Chapter one
General introduction

"When it comes to government policy, I tend to think, 'please, just let me be and let me do my work.' All those plans… I mean, I'll just see what comes round. I mean, considering all the changes that happened in the last three years, it's impossible to anticipate how it will be in ten years from now."

Interviewer: I understand.

"You have to go about it day by day. I mean, of course you have to be up to date and check what's happening. But you can't predict everything, and you can't be ahead of everything, or reason or anticipate what will happen. Surely that's one thing we've learned in the last two-three years!"

Interviewer: So, looking back on the past three years, how would you describe your work?

[With a cynical grin]

"TUR-BLUE!

On the national policy level and within our organization a lot has changed. This made it rather turbulent, to say the least. But I guess that's actually also why I continue to like it. I have tried to stop worrying about it, though it's nonetheless tiring at times. Then I think, 'Oh boy, they're thinking of something new!'" (Nurse, interview, fall 2016).

Signifying the subject of study in this dissertation, the nurse is reflecting on changes in the Dutch home-care sector, and how she has experienced these. The Dutch home-care sector is probably best characterized as a complex and dynamic institutional environment.

Institutional complexity refers to the coexistence of multiple institutional logics (Greenwood et al., 2011; Kraatz & Block, 2008). Institutional logics are "the socially constructed, historical patterns of cultural symbols and material practices, including assumptions, values, and beliefs, by which individuals and organizations provide meaning to their daily activity, [and] organize time and space" (Thornton, Ocasio, & Lounsbury, 2012, p. 2; see also Friedland & Alford, 1991). Institutional complexity thus implies the existence of multiple beliefs, valued ends and associated practices. Within a complex institutional environment, dominant and less dominant, but nonetheless influential, logics jointly guide...
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[With a cynical grin] “TUR-BU-LENT! On the national policy level and within our organization a lot has changed. This made it rather turbulent, to say the least. But I guess that’s actually also why I continue to like it. I have tried to stop worrying about it, though it’s nonetheless tiring at times. Then I think, ‘Oh boy, they’re thinking of something new again!’” (Nurse, interview, fall 2016).

Signifying the subject of study in this dissertation, the nurse is reflecting on changes in the Dutch home-care sector, and how she has experienced these. The Dutch home-care sector is probably best characterized as a complex and dynamic institutional environment. Institutional complexity refers to the co-existence of multiple institutional logics (Greenwood et al., 2011; Kraatz & Block, 2008). Institutional logics are “the socially constructed, historical patterns of cultural symbols and material practices, including assumptions, values, and beliefs, by which individuals and organizations provide meaning to their daily activity, [and] organize time and space” (Thornton, Ocasio, & Lounsbury, 2012, p. 2; see also Friedland & Alford, 1991). Institutional complexity thus implies the existence of _multiple_ beliefs, valued ends and associated practices. Within a complex institutional environment, dominant and less dominant, but nonetheless influential, logics jointly guide
and inform peoples’ day-to-day practices. As will become clear throughout this dissertation, institutional complexity in the Dutch home-care sector particularly comprised the co-existence of a professional care logic and a logic of managed care. Briefly, a professional care logic reflects values and practices such as client-centeredness, professional autonomy, competence, effectiveness and care delivery that does not harm the client (Goodrick & Reay, 2010), while a logic of managed care is characterized by values and practices such as accountability, control, efficiency, transparency, and standardization (Thomas & Hewitt, 2011).

Over time, the layering and relative dominance of co-existing logics in an institutional environment may be subject to change (Goodrick & Reay, 2011; Van de Bovenkamp et al., 2014). As such, institutional change “can be described as a process of layering (Mahoney & Thelen, 2010): new layers overlie others but do not replace them or do away with them” (Van de Bovenkamp et al., 2014, p. 211). Although institutional change can happen rather abruptly, “in dramatic episodes that present large discontinuities with former patterns” (Dacin, Goodstein, & Scott, 2002, p. 48), more often it involves an incremental, fairly subtle process (Dacin et al., 2002; Powell & Rerup, 2017). Either way, institutional change tends to affect the nature and essence of the role and work of people working in a particular sector (Goodrick & Reay, 2011). Institutional change within the Dutch home-care sector has involved (incremental) shifts in the layering of the logic of managed care and the professional care logic, specifically in terms of which logic has been dominant in guiding the organization of the caregiving process over time (Van de Bovenkamp et al., 2014).

It is against this contextual backdrop that I explore and explain how actors in the Dutch home-care sector have perceived and acted upon the co-existence of multiple institutional logics and the shifts in their layering over time. In so doing, I unravel actors’ micro-level perceptions, experiences and practices and how these are informed as well as enhanced and/or constrained by the co-existing institutional logics (Cardinale, 2018; Suddaby, Viale & Gendron, 2016). The following main question guides this endeavor: How do actors in the Dutch home-care sector perceive and act upon co-existing institutional logics as well as alterations in their relative dominance over time?
In the remainder of this introductory chapter my main aim is to provide the reader with the necessary understanding of the complex and changing institutional environment in which this research took place. In what follows, I first provide a brief but comprehensive overview of developments that have characterized institutional complexity and change in the Dutch long-term care sector, of which home-care is part. After that, I detail how these developments have given rise to challenges for home-care organizations, and particularly the people working in them, which are elaborated upon in the empirical chapters that form the core of this dissertation. In doing so, I touch upon the conceptual lenses and perspectives adopted in the empirical chapters. Next, I provide an outline of the research approach and methodology adopted. This is followed by a synopsis of the four empirical chapters.

It needs mention that this introductory chapter thus has as its main aim to contextualize the present research, using concepts from institutional theory, i.e., institutional complexity, institutional change and institutional logics. In turn, the last chapter (six) comprises a more elaborate discussion of the literatures from institutional theory and professions and occupations drawn upon in the empirical chapters. In chapter six, I also delineate the theoretical contributions of this dissertation.

Finally, this dissertation is article-based. It follows that chapters two to five are manuscripts in their own right (i.e., articles published in, or under review and revision for publication in peer-reviewed journals), and can be read as such. As a result, some overlap exists between this introduction and the empirical chapters, in particular with regard to descriptions of the empirical setting as well as the research methodology used.

1.1 Setting the scene: Developments in the Dutch home-care sector

In essence, the nurse quoted at the beginning of this introduction is referring to developments in the Dutch home-care sector in the last few years. However, more broadly, the Dutch long-term care sector – which besides home-care includes care in residential care homes as well as nursing homes, with the latter providing care and support that is more intensive and elaborate – has seen incremental reforms and changes for about three decades (Da Roit, 2013; Oomkens, Hoogeboom, & Knijn, 2015; Van de Bovenkamp et al,
2014; Van der Boom, 2008). I will succinctly describe the changes in the Dutch long-term care sector in the following subsections, focusing on developments at the societal and policy level. The manner in which these developments have affected the organization of the caregiving process and, subsequently, the work of people working in the home-care sector is described after this overview of developments, and further elaborated upon in the empirical chapters of this dissertation.

1.1.1 From local anchor to conglomerates of centralized care delivery

Until about the 1970s, no national health care system existed in the Netherlands (Oomkens et al., 2015). Between the late 19th century and the 1970s, regional and local non-governmental “Cross Associations” provided care, among which home nursing, for their members. These Cross Associations were associated with so-called “pillars” with different religious or ideological orientations that existed in Dutch society for decades.\(^1\) Everyone who was a member of a Cross Association and was insured through similarly pillarized sickness funds had access to care (Oomkens et al., 2015; Van der Boom, 2008). In addition to relatively low payments by clients, membership fees and gifts covered costs for care delivery. Care was delivered by nurses that were linked to, and trained within these pillars. These nurses closely cooperated with general physicians, but mostly worked as autonomous practitioners who had a central role in the assessment and provision of care and were community-insiders enjoying considerable authority and status.

As off the 1950s, the state incrementally augmented its influence. It mainly did so by making eligibility for funds dependent on quality standards, e.g., with regard to home nurses’ training, as well as the inclusion of clients that were not a member of the Cross Association (Oomkens et al., 2015). Moreover, the relative independence of the Cross Associations was altered as they became increasingly dependent on state financing to cover for growing medical consumption, which evolved out of expanding provisions, and the need to perform the newly attributed task to focus on the prevention of diseases among the

\(^1\) Having different ideologies and religious groundings, these pillars were basically compartmentalizing Dutch society. In addition to having “political parties, labor unions, employers’ associations, schools, periodicals, universities, charities, housing associations, athletic clubs, and so on” (Oomkens et al., 2015, p. 860), each pillar had their own not-for-profit, private and autonomously self-governed Cross Associations for the provision of home-care.
general public. Increasing surveillance by the government additionally comprised the introduction of a registration system, which basically surveyed what home nursing services were provided and whether it was done efficiently. Yet, compared to subsequent developments in the home-care sector, discussed shortly, accountability requirements for home-care organizations that received government funding were negligible in the 1950s and 1960s (Oomkens et al., 2015). It followed that nurses continued to work relatively independently.

While 1960s marked the period of de-pillarization of Dutch society, the 1970s saw both the growth of a universal system of long-term care and the rise of critique on this development (Grootegoed & Van Dijk, 2012). In 1968, the government introduced a compulsory health insurance act, the “Exceptional Medical Expenses Act” (henceforth: AWBZ), which covered, amongst other things, personal care and nursing services as well as support with daily living in one’s own home (Oomkens et al., 2015).\(^2\) Personal care services include showering, dressing, and other basic care tasks such as putting on compression stockings or supervising the taking of medication. Nursing care includes more complex care such as giving injections, dressing wounds, and providing specialized care (e.g., to diabetics). In contrast to policy measures some four decades later, the aim of covering a broad range of services through public funds was to alleviate the caregiving burden of family members.

However, “the extent of AWBZ coverage and the development of a universal [long-term care] system was controversial from its inception” (Grootegoed & Van Dijk, 2012, p. 3). Subsequent governments were particularly criticized for recurrently (over)spending more budget on the welfare state, and health care in particular, which was the result of growing consumption (Da Roit, 2012). Besides, professionals in various public (welfare) domains were condemned for their relatively powerful position in relation to service recipients and the state, as well as for their authoritarian attitude in service delivery. Rising critiques resulted in considerable changes in the organization of health care that altered the relative positioning of professionals towards the end of the 20th century. That is, the state’s response involved increasing its control and surveillance on various public professionals and

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\(^2\) The AWBZ was covered by the sum of premiums levied through paid employment, input from the government and co-payments from care recipients. A social health insurance covered costs of hospital and primary care, for roughly “two-thirds of the population with lower incomes. For the other one-third a private health insurance scheme applied” (Nivel, 2016, p. 16).
sects (Schut, 1995), among which home-care, therewith taking a prominent role in (re-) organizing the health care sector.

In essence, this re-organization reflected notions of New Public Management (NPM) as it involved policy measures to control and restrain overall health care expenditure, ensure efficiency, and the implementation of progressive accountability requirements to safeguard equity and impartiality with regard to the division (of ever growing) budgets. Aside from the government-led introduction of NPM into the Dutch health care sector about halfway through the 1980s, government control over the home-care sector was enhanced as, due to the process of de-pillarization, Cross Associations dissolved. Home nursing “gradually lost its traditional anchor of local, denominational recognition” (Oomkens et al., 2015, p. 865, see also Van der Boom, 2008), because government directives led to mergers between home-care organizations. The result was the establishment of large region-based hierarchically structured home-care organizations, in which managers rather than independent professionals were managing the organization of the caregiving process. The establishment of such organizations entailed the Taylorisation of the organization of work processes, which is characterized by a high level of task differentiation and division of roles and responsibilities (Da Roit, 2012; Nies, Leichsenring, & Mak, 2013), and with tasks, roles and responsibilities being allocated based on skills acquired through training (see box 1). Whereas the rules and protocols that directed the work of nurses enhanced the monitoring task of managers, it turned nurses into exchangeable professionals (Oomkens et al., 2015; Van der Boom, 2008). Further reflecting the “belief in the manageability of home care” (Oomkens et al., 2015, p. 867), the government introduced a system to regulate supply, thereby also ensuring accountability.

As off the 1980s, the aforementioned AWBZ covered all expenditure on nursing care in the community. Concurrently, though, the government faced the challenge of being responsive to two seemingly incompatible lines of policy and social pleas (Oomkens et al., 2015). On the one hand, during the 1970s and more so the 1980s, normative appeals for the de-institutionalization of care delivery – i.e., receiving care in one’s own home for as long as possible rather than in an intramural care setting – became ever more prominent. The government responded by making available extra budgets, which included the coverage of home help services (i.e., house-making services) by the AWBZ. On the other hand, the
economic crisis that had imprinted the 1980s necessitated cost containment strategies, also in home-care, which resulted in stricter eligibility criteria for publicly funded professional care, and accountability requirements. In essence,

“home nursing that could be identified in medical terms experienced small budget increases until 1990, while services that were more difficult to assess faced budget constraints.” (Oomkens et al., 2015, p. 867).

Box 1. Nurses in the Netherlands
In this research I study registered nurses and auxiliary nurses (also referred to by others as certified nursing assistants). Registered nurses either have a bachelor’s degree – after four years of training at a university of applied science – or have an associate degree – earned after three to three and a half years of education in a vocational educational centre. Auxiliary nurses have enjoyed three years of practice-oriented nursing education, also at a vocational educational centre (Nivel, 2016). Compared to other Western countries, the training of auxiliary nurses is relatively long. Unless specified otherwise, I refer to these three groups of nurses (registered nurse with a bachelor’s or associate degree, and auxiliary nurses) when I discuss “nurses.” When I describe “community health nurses” (also referred to by others as district nurses) in chapter five, I refer to the registered nurses with a bachelor’s degree.

Given that Dutch society clearly had, and still has, to do with an aging population, costs for long-term care grew in subsequent decades. Considering costs for care financed from the AWBZ scheme, these rose from roughly 13 billion euro in 1999 to some 23 billion euro in 2009, with the government covering roughly one-fourth of the costs. When the government took measures to curb rising costs and restrained care provisions in the 1990s, waiting lists for home-care gradually grew (Da Roit, 2012). The notion of “aging in place” by means of receiving care in one’s own home as long as possible, logically was an important cause of rising costs for home-care. Consequently, this development eventually informed another change in the funding system. As of 1994, contracts between insurance agencies

and home-care organizations were introduced, specifying funding conditions such as performance quality criteria. At the same time, the government ensured supply regulation by means of austerity measures through the AWBZ. The ideal of efficiency was furthered through the progressive standardization of publicly funded home nursing care, involving so-called “care packages” that delineated what types of care individual clients were entitled to and minutely described how much time nurses could spend on doing so, as well as increased eligibility requirements (Algera, Francke, Kerkstra, & Van der Zee, 2003; Da Roit, 2012, 2013). The standardized care packages were allocated by region-based Care Assessment Centers (CACs), which became increasingly influential after the turn of the century (Da Roit, 2012). Together with health insurances agencies, the CACs controlled and assessed accessibility for home-care. This change meant that a bureaucratic layer was added in the assessment and attribution of care. More importantly, relocating this “essential part of professional caregiving” (Van der Boom, 2008, p. 218-219) from nurses to non-practitioners was fundamental to what was considered the de-professionalization of community health nurses, and the nursing profession more broadly.

1.1.2 Ideals of self-reliance, formalization and (distributed) control

Since the start of the 21st century, the government’s response to the challenge to curb rising costs comprised two main directives in ensuing policy (Da Roit, 2012, 2013). First, the Social Support Act (henceforth: Wmo) was introduced in 2007 (Grootegoed & Van Dijk, 2012). With this scheme, the allocation and financing of home-making services and other daily support services became the responsibility of the municipal government. Such decentralization of support services, i.e., organizing support at the local level, was supposed to enhance its alignment to clients’ needs. Yet, the Wmo essentially was informed by the notion of promoting self-reliance and civic responsibility. In fact, the “message of the 2007 Social Support Act is normative, as it explicitly promotes independence from public services” (Grootegoed & Van Dijk, 2012, p. 4). This policy was mostly substantiated by the notion that it heeded the normative plea and wish of care recipients to age in their own homes, described above. Second, and related, the (run up to the) introduction of the Wmo coincided with increased moral calls upon informal caregivers, i.e., family, close friends and/or neighbors, to look after their loved ones when in need, and to provide (initial) non-
medical support. Citizens were called upon to only request for professional publicly funded when informal caregivers were unavailable or no longer able to provide the support needed. Municipal governments were allocated the task to provide support services for informal caregivers, so as to both enhance and safeguard the latters involvement (Ministry Ministry of Health, Welfare and Sport (henceforth: VWS), 2001, 2007, 2009, 2012).

As such, the Dutch long-term care sector saw a shift from an (almost) universal publicly funded long-term care system, including generous home-making and other services, to an emphasis on private responsibilities. Whereas government policy (has) continuously framed the appeal on self-reliance and support of informal caregivers as contributing to a future-proof long-term care system (RMO, 2013; VWS, 2012), others disputed it for the very reason that these appeals became more prominent at a time when government expenditure continued to rise. According to critics, the formalization of an increasing role for informal caregivers entailed another austerity measure, while accessibility to publicly funded professional home-care decreased (Da Roit, 2013; Grootegoed & Van Dijk, 2012).

Throughout the 2000s, parallel to increasing public expenditure in the long-term care sector, government control expanded. This control, executed by insurance companies, entailed the introduction of “functional budgeting”, with functions (i.e., services) including: “domestic help, personal care, nursing, supportive guidance, activating guidance, treatment, and accommodation” (Oomkens et al., 2015, p. 874). It also included contracts about the maximum number of hours of care that could be provided and could subsequently be reimbursed to home-care organizations. Besides, contracts for care delivery were issued per year after a process of tendering, with performance measures playing a decisive role in issuing contracts for the subsequent year. What allowed for progressive state control and a decisive role of insurance companies was the fairly precarious position of home-care organizations and professionals working it in. Due to the described formalization and standardization, care delivery came under ever more pressure.

Yet, halfway through the 2000s, criticism from society and professionals regarding the delivery of home nursing grew. It was against this contextual backdrop that a new type of organization was established in the Dutch home-care sector. Instead of several management layers, this new organization was characterized by its flat organizational
structure and the fact that nurses worked in small self-managing teams, where they enjoyed relative discretionary space (Nies et al., 2013). This way of organizing and particularly the (re)attribution of discretionary space to nurses found political traction over time, as will become clear shortly. Both types of organizations, i.e., with a hierarchical and flat organizational structure, were private non-profit home-care organizations, regulated by government laws, and expected to offer affordable and good-quality care that responds to clients’ needs (Oldenhof, Postma, & Putters, 2014).

1.1.3 Furthering self-reliance, reviving the local anchor?

Since the early 2010s, the need for yet another reform became apparent in order to assure a future proof long-term care system. According to the Ministry of Health, three motives were informing the imminent reform: “improving the quality of support and care, increasing the involvement of society (caring more for each other), and the financial sustainability of long-term care and support services” (VWS, 2013, p. 2). As a result, the long-term care sector was profoundly re-organized in 2015 with regard to funding schemes, eligibility requirements, and, relatedly, (responsibilities for) the organization of care delivery. Furthering previous policy measures as well as normative pleas, aging in place was ever more prioritized over care in residential or nursing home settings. To this end, public funding for care in residential care homes was no longer self-evident, and eligibility requirements for nursing homes became stricter (Nivel, 2016). Responsibility for the allocation of home-making and social support services was also attributed to municipalities and financed from the Wmo, and no longer from the AWBZ. Following the assumption that the local organization of care was more tailor-made and therewith more efficient, the budget for services such as home-making was reduced: in 2015, funds for home-making services were reduced by 30% compared to the year before. Relatedly, government policies continued to stress self-reliance. It followed that municipalities based eligibility for various services on an exploration of client capabilities to be self-reliant as well as availability of informal caregivers to provide support. Only when both are lacking, publicly funded services are allocated.

Besides, involvement of the CACs in the allocation of publicly funded home-care was dissolved. Instead, private health insurers became responsible for the final allocation of
home nursing and personal care services. These services, which previously were financed from the AWBZ, were re-allocated, and included in the package of obligatory basic health insurance (Nivel, 2016).\(^4\) Importantly, the task of independently assessing and allocating care was re-attributed to registered nurses with a bachelor’s degree, re-emphasizing their important role in the care delivery in the community (VWS, 2013), suggesting that the local anchor of home-care was revived. Yet, accountability requirements did not cease to exist. Moreover, health insurance companies, an evermore prominent player in the domain of home-care, continued to negotiate a so-called budget ceiling with home-care organizations, meaning that there was a maximum number of hours of nursing and personal care services that could be delivered (Nivel, 2016).

Between 2012-2017, the period in which this research took place, the average number of people working in the Dutch health care sector was between 1 and 1.1 million (on a working population of about 8.3 million in the Netherlands), with some 14% of these working in extramural (home) care (UWV, 2018\(^5\)). In 2016, public expenditures for homemaking services amounted to 1 billion euro. In the same year, some 3.5 billion euro of public funds was spent on personal care and nursing services. Some 270,000 clients received these types of care. By comparison, some 10 billion euro was spent on care delivered in nursing homes, to roughly 110,000 clients.

To reiterate, this concise overview shows how the Dutch home-care sector has been a complex and dynamic institutional environment. Initially, professional norms, values and practices (i.e., a professional care logic) were dominant in shaping the organization of the caregiving process and shaped nurses’ day-to-day work in particular. While nurses had long worked as independent professionals, the proliferation of managerial norms, values and practices (i.e., NPM, i.e., a logic of managed care) involved the introduction of managers in home-care organizations and implicated a decrease in nurses’ autonomy (Van der Boom, 2008). Coinciding with a decrease in publicly funded care, a call for self-reliance by means of informal caregiver support became ever more prominent. These developments were moreover associated with policies aimed at decentralizing the organization and allocation

\(^4\)\) The considerable number of other services that used to be financed from the AWBZ were also re-allocated and the AWBZ ceased to exist.

of care and support services. Finally, the most recent dynamics allegedly point toward changes in the relative salience of the professional care logic in relation to the logic of managed care. As will become clear in the next section, and more so in the empirical chapters of this dissertation, the co-existence of a professional care logic and a logic of managed care, and the shifting balance between them considerably influenced the (organization of the) caregiving process, gave rise to several challenges, and affected the work of people working in the sector. The ensuing section commences, though, with a brief introduction of the conceptual apparatus and perspective adopted in this dissertation.

1.2 Studying actors’ responses to challenges resulting from institutional complexity and change

To guide my analysis, I draw upon the conceptual framework of institutional theory, in particular institutional logics. Institutional logics provide a valuable lens to study and “understand the interrelationship between contextual circumstances – i.e., the “institutional context” – and organizational responses” (Raynard, 2016, p. 19) as well as responses at the individual level. Institutional logics include shared values, norms and associated practices, and therewith shape the everyday perceptions and actions of organizations and individuals (Friedland & Alford, 1991; Thornton et al., 2012). Institutional logics “may – or may not – be mutually incompatible” and when “different logics are [italics in original] incompatible, or at least appear to be so they inevitably generate challenges and tensions for organizations” (Greenwood et al., 2011, p. 318) and individuals confronted with them. That is, logics have the capacity to enable, constrain and orient actions at the organizational level and individual level (Cardinale, 2018; Raynard, 2016). Besides, and as shown above with regard to the Dutch home-care sector, the salience of logics may vary over time (Goodrick & Reay, 2011; Thornton et al., 2012).

As articulated, I study how particular actors in the Dutch home-care sector have perceived and acted upon the co-existence of multiple institutional logics and the shifting balance between them over time. In focusing on the local meaning-making processes and responses of people, I join and build upon institutional research adopting an “inhabited institutions perspective” (Hallett, 2010; Hallett & Ventresca, 2006). In keeping with this
body of research, my “focus is on how situated actors enact existing institutions and, in particular, how local social interactions influence the meaning and enactment of institutional logics” (Delbridge & Edwards, 2013, p. 8). Only by focusing on the micro-level in this way, and specifically attending to the particular ways in which “logics affect the behaviour of individuals and groups in and across organizations” (Lounsbury & Boxenbaum, 2013, p. 7), we are able to capture how and why people respond and act in particular ways.

As articulated briefly above, the co-existence of a professional care logic and a logic of managed care considerably influenced the caregiving process. That is, the micro-level instantiations of institutional complexity and change gave rise to at least four challenges for home-care organizations and, particularly, for the people working in these organizations. These challenges comprise the empirical foci of the four empirical chapters of this dissertation.

First of all, at the intra-organizational level, one challenge involved responding to government policy regarding informal caregiver involvement and support, and how incorporate this in the (organization of the) caregiving process. In fact, the initial questions that guided my entry into the field were how informal caregiver involvement was reflected in organizational policy and in the organization of the caregiving process and day-to-day work of professionals in home-care organizations, as well as what challenges they encountered in involving informal caregivers.6,7 Considering that different types of home-care organizations existed – with the hierarchically structured organizations ostensibly differing from the organizations with a flat organization structure with regard to the organization of the caregiving process, yet facing similar institutional demands – I was particularly interested in studying how these different types of organizations each solved this challenge. As such, I set out to explore how organizational policy was aligned with institutional demands within two differently managed home-care organizations. In chapter two, I specifically explore how within these different types of home-care organizations the

6 Two reports for practitioners show parts of the results of the initial exploration of these questions. See Van Wieringen, Broese van Groenou & Groenewegen (2014) and Zwart-Olde, Jacobs, Broese van Groenou & Van Wieringen (2013).
7 It needs mention that the present research was initiated as part of a larger research project called “Care networks of frail older adults: The cooperation and tuning among care providers”, funded by The Netherlands Organisation for Health Research and Development as part of The National Care for the Elderly Programme. In Dutch: “ZonMw” and “Nationaal Programma Ouderenzorg.”
involvement of informal caregivers was framed in organizational policy, how this was reflected in the organization of work processes, and how this resulted in contact between formal and informal caregivers in actual care settings.

A second challenge pertains to the inter-professional level of managers and nurses. Research has shown the dynamics between and relative positioning of managers and professionals working in the public service sector, and how this is subject to change (e.g., Brock & Saks, 2016; Noordegraaf, 2015; Reay & Hinings, 2009; Scott et al., 2000). Whereas professionals were once relatively powerful, “[a] growing managerialism in public services [has led] to diminished professional and financial autonomy for professional groups to the benefit of the growing management cadre” (Farrell & Morris 2003, p. 136). Various studies have exemplified how a logic of managed care has marginalized professional spheres (Brock & Saks, 2016; Ocasio et al., 2017; Thornton, Ocasio & Lounsbury, 2015). The challenge that managers and nurses in the Dutch home-care sector faced was that they were to solve the issue of a lower budget and less time to spend on caregiving, while facing a growing number of clients with more complex care needs as well as the requirement to involve and support informal caregivers. In doing so, they ostensibly were receptive to different institutional logics and occupational commitments. Consequently, they were expected to have different ideas on how to solve this challenge. In chapter three I zoom in on how the different institutional logics and occupational commitments inform the particular ways in which actors perceive and act upon institutional complexity, and, specifically, conceptualize how actors relate to each other with regard to their particular responses.

Third, in chapter four, I further zoom in on how nurses solve the challenge of having to accommodate competing institutional demands in their day-to-day work. On the one hand, nurses continued to be trained in and thus guided by a professional care logic. On the other hand, the prominence of the logic of managed care in the organization of the caregiving process required nurses to accommodate standardization, efficiency, accountability requirements and to hand over tasks to informal caregivers. I depart from the insight that “institutional logics are enacted and transformed in the mundane activities of individuals and in response to the localized demands of situated activity” (Smets, Morris & Greenwood, 2012, p. 900). In studying how and, more so, why this is done by nurses in a
particular way, I explore the entwinement of normative and emotive elements in conceptualizing the nurses’ response to institutional complexity.

Fourth and finally, as off 2015 a new challenge arose for registered nurses (in that chapter referred to as community health nurses) in particular. This occupational group faced the challenge of reassuming a primary role in the process of care delivery, after decades of being sidelined, and in an institutional environment in which the logic of managed care also continued to exist. To elaborate, in the same way that institutional complexity and change can undermine the essence of one’s occupational role and jurisdiction (see Dacin et al., 2002), it can also promulgate an occupational group. That is, when the salience of institutional logics changes over time due to changes in their layering (Dacin et al., 2002; Goodrick & Reay, 2011), the power and prominence of particular occupational groups may wax and wane alongside (Scott et al., 2000). The most recent reform in the Dutch home-care sector ostensibly showed signs of an alteration in the relative dominance of the co-existing logics, with the professional care logic (re)gaining potency as registered nurses regained responsibility for the re-allocation of the task of assessing and allocating care. In chapter five, adopting a more longitudinal approach, I study how registered nurses and other stakeholders experience and act throughout the process of reviving and re-habitualizing this role.

1.3 Research methods

How people perceive and act upon institutional complexity and change is not fixed. Instead perceptions and actions depend on the micro-level instantiations of co-existing logics. Although perceptions, experiences and motivations were not the initial focus of this dissertation, the (mostly) qualitative methods adopted allowed for the perceptions, experiences and motivations that were at play among different respondents to surface (Suddaby, 2010; Zilber, 2002). The, mainly, qualitative methods I employed for data collection were interviewing, collection of textual material and various media accounts, field observations, and informal conversations, while some descriptive analyses of quantitative data are included in chapter two.
As they are manuscripts in their own rights, the empirical chapters of this dissertation each have a section on methodology. The reader is kindly referred to the individual chapters for the particulars of the data collection and analyses adopted for each chapter. In what follows, I provide a general overview of the research methodology and data drawn upon in this dissertation. Table 1.1 shows what parts of the empirical material is drawn upon in the individual chapters.

1.3.1 Respondents

As was mentioned above, the present research was initiated as part of a larger research project called “Care networks of frail older adults: The cooperation and tuning among care providers”, which started in 2011. Within this larger project, my focus was on people working in home-care organizations in an urban area in the Netherlands. A field work coordinator initially contacted managers in home-care organizations, informed them about the purposes of the larger project and asked them whether they wanted to participate. When they had agreed to participate, managers were asked to inform other organizational members (mostly middle managers) about the research project by distributing a leaflet outlining what participation entailed. When the field work coordinator and I approached respondents for the present research, most of them were informed about the research. If not, we informed them about its purposes.

As articulated, I particularly studied managers and, more so, nurses. Managers were responsible for the functioning of multiple teams of nurses providing personal care and nursing services, and as such were indirectly responsible for the quality of care that is delivered. Managers’ tasks particularly related to the financial management of teams of nurses, including areas such as budget-holding, brokerage, and contracting (Postma et al., 2015). The nurses I studied were registered nurses and auxiliary nurses (see box 1 above). Auxiliary nurses generally provided personal care services. This includes showering, dressing, and other basic care tasks such as putting on compression stockings or supervising the taking of medication. In addition to supervising auxiliary nurses, registered nurses provide more complex care such as giving injections, dressing wounds, and providing specialized care (e.g. to diabetics). Registered nurses with a bachelor’s degree generally also have responsibility for requesting care packages and for managing the coordination and
overall quality of care. Consequently, registered nurses often also performed the role of “care coordinator” (see chapter two). Registered nurses were the ones that were re-attributed the task of care assessment and allocation after the 2015 reform of the long-term care sector.

1.3.2 Interviews

Interviews with managers and, particularly, nurses, formed the core of the empirical material on which this dissertation is based. Interviews with managers were conducted between December 2012 and December 2013. Interviews with nurses were conducted at two points in time: between December 2012 and December 2013 and between August 2016 and April 2017. The first round of data-gathering consisted of interviews with executive and middle managers as well as auxiliary and registered nurses. The main topics discussed in these interviews were aimed at uncovering the organization of the caregiving process, including the role and tasks and responsibilities of the respondents and referent others, such as informal caregivers, as well as the extent to which and how this was discussed among nurses and informal caregivers throughout the process of care delivery. By deconstructing the organization of the caregiving process, I tried to unravel the congruence of interests and commitments of different actors involved. The second round of interviews was with registered nurses with a bachelor’s degree. I particularly discussed changes in the process of care delivery as well as the division of tasks and responsibilities between themselves and referent others. Moreover, respondents were asked, among other things, to reflect on the reform and (policy) changes that had taken place in the home-care sector in 2015 and how these had affected their role and day-to-day work.

All interviews were structured to the extent that I knew what topics I wanted to discuss with respondents, while only a few questions were formulated in advance. I generally aimed for interviews to take the form of conversations, in which respondents were to a large extend free to discuss what they considered important. All interviews were

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8 An external advisory group gave advice on the topics discussed during the interviews. This group consisted of scientists, government policy-makers (national and local level), policy-makers from two agencies that participated in the larger project, and formal and informal caregivers. Members were either known to the researchers personally, or via mutual relatives; they were all purposefully chosen based on their expertise in the field.
recorded and transcribed verbatim. At the start of each interview, confidentiality was emphasized so as to encourage respondents to speak freely.

1.3.3 Textual material and various media accounts

A large part of the textual material collected consisted of organizational documents of the participating home-care organizations, such as annual reports, policy documents and/or mission statements. These documents provided vital information about the organizations’ (policy) goals as well as the organization of work processes. These organizational documents were mainly gathered between December 2012 and December 2013, and thus include documents from those years or the preceding years.

Besides, over the course of about five years, I kept a close watch on developments as they unfolded in the home-care sector. In the process of doing so, I gathered an extensive amount of documents and archival data. They comprised (mostly) publicly available documents, broadly including (historical) documents about the occupational group of community health nurses, government policy documents, practice-oriented research reports written to inform government policy, popular press articles (both online and offline), pictures, and film documentaries and news items. Finally, I gathered weblogs (henceforth: blogs) written between October 2013 and April 2018 by registered nurses and other stakeholders in the home-care sector. The blogs were publicly available and published on the website of the Dutch Nursing Association and on the website of “Nursing”, an important magazine for nurses in the Netherlands. Overall, I gathered materials that were generated roughly between 1985 and 2018. Combined, these materials provided important historical and contextual data, information on changes in the home care sector, as well as accounts of experiences of different interested actors at various points in time.

1.3.4 Observations and informal conversations

Finally, I build on empirical material derived from field observations during meetings and conferences that I attended over the course of some five years, but particularly between 2015 and 2018. Specifically, I went to meetings and conferences organized around the topic of developments in the Dutch home-care sector, where the majority of those attending were nurses, but where other stakeholders (e.g., former nurses, managers, or policy makers
at the organizational, local or national level) were also present. Observations during such meetings allowed me to gather data on how changes were framed and perceived by stakeholders. During the meetings, I also paid attention to the exchanges and discussions between nurses and other stakeholders. If possible, I took extensive notes during the meetings. When I felt this was inappropriate, I made sure to write down what I had observed and heard as soon as possible after the meeting was over. Attendance of these meetings also provided ample opportunities to have informal conversations with other attendees. For example during breaks, when discussions that had started in plenary sessions or workshop settings generally continued. This allowed me to follow-up upon statements made earlier by particular attendees as well as to inquire about experiences and opinions that attendees (had) expressed.

1.4 Research approach and rationale of the (evolved) research

In this dissertation, I adopted an abductive research approach (Tavory & Timmermans, 2014). An abductive approach means that the researcher enters the field with substantial knowledge of various literatures. When the researcher encounters “surprising” or unanticipated empirical findings, in the sense that a discrepancy between existing literature and the empirical findings exist, such findings can subsequently be further explored, eventually allowing the researcher to engage in the development of new, or refinement of existing, theory (Locke, 2011; Timmermans & Tavory, 2012). Abduction differs from both deductive and inductive research approaches. In short, research taking a deductive approach seemingly assumes that researchers enter the field or approach their empirical data with theoretical assumptions of one theory, with studies generally aimed at the verification, falsification, or modification of these assumptions to refine existing, or develop new theory (Tavory & Timmermans, 2014). In turn, inductive approaches tend to advise engagement with existing literature only at, or near, the end of a research project, thereby privileging “the emergence of theoretical insights out of data that are mythically unencumbered with theoretical preconceptions” (Tavory & Timmermans, 2014, p. 20). As is exemplified in the empirical chapters, an abductive approach involves the continuous iteration between the data, emerging ideas and existing literature. This abductive approach
materialized during fieldwork. That is, findings and developments that intrigued and surprised me in light of existing literature informed endeavours to collect subsequent data.

In the remainder of this section, I describe the rationale of the evolving focus of the research on which this dissertation builds, thereby simultaneously providing an outline of the thesis. In (describing) three of the four empirical chapters (2-4), the ‘we’ instead of the ‘I’ form is used, because these were co-authored articles. I was the first author on these manuscripts, and as such I took the lead in the different phases of the research process and in writing the manuscripts.

As articulated, the present research was part of a larger research project. In light of an increasing emphasis in government policy on informal caregiving halfway through the 2000s, the larger project departed from the proposition that informal caregiving was becoming increasingly important, while our understanding of the functioning of mixed care networks of frail older adults, consisting of both professional and informal caregivers, was limited and needed to be developed further. Hence the overall focus of the larger project was on the cooperation between formal and informal caregivers in mixed care networks of home-dwelling frail older adults. Consequently, and as articulated, my aim when entering the field was to explore how informal caregiver involvement was reflected in organizational policy, how it materialized in the organization of the caregiving process and resulted in actual contact between formal and informal caregivers.9

In chapter two, “Impact of home-care management on the involvement of informal caregivers by formal caregivers”, we explore 1) how within two different types of home-care organizations the involvement of informal caregivers was framed in organizational policy, 2) how this view was reflected in the organization of work processes, and 3) how this resulted in contact between formal and informal caregivers in actual care settings. The study is based on the analysis of policy documents and interviews with 5 managers and 31 nurses from two differently structured home-care organizations. We show that, although the importance of involving informal caregivers is emphasized in official documentation, actual contact with informal caregivers is often lacking. Comparison of the

9 Two reports for practitioners (see Van Wieringen, Broese van Groenou, Groenewegen, 2014; Zwart-Olde, Jacobs, Broese van Groenou & Van Wieringen, 2013) show parts of the results of the initial exploration.
work processes of the two organizations shows that contact with informal caregivers and their potential involvement are enhanced by smaller teams, less task division, and clarity about the responsibilities of nurses. More importantly, we discuss how a lack of policy implementation is the main reason for the identified misalignment between policy and practices. This lack of policy implementation is reflected in ambiguity about the division of responsibilities and nurses indicating that they were unaware of organizational policy on informal caregiver involvement. The main conclusion of this chapter is that micro-level day-to-day work practices are decoupled from organizational policy on informal caregiver involvement, as policy seems to be adopted symbolically in response to external pressures and to enhance organizational legitimacy (Meyer & Rowan, 1977; Yang, Fang, & Huang, 2007).

During the first interviews, I was intrigued to learn that informal caregiver involvement was largely considered as just one amongst other challenges that managers and nurses encountered in their day-to-day work. As articulated, the most important other challenge was a decreasing budget versus the commitment to deliver the best possible quality of care. Besides, and following the main conclusion of chapter two, I became intrigued to further unravel and understand the particular manner in which these challenges were perceived and acted upon by managers and nurses. As such, I reconsidered and widened the focus of my research.

Chapter three, “We’re all Florence Nightingales’: Managers and nurses colluding in decoupling through contingent roles”, further examines how and why managers and nurses are involved in decoupling in response to institutional complexity. We address the question: How do various occupational groups engage in decoupling when working in complex institutional environments? Building on interviews with 21 managers and 21 nurses, we show that managers facilitate decoupling through ambiguity regarding the co-existing institutional logics, and by purposefully abstaining from enacting the logic of managed care (in chapter three referred to as “business logic”) in work processes. Nurses, in turn, deflect institutional pressures by engaging in a classic form of decoupling, i.e., complying symbolically with the logic of managed care. We conceptualize how managers’ and nurses’ occupational commitments and jurisdictions, their relative social positions, and other situational conditions are integral to how and why they collude in decoupling. By
delineating how and why different occupational groups collude in decoupling in an institutionally complex environment through contingent roles, we add to the understanding of micro-level intra-organizational conditions and inter-professional dynamics of decoupling.

Chapter four, “That’s why we deliver care between the lines’: Nursing values, emotions and interests in micro-level decoupling practices”, draws upon interviews with 39 nurses; 28 in the first round of interviews and 11 follow-up interviews about three years later. We further explore what motivates nurses to engage in decoupling by focusing on the role of values, emotions and interests. We ask: What is the role of values and emotions in micro-level decoupling practices, and how do people experience their engagement in decoupling in a complex institutional environment? We identify how perceived threats to the enactment of nursing values, combined with subsequently triggered anger, anxiety and compassion, inform decoupling practices. We also show how decoupling allows for the continued enactment of nursing values as well as the preservation of the interests of the nurses and their clients. Involving both institutional subversion and preservation of the logic of managed care at the micro-level, the nurses’ decoupling practices simultaneously helped to institutionalize – at least superficially – this logic. In this light, we also identify that, due to the continued confrontation with conflicting co-existing logics, over time, decoupling practices became more intricate and emotionally distressing for the nurses. This chapter contributes to the literature on decoupling, first, by developing a more nuanced and comprehensive understanding of decoupling by revealing how normative and emotive elements and professional interests concurrently inform micro-level decoupling practices. Second, we conceptualize decoupling as an ongoing process with emotional consequences.

About halfway through the first round of interviews, respondents made initial mention about the reform of the long-term care sector in 2015. Although the details of what would constitute the changes remained rather vague for quite some time (see chapter five), respondents’ were clearly apprehensive about the changes ahead. I was interested to trace on-going and imminent developments. That is, I was particularly eager to trace how the supposed re-assumption of a central role in caregiving of registered nurses would turn out, especially because this was actually precisely the role and position that registered nurses as well as other respondents had directly or indirectly advocated (for themselves) during the...
interviews in the first phase of data gathering. Therefore, I used the opportunity to capture how the occupational group of registered nurses lived up to and perceived the reform, and, more importantly, how they managed to take up their supposedly new role once the reform had taken place.

In chapter five, “The institution reincarnated? Precariousness and predicament in reviving and re-habitualizing professional values, traits and practices”, I take a more longitudinal approach and address the question: How does a process of reviving and re-habitualizing professional values, traits and practices after decades of latency evolve? In addressing this question, I draw upon 40 interviews with community health nurses, weblogs, observational data, and primary/archival and secondary data sources. My main focus is on the role and experiences of former and existing members of the occupational group of community health nurses (i.e., registered nurses with a bachelor’s degree). I identify how the process of reviving and re-habitualizing professional values, traits and practices was characterized by four different though entwined micro-processes: nostalgic projection; apprehensive questioning; disillusioned re-assumption; imputing celebration. By studying a unique process that quite literally involved the reincarnation of an institution by members of an occupational group, the first contribution is found in rendering visible how in processes of institutional reincarnation the nature of what is revived is integral to the particular micro-processes and sentiments that characterize the process. Attending to the normative underpinnings, subjective experiences and challenges that characterize the process of institutional reincarnation, a comprehensive understanding is developed of why such processes may be more precarious than previous research suggests. In extension, I exemplify how the convergence of past, present and future are crucial with regard to the sentiments and experiences that actors exhibit throughout the process.

Finally, in the concluding chapter six, I provide an answer to the main research question. Moreover, chapter six comprises more elaborate discussions of the literature drawn upon in the empirical chapters and the contributions this dissertation has to these literatures, while also proposing some directions for future research. Besides, I provide some reflections on the methodology used and discuss some practice implications of the present research.
Table 1.1. Overview of empirical chapters and the data on which they are based

<table>
<thead>
<tr>
<th>Chapter title</th>
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<th>Empirical data</th>
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| **Chapter two.** Impact of home-care management on the involvement of informal caregivers by formal caregiver | To explore 1) how home-care organizations frame informal caregiver involvement, 2) how this view is embedded in work process, 3) how this results in actual contact between formal and informal caregivers. | - In-depth interviews with 31 nurses and five managers in two home-care organizations, from the first round of data collection between December 2012 and December 2013.  
- Organizational policy documents from 2010-2013.                                                                                                                                                                                                                                    |
| **Chapter three.** “We’re all Florence Nightingales”: Managers and nurses colluding in decoupling through contingent roles | How do various occupational groups engage in decoupling when working in complex institutional environments?                                                                                                                                                                      | - In-depth interviews with 21 managers and 21 nurses, from the first round of data collection between December 2012 and December 2013.  
- Organizational policy documents from 2010-2013.                                                                                                                                                                                                                                  |
| **Chapter four.** “That’s why we deliver care between the lines”: Nursing values, emotions and interests in micro-level decoupling practices.                                                                                                           | What is the role values and emotions in micro-level decoupling practices, and how do people experience their engagement in decoupling in a complex institutional environment?                                                                                                          | In-depth interviews with 39 nurses, conducted at two points in time:  
- 28 between December 2012 and December 2013  
- 11 follow-up between August and December 2016.                                                                                                                                                                                                                                   |
| **Chapter five.** The institution reincarnated? Precariousness and predicament in reviving and re-habitualizing professional values, traits and practices.                                                                                               | How does a process of reviving and re-habitualizing professional values, traits and practices after decades of latency evolve?                                                                                                                                                  | - In-depth interviews with 40 community health nurses conducted at two points in time:  
- 22 between December 2012 and December 2013;  
- 18 between August 2016 and April 2017.  
- Weblogs: 175 in total, written between October 2013 and April 2018.  
- Field observations (18 hours) of conferences and expert meetings  
- Archival data and secondary sources and media accounts.                                                                                                                                                                                                                   |
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<td>Three</td>
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<td>What is the role of values and emotions in micro-level decoupling practices, and how do people experience their engagement in decoupling in a complex institutional environment?</td>
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