanities (EGSH)
2019	Responsible research data management	EGSH
2019	Getting it published	NIG
2019	Classics in Public Administration and Political Science	NIG
2019	How to finish your PhD in time	EGSH
2020	Academic writing in English	EGSH
2020	Writing ethnographic fieldnotes (workshop)	Research colloquium Critical Interpretative Public Administration (CIPA)
2021	Collaborative governance for public value, innovation and the role of leadership	NIG
2021	Responsibility and integrity in research and advice	NIG
2022	Partial University Teaching Qualification (BKO) ('delivery' component)	Risbo
2022	Network and collaborative governance: Theories, methods and practices	NIG
2023	University Teaching Qualification (BKO)	Risbo

	Teaching activities	Program
2018-2019	Advanced Research Methods	Master Health Care Management
2018-2024	Governance & Strategy	Master Health Care Management
2019-2020	Wetenschapsfilosofie	Bachelor Health Sciences
2019-2020	AVV Ziekte en Gezondheid	Bachelor Health Sciences
2020-2024	Comparative Health Policy	Master Health Economics, Policy and Law
2020-2022	Academische Leergang Zorgmanagement (program assistant)	Erasmus Center for Healthcare Management
2021-2022	Quality & Safety	Master Health Care Management
2021-2022	Thesis supervision	Institute of Social Studies and FHR Institute for Higher Education, Suriname
2021-2022	Serious game development ('Pandemic game')	Bachelor Health Sciences and Risbo
2022-2023	Panelist Genomics and the City assignment	Master Genomics in Society, Erasmus MC
2022-2023	Besturen van Zorgvernieuwing (coordinator)	Master Public Administration, Vrije Universiteit Amsterdam
2022-2023	Module Strategie en beleid in de publieke gezondheid (reviewer assignments)	Netherlands School of Public & Occupational Health
2023-2024	Thesis supervision	Master Health Care Management
2023-2024	Executive Master Health Business Administration (program manager)	Erasmus Center for Healthcare Management
2023-2024	Regie in Zorgnetwerken en Zorgketens (program coordinator)	Erasmus Center for Healthcare Management
2023-2024	Governing Healthy Cities (lecturer)	Master Health Economics, Policy and Law

	Presentations	Organization
2019	Guest lecture *'Introductie in de besturing van de zorg'*	Bachelor Open Day, EUR
2019	Seminar presentation *'Zorgnetwerken: wat we (nog niet) weten over netwerkbe-*	Erasmus Center for Healthcare Manage-

	sturing'	ment
2019	Research presentation *'Op weg naar regionalisering: Duurzame medische zorg voor ouderen'*	Platform 'Netwerk zorg' Zeeland
2020	Research presentation *'Healthcare governability in a network society: A multi-actor approach on leading principles for governing beyond silos'*	EHMA Conference
2020	Research presentation *'Regional network-building: How a Dutch rural area responds to increasing and distributed demands for older person care'*	IJIC Conference
2020	Research presentation *'Evaluatie BeterKeten: resultaten en vervolgstappen'*	Board meeting BeterKeten
2020	Alumni seminar presentation *'Gedeeld besturen in de zorg: wat, waarom en hoe?'*	Health Business Week
2020	Guest lecture *'Besturen in en door netwerken: theorie en praktijk'* (Master Class)	Erasmus Center for Healthcare Management
2021	Seminar presentation *'Rethinking Suriname-Dutch ties in uncertain times'*	Erasmus Migration & Diversity Institute
2021	Research presentation *'Networking practice: A realistic evaluation of four disease-specific networks'*	IRSPM Conference
2021	Research presentation *'Wat is de synergie van netwerken? Een realistische evaluatie na(ar) 10 jaar BeterKeten'*	BeterKeten Conference
2021	Research presentation *'Governing (through) networks: An explorative research on the consequences of multiple network involvement for hospital governability'*	NIG Conference
2022	Reflective presentation on the book 'Zusters uit Suriname' (2003) from Annemarie Cottaar as part of the 'Dutch Nurses' session	Kunstinstituut Melly
2022	Guest lecture *'Ontwerpen of ontwikkelen? Beleidsvorming in perspectief'* (module 'Strategie & Beleid')	Netherlands School of Public & Occupational Health
2022	Seminar presentation *'Regionalisering in de ouderenzorg: geleerde lessen'*	ESHPMa
2022	Research presentation *'Mediating policy figures for large-scale healthcare change:*	NIG Conference

	The case of regional networks in Dutch older person care'	
2023	Guest lecture *'Ontwerpen of ontwikkelen? Beleidsvorming in perspectief'* (module 'Strategie & Beleid')	Netherlands School of Public & Occupational Health
2023	Seminar presentation *'Bestuurlijke lenigheid: theorie en praktijk van netwerkbesturing'*	Antonius Zorggroep, strategy day
2023	Seminar presentation *'Handelingspraktijken van regionalisering in de ouderenzorg'*	Healthcare Inspectorate, section 'Netwerktoezicht'
2023	Seminar presentation *'Het (be)sturen van zorgnetwerken: navigeren door een multi-netwerk context'*	Ministry of Health, section 'Goed bestuur'
2023	Guest lecture *'Navigeren door de zorgregio: een sturingsobject in de maak?'*	Vrije Universiteit Amsterdam
2024	Seminar presentation *'Rediscovering 'the region' as a governance order in the Netherlands*	Radboud University, IMR Academy
2024	Research presentation *'Mediating policy figures for large-scale healthcare change: The case of regional networks in Dutch older person care'*	European Health Policy Group (EHPG) Spring Meeting

	Policy engagement	**Contribution**
2020	Group discussion 'Working pressure and teaching' with Minister of Education, Culture and Science as part of EUR visit	Participant
2022	Essay 'De regio als redding?' (The Council of Public Health & Society)	Expert opinion
2022	V-100 Verantwoordingsdag panel 'Healthcare workforce' (Parliament commission Ministry of Health)	Participant
2023	Group discussion on educational innovation and impact with Surinamese Minister of Education, Culture and Science as part of EUR visit	Participant
2023	'Werkagenda 2024-2028' (The Council of Public Health & Society)	Expert opinion

	Recognition	Organization
2020	Nomination Kees van Wijk Education Award	ESHPM
2023	Pauline Meurs Impact Award	ESHPM

	Ancillary activities	Organization
2019	Working group member 'Herziening strategie ESHPM'	ESHPM
2020	yESHPM board position 'External affairs and relations'	ESHPM
2020	Explorative study 'Netwerkzorgmodellen en de toepasbaarheid hiervan voor het Surinaamse binnenland'	Stichting Bonama en Medische Zending
2021	Member Jong Genero (participant 'Levenspadcast', episode 5)	Genero
2021	Co-editor in chief Public Note	Public Note
2022	Co-organizer conference 'Caring geographies'	ESHPM
2022	Panel chair 'Critical Interpretative Public Administration'	NIG
2023	Reviewer for several journals	IJIC, IRSPM, NTVG

About the author

Photo made by Kunstinstituut Melly

Oemar van der Woerd (1993) — born in Helmond, the Netherlands, and living in Rotterdam — is currently working as a Postdoctoral researcher in the Department of Healthcare Governance and the Erasmus Center for Healthcare Management of Erasmus School of Health Policy & Management, Erasmus University Rotterdam. Through primarily ethnographic research methods, his research focuses on the meaning and practice of governing across traditional organizational boundaries for healthcare organizations and their management. He aims to shed light on how situated actors work within networked healthcare settings.

Before starting his PhD, Oemar has completed a BSc degree in Health Sciences and MSc degrees in Healthcare Management and Public Administration (specialization in Policy & Politics), all at Erasmus University Rotterdam. After his studies, he carried out his PhD research at the Department of Healthcare Governance and the Erasmus Center for Healthcare Management of the Erasmus School of Health Policy & Management. As part of the PhD representation board of ESHPM in 2020, he co-organized various seminars on career development and the science-policy intersection.

In his research, he follows a practice-based governance approach to explore networking processes among a variety of actors who oper-

ate on different organizational and policy levels. As a 'network researcher', he concentrates on the (everyday) actions and interactions that specific actors undertake in concrete situations—and the dynamics between them—against wider webs of governance and institutional arrangements. His research interests hence include the enactment of network and collaborative governance, health policy reforms (and in particular processes of regionalization), as well as health and care developments in postcolonial countries like Suriname.

Over the course of his PhD research, he has published articles in national and international peer-reviewed journals such as Public Management Review, Public Administration, Policy & Politics, the International Journal of Integrated Care, and Beleid en Maatschappij. He also co-authored various research reports about (the organization of) older person care and hospital care, and presented his research on national and international conferences, as well as in healthcare organizations and a variety of network gatherings.

Alongside his research, Oemar enjoys teaching. He obtained a University Teaching Qualification (BKO) in 2023, received the Pauline Meurs Impact Award together with the 'RegioZ' project team in 2023, and was nominated for the Kees van Wijk Education Award in 2020. He has taught in several bachelor and master courses in the field of healthcare management, health policy, and public administration, served as a guest lecturer, speaker, and coordinator, and supervised thesis students of various study programs.

In his spare time, Oemar likes to read about Surinamese history, visiting cultural events and rap and hip-hop concerts, and playing (indoor) soccer.