HEALTHY CARE

Exploring the developing discourse of sustainable healthcare and dynamics of transition in health and care

Françoise Johansen

Healthy Care

Exploring the developing discourse of sustainable healthcare
and dynamics of a transition in health & care

Françoise Johansen

Copyright © Françoise Johansen 2023

ISBN	978-94-6361-907-3
Cover design	Jan-Willem Jekel
Lay-out & printing	Optima Grafische Communicatie, Rotterdam

Healthy Care

Exploring the developing discourse of sustainable healthcare and dynamics of a transition in health & care

Gezonde zorg

Verkenning van het ontwikkelende discours van duurzame zorg en de dynamiek van een transitie in gezondheid & zorg

Thesis

to obtain the degree of Doctor from the
Erasmus University Rotterdam
by command of the
rector magnificus

Prof.dr. A.L. Bredenoord

and in accordance with the decision of the Doctorate Board.

The public defence shall be held on:

6 December 2023 at 10.30 hrs

by

Françoise Gudrun Johansen
born in Rotterdam

Erasmus University Rotterdam

DOCTORAL COMMITTEE:

Promotor:	Prof.dr. D.A. Loorbach
Other members:	Prof.dr. J.E.W. Broerse
	Prof.dr. R.A. Bal
	Prof.dr. M.A. van der Steen
Copromotor:	Dr. A.M.V. Stoopendaal

Il existe une chose plus puissante que toutes les armées du monde,
c’est une idée don’t l’heure est venue.

Er is maar één ding sterker dan alle legers van de wereld,
en dat is een idee waarvoor de tijd rijp is.

(Victor Hugo)

TABLE OF CONTENTS

Summary **15**
Samenvatting **25**

Chapter 1 Shifting perspectives in healthcare **37**
1.1 The value and cost of (good) health 38
1.1.1 Health system vs healthcare system 38
1.1.2 Healthcare expenditure 38
1.1.3 Planetary health and climate change 39
1.1.4 Healthcare fit for the future? 41
1.2 Challenge: realigning to a changing context 42
1.2.1 Design of the Dutch healthcare system 42
1.2.2 The success and drawbacks of the medical model 43
1.2.3 Gap between supply and demand 44
1.3 Need for a different approach 45
1.3.1 The danger of old remedies for current problems 45
1.3.2 Persistent nature of problems 45
1.3.3 Diagnosis: care infarct 47
1.4 The sustainability perspective 48
1.4.1 Main perspectives on (un)sustainable healthcare 48
1.4.2 Social perspective: sustainable healthcare (system) 50
1.4.3 Environmental perspective: sustainability in healthcare 51
1.4.4 Conceptualizations of sustainable healthcare 52
1.5 Developing perspectives on sustainable healthcare through transitions research 53
1.5.1 Sustainability transitions research 53
1.5.2 Outline 54

Chapter 2 Studying transition dynamics in the field of healthcare **59**
2.1 Systemic perspective on fundamental change in healthcare 61
2.2 Aim and research questions 63
2.2.1 Research aim 63
2.2.2 Building on earlier research 63
2.2.3 Research questions 64
2.3 The transition perspective 66
2.3.1 Transition studies 66
2.3.2 Multi-Level Perspective (MLP) 67
2.3.3 Transition dynamics 67
2.3.4 Characterizing the regime in a triplet of Culture-Structure-Practices 70

2.3.5 Socio-technical vs socio-institutional 72
2.3.6 Transition Management and transformative agency 72
2.4 Research approach 74
2.5 Research journey: exploring transition dynamics in practice 75
2.6 Case study overview 78

Chapter 3 Exploring a transition in Dutch healthcare 83
3.1 Introduction 84
3.3 Method 89
3.4 Dutch CSR Network for Healthcare 90
3.4.1 Establishment and development 90
3.4.2 Expedition to Sustainable Healthcare 90
3.5 Results 93
3.5.1 Rewards 93
3.5.2 Positive Health 93
3.5.3 Changes in structure, culture and practices 94
3.5.4 Challenges 95
3.5.5 Frontrunners in the making? 97
3.6 Discussion 98
3.6.1 Examining the 'Expedition' as a transition process 98
3.6.2 Healthcare in transition? 100
3.7 Conclusions and recommendations 101

Chapter 4 The scaling-up of Neighborhood Care: from experiment towards a transformative movement in healthcare 105
4.1 Introduction 106
4.2 Transition perspective on scaling-up 108
4.2.1 Transition experiments as instrument of transition management 108
4.2.2 Conceptualizing 'scaling-up' 108
4.2.3 Focus on strategic activities 109
4.2.4 Framework of deepening, broadening and scaling-up 110
4.3 Method 111
4.4 Buurtzorg and the Dutch system for long-term care 112
4.4.1 The Dutch system for long-term care 112
4.4.2 Transition Management approach in long-term care 113
4.4.3 Introduction to Buurtzorg 114
4.5 Strategic activities of Buurtzorg 117
4.5.1 Deepening: Learning and experimenting 117
4.5.2 Broadening: Repeating and connecting 118

4.5.3 Scaling-up: societal embedding 119
4.5.4 Reflection on scaling-up and key strategies of Buurtzorg 121
4.6 Towards a transformative movement in Dutch healthcare 123
4.7 Discussion and conclusion 125

Chapter 5 Positive Health: from niche-discourse to government jargon 131
5.1 Inleiding 132
5.2 Theoretische perspectieven 135
5.2.1 Discours 135
5.2.2 Transitie 136
5.3 Methode 138
5.4 Ontwikkeling van en groeiende aandacht voor Positieve Gezondheid 139
5.5 Diffusieproces 142
5.6 Discussie 147
5.7 Conclusie 149

Chapter 6 Transition Pains: recognizing effects of organizational realignment to a changing context 153
6.1 Introduction 154
6.2 Theoretical perspective 155
6.2.1 Introduction to the transition perspective 156
6.2.2 Dissonance 156
6.3 Case and Methods 158
6.3.1 CASE 158
6.3.2 Methods 159
6.4 Periods of change 161
6.4.1 Reconstruction 161
6.4.2 Critical period 161
6.4.3 Transformative period 163
6.4.4 Adaptive period 164
6.4.5 Summary of findings 166
6.5 Conceptualizing Transition Pains 166
6.5.1 Pain as a metaphor 166
6.5.2 Developing the language of transition pains 167
6.6 Exploring the relation between dissonance and transition pain 170
6.7 Implications for theory and practice 172
6.7.1 Theory 172
6.7.2 Practice 172
6.8 Discussion and conclusion 173

Chapter 7 Conclusions and recommendations: towards Healthy Care **177**
7.1 Recap of this thesis research 178
7.2 The healthcare system in transition? 180
7.3 Sustainability in healthcare: gaining meaning and significance 183
7.3.1 Tenability of healthcare as a system 183
7.3.2 Social and human-oriented care 184
7.3.3 Sustainability in healthcare: green care 185
7.3.4 Making sense of sustainability in healthcare 186
7.4 Conceptualizing sustainable healthcare as Healthy Care 187
7.5 Transformative agency 188
7.5.1 Development of alternative practices 189
7.5.2 New common language 189
7.5.3 Working with a coalition of the willing and doing 190
7.5.4 Building support structures 191
7.5.5 Niche-regime interaction 191
7.5.6 Taking transition in healthcare to the next phase 192
7.6 Implications & recommendations for theory, governance & policy and practice 193
7.6.1 Implications for theory 193
7.6.2 Implications for governance and policy 195
7.6.3 Implications for practice 198
7.7 Limitations of the study 199
7.8 Final remarks 200

References **203**
Appendix: Summary of chapter 5 **217**
PhD Portfolio **219**
About the author **221**

DANKWOORD VOORAF

De afgelopen jaren heb ik vele metaforen gehoord die de kern proberen te vatten van wat een promotietraject inhoudt: het is een reis, een bevalling en een Olympische sport. Het was in ieder geval zowel energiegevend als energieverslindend op bepaalde momenten. Wat voor bijna elke promovendus geldt, geldt ook voor mij: het zou niet mogelijk zijn geweest dit tot een goed einde te brengen zonder de onvoorwaardelijke steun van familie, vrienden, collega's en iedereen die aan het onderzoek heeft meegewerkt of op een of andere manier interesse en steun heeft getoond. Vooral de ontmoetingen met veel fantastische mensen, en inzichten die andere disciplines en denkwijzen te bieden hebben was bijzonder en maakte deze reis de moeite waard. Specifiek wil ik mijn dank en waardering uitspreken voor:

Allereerst mijn promotor Derk Loorbach (DRIFT) en copromotor Annemiek Stoopendaal (ESHPM), die de hele rit hebben uitgezeten en de rol van opbouwende criticus, ondersteunende collega of zelfs troostende ouder hebben afgewisseld. Jullie hebben alle mijlpalen onderweg (mee)gevierd en boden schouders om op te leunen wanneer dat nodig was, tissues altijd bij de hand. Ik ben heel dankbaar voor deze begeleiding in mijn eigen kleine multidisciplinaire supervisieteam. Grote dank aan Derk voor het nemen van een risico met een externe promovendus en het geduldig steunen van mijn voortgang. Grote dank gaat ook uit naar Annemiek Stoopendaal, voor haar rechttoe rechtaan, soms ongenuanceerde, maar altijd liefdevolle en ondersteunende feedback. Voor de kopjes koffie in het Erasmus Paviljoen en de niet aflatende aanmoediging. Bedankt dat je zo betrokken bent geweest en me samen met Derk naar de eindstreep hebt getrokken.

Dit onderzoeksproject is gestart bij de Expeditie Duurzame Zorg van het MVO Netwerk Zorg. Helene van der Vloed, destijds manager van het MVO Netwerk Zorg, ben ik dankbaar voor de gelegenheid om bij de expeditieleden aan te sluiten om onderzoek te doen. Ook de steun van Ailin Haijer en Marloes Gerritsen, destijds de gezamenlijke ruggengraat van het MVO Netwerk Zorg en expeditie, is heel waardevol geweest. Het bijwonen van bijeenkomsten van zowel de expeditie als het Netwerk heeft geholpen om mijn eigen kijk op duurzame gezondheidszorg te verbreden en via deze weg heb ik kennisgemaakt met Positieve Gezondheid. De adviseurs verbonden aan de expeditie deelden vrijelijk hun kennis en ervaringen. Ook speciale dank aan Jord Neuteboom die extra tijd investeerde in het bespreken van het onderzoek met mij. Bovenal ben ik de geïnterviewden van de acht deelnemende zorgorganisaties dankbaar dat ik hen na de expeditie drie opeenvolgende jaren mocht bezoeken om te horen over hun vorderingen en uitdagingen om koplopers te worden in duurzame gezondheidszorg. De gesprekken met Harriette Laurijsen, Esther Willems, Bert Visser, Wiekie Gorter, Siem van den Broek en

Ineke de Bruin hebben dit proefschrift enorm verrijkt. Deze mensen hebben mijn manier van denken herhaaldelijk uitgedaagd wat een enorm genot en verrijking was.

Bij het MVO Netwerk Zorg ontmoette ik DRIFT-alumna Suzanne van den Bosch, een van de weinige mensen die destijds onderzoek had gedaan naar transitie in de zorgsector. Wat ontzettend fijn dat we elkaar hebben ontmoet en dat je me hebt uitgenodigd om mee te doen aan het onderzoeksartikel over Buurtzorg. Dit werd uiteindelijk het eerste gepubliceerde artikel voor dit proefschrift. Daarmee heb je mij zo enorm op weg geholpen! Bedankt voor het leuke weekend in Brighton, samen met Anne van Strien, waar we onze paper presenteerden op de IST-conferentie van 2015. Door activiteiten met HEALTi is is het eerste zaadje voor Healthy Care geplant!

Veel dank gaat uit naar de mensen bij het instituut voor Positieve Gezondheid (toen en nu) voor het onderschrijven van mijn onderzoek naar Positieve Gezondheid en het beschikbaar stellen van tijd, feedback, ondersteuning, aanmoediging en ook het bieden van een podium om mijn bevindingen te delen. Dank voor de steun: Machteld Huber, Marja van Vliet, Angelique Schuitmaker, Karolien van den Brekel, Jan Berndsen, Miriam de Kleijn en Joanca van den Bosch.

Het werken aan dit proefschrift was altijd parttime en ik heb gelukkig hierin veel steun gehad van fijne werkgevers. Grote dank aan Dorine Duwel (Facit), Nyncke Bouma en Marja van Leeuwen (beiden Fonteynenburg) voor het ondersteunen en aanmoedigen van dit onderzoekstraject en het faciliteren in tijd, interesse en onderzoeksmogelijkheden. Vele collega's waren van grote ondersteuning, bemoediging én aanmoediging bij zowel Facit en Fonteynenburg. Speciale dank gaat ook uit naar Sylvia Kreijenbroek en de connectie met de academische werkplaats zelforganisatie bij Erasmus School of Health Policy & Management (ESHPM) alsmede naar de collega's bij Fonteynenburg die ik mocht interviewen voor dit onderzoek.

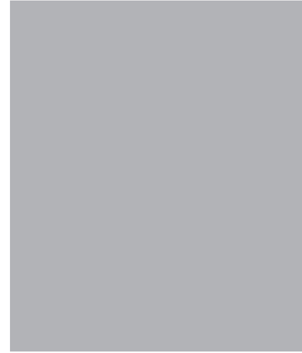
Vorig jaar, sinds ik afscheid heb genomen van mijn vaste baan, hebben de fantastische mensen bij DRIFT mij verwelkomd in hun midden en de laatste fase van dit traject verrijkt met collegialiteit en inspirerende sessies maar ook veel lachen bij de lunch. Alle DRIFT-ers, bedankt voor de steun en interesse in mijn traject!

Er zijn zoveel mensen die ik onderweg heb ontmoet en die me hun tijd, hun gedachten en ideeën en hun aanmoediging hebben gegeven. Ik waardeer elk gesprek dat ik heb gehad! Hoewel ik niet altijd duidelijk kon maken waar ik aan werkte ;-) gaat een grote dank uit al mijn vrienden, vrienden van vrienden en buren die mijn vooruitgang door de jaren heen hebben gevolgd, interesse en steun hebben getoond.

Ik koester de koffiedates, lunches, wandelingen en werksessies met dierbare vriendinnen Suzanne Polinder en Léonie Ridderstap. Het delen van promotie-ervaringen en perikelen is ontzettend waardevol en steun en advies zijn van onschatbare waarde geweest. Ik ben zo blij dat deze vrouwen mijn paranimfen zijn.

Dank aan Jan en Christien, omdat ze trotse en ondersteunende schoonouders zijn en meer dan goedmaken dat ik dit zonder mijn eigen ouders heb moeten doen.

En met al mijn liefde voor Jan-Willem, omdat jij er bij elke stap was, nooit het vertrouwen verloor in mijn vermogen om dit project af te ronden (en het sowieso niet toestond om te stoppen), voor het geloven in mij, voor het vieren en , voor de *happy smiles* en voor alle liefde in de wereld. Dankjewel ♥



Summary

SUMMARY

If we consider the combination of an ageing population, a declining labor force and rising costs of healthcare, as well as the broader context of climate change, we can ask if the Dutch healthcare system in its current form is, literally, sustainable: can it continue to perform facing such critical challenges?

The past ten years sustainable healthcare has become a key concern for politicians, policymakers and healthcare professionals: can we continue to offer accessible, affordable and quality care? More recently, increasing concerns regarding the climate footprint of healthcare, enhanced by the COVID-19 pandemic, have raised the question if the sector can stay within planetary boundaries? This context, together with ongoing discussions concerning rising costs of healthcare delivery, have sparked new interest in sustainable healthcare and the need for a fundamental transformation.

Sustainability transitions research studies complex societal problems from a systemic perspective. Studying transition dynamics in societal systems brings us knowledge on the nature of fundamental change by looking at shifts in the way of thinking, doing and organizing. These shifts are driven by persistent pressures (recurring problems) and enforced by external changes and crises on the macro or landscape level. These crises provide windows of opportunity for change e.g., the COVID-19 pandemic suddenly created opportunities for change such as remote working and an awareness of the problem of hospital waste. The transition lens identifies and understands the underlying patterns driving fundamental change as the interplay between the incumbent regime (or dominant way of doing things) and rising alternatives (niches). This in turn informs a transition (research) agenda in healthcare.

This thesis explores a transition movement in Dutch healthcare by highlighting the developing discourse around sustainable healthcare. Additionally, several emerging alternatives are studied that introduce new cultures, structures and practices and interact and develop with the incumbent regime.

The main question guiding this research is:

How does sustainability develop meaning and significance in Dutch healthcare?

Transitions are a process of sense-making in society in which persistent problems are acknowledged and new practices, ideas and concepts gain meaning and significance. Investigating the meaning attributed to the concept of sustainability in healthcare is

relevant to build a vocabulary that can support actors in the transition. The research question is explored through the study of different conceptualizations of sustainable healthcare, investigating empirical examples of newcomers with an alternative proposition (niches). This study also looks at transformative agency (the capacity to act or influence) to learn how experiments, new practices and focused policies can support alternative ways of thinking, doing and organizing.

The patterns and mechanisms (dynamics) that explain transitions include how established regimes develop through optimization and how landscape changes can increase pressure for change. Transition dynamics illustrate how alternative ideas, technologies and practices (experiments) can break through and accelerate a transition process while the incumbent regime destabilizes. The phase of destabilization and acceleration is followed by chaos and loss of securities while the contours of a new regime emerge. New culture, structures and practices are then institutionalized while old ones are phased out.

Theoretical contribution: operationalizing sustainability in the healthcare domain

Transition studies have their roots in socio-technical domains such as energy or mobility. Application in healthcare and other social domains is still scarce. The operationalization of (un)sustainability in the healthcare system offers insights into transition dynamics in the socio-institutional domain of healthcare, not driven by technological innovation but by institutional, cultural and social forms of innovation.

Medical science has effectively dealt with a large number of (infectious) diseases. This medical model as a conceptualization of health is focused towards *the absence of disease or disability*. This perspective has inspired a medical focus on 'repair' or 'fixing the malfunctioning part' (whether body or mind) and has added to an increased life expectancy by finding cures for (infectious) diseases. The focus of the medical model is reflected in how the Dutch healthcare system is organized: medical education, specialization, financing structures, a large industry for pharmaceuticals and medical devices. Diagnostic abilities, treatment together with the industries for pharmaceuticals and medical devices have led to an extensive supply in and of healthcare. Technological advances combined with increased prosperity and availability of care have developed into a believed 'right' to healthcare and trigger demand. In this way, medical rationality and the demand for (high quality) treatment and care have become self-reinforcing in both supply and demand, creating an overexpanded and unsustainable healthcare system.

When it comes to linking sustainability and healthcare, several overarching perspectives can be identified:

- System (un)sustainability: landscape developments such as ageing of the population, increase in chronic disease, technological progress and a shrinking workforce have increased demand and put pressure on the current organization of the system in terms of affordability, quality and accessibility.
- People perspective: dehumanization of healthcare as a result of focus on financial performance and increasing work pressures.
- Closely related is the perspective that advocates a preference for salutogenesis (promotion of health and well-being) rather than pathogenesis (development of disease): health as leading principle instead of sickness.
- Environmental perspective: could be called 'green' healthcare, concerned with (reducing) the effect of healthcare on the environment in terms of carbon footprint, circularity, waste, water quality, concerned with climate change.
- Ecological perspective: concerned with the impact of climate change (and globalization) on health and (global) health systems that are not prepared for this e.g., pandemics, wars, population movements caused by flooding.

The first four perspectives are studied in this thesis. The more large-scale ecological perspective was not explored extensively in this study as the primary focus is on (localized) Dutch healthcare.

Empirical contribution: transition dynamics in healthcare

This thesis explores the uncharted territory of transition in healthcare by investigating initiatives and experiments in the field of Dutch healthcare. This thesis specifically looks at sustainability programs, frontrunners who offer alternatives, development of a new language and a new paradigm, and the struggle of incumbents charged with everyday delivery of healthcare. Alternatives to the dominant way of thinking, doing and organizing in healthcare, as well as the niche-regime interaction, are explored through three cases:

- Expedition to sustainable healthcare (chapter 3)
- Neighborhood are (Buurtzorg) (chapter 4)
- Positive Health (chapter 5)

The *Expedition to sustainable healthcare* was developed by the Dutch CSR Network for Healthcare: a learning program aimed at creating frontrunners in the healthcare transition. During a three-year period, the eight participating healthcare organizations are followed to investigate changes in culture, structure and practices as well as the results

and challenges in developing and maintaining a frontrunner status. As such, this chapter provides an empirical description of a transition management process.

Neighborhood Care (in Dutch: Buurtzorg) has known a remarkable development trajectory and is studied as example of delivering healthcare in a radically different way. Buurtzorg was initiated as an alternative for the standard homecare and participated as a *transition experiment* in the *Transition Program in Long-term Care* that ran as early as 2007-2009. In this program, a transition in healthcare was envisioned as "a fundamental change towards a more human-centred, affordable and socially embedded healthcare system". As a transition experiment, Buurtzorg was able to make use of shielded space and transition support in the form of financial protection and making use of transition knowledge from experts. The study looked at the strategies that Buurtzorg applied to gain momentum and influence in a relative short period of time by analyzing these strategies in terms of deepening, broadening and scaling up. The rapid development of Buurtzorg is explained by identifying their strategic activities, the alignment of contextual factors and their strategic position as outsider to the regime. We conclude that Buurtzorg has become a 'symbol' in a transformative movement that can contribute to a future transition in healthcare.

The case of *Positive Health* is focused on niche-regime interplay, specifically the perspective of influencing policy development in Dutch healthcare through adoption of niche-discourse. In Dutch healthcare a shift in discourse is taking place where the focus is moving from 'disease and care' to 'health and behavior'. Using a discourse analysis combined with a transition perspective, we analyze this shift through the development and diffusion of the concept of Positive Health, which has developed from niche discourse to an important part of the national health policy. This chapter reflects on this successful integration in government policy and the applied (discursive) strategies to achieve legitimacy for Positive Health. This case illustrates the diffusion process, actions and strategies on different levels as well as enabling factors and potential barriers. This tracing of discourse displays the growing (systemic) tensions that are felt in Dutch healthcare as well as the need for alternatives.

This study has been an exploration of a transition from a variety of angles: transition intervention, discourse, organizational change, and as a creator of disturbances, discussion and dialogue. The empirical cases in this study each make contributions to the exploration and adoption of the health and well-being paradigm as an important foundation for a transition in Dutch healthcare. The empirical cases also share the challenge of (societal) embedding: the dominant 'repair' system is still omnipresent. Yet, it is also clear that there is a strong drive behind a potential transition to Healthy Care.

Conceptual contribution: Healthy Care

The perspectives on sustainable healthcare combined, in essence are all about how we can ensure a healthy future for healthcare. I propose that Healthy Care may function as a binding concept that connects the different perspectives on sustainable healthcare. Healthy Care implies a health and care system based on supporting a healthy population and employees in a healthy environment that is affordable and accessible. Healthy Care builds on the health paradigm to bind the different perspectives together. The aim here is not to provide or suggest a specific definition, but to identify characteristics of Healthy Care as interpretation of sustainable healthcare.

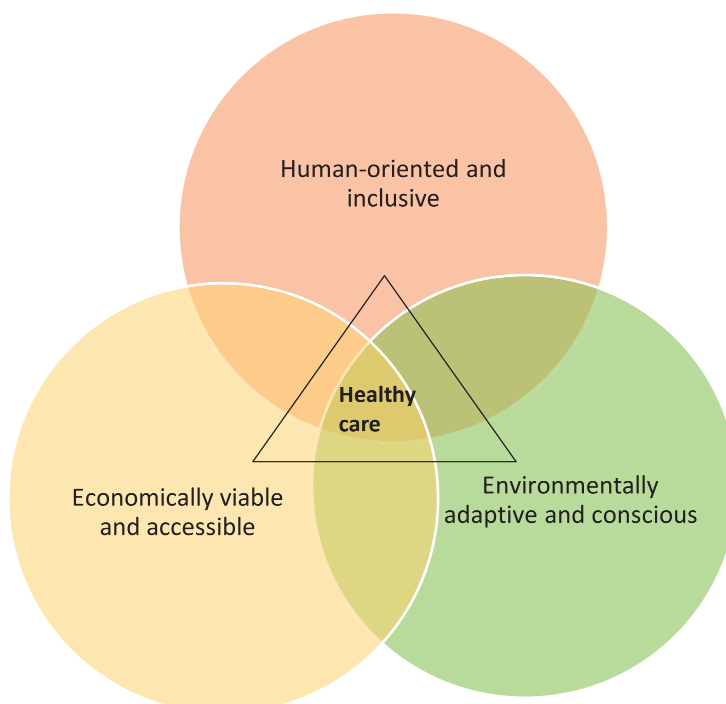


Figure: Visualization of Healthy Care

Based on this study I propose that Healthy Care has the following characteristics:

- Health paradigm as starting point: health and well-being are central as well as an orientation on what makes and keeps us healthy. This offers the possibility of looking to other domains or areas of life to find solutions to questions that are posed in the medical domain e.g., integrated lifestyle interventions may be more supportive of health than a pharmaceutical intervention;

- Human-oriented and inclusive: compassionate, holistic and integrated care. This characteristic is community-oriented and also calls attention to a healthy and happy workplace for healthcare professionals and -workers;
- Environmentally adaptive and conscious: addresses the burden of disease and thus healthcare delivery that is environmentally focused on reducing environmental footprint and creating healthy and healing environments (nature positive);
- Economically viable and accessible: balancing supply and demand in a way that is financially affordable without compromising other values (e.g., quality) or domains and realistically dealing with scarcity.

Healthy Care suggests cultures, structures and practices that are designed to prevent disease and maintain health, healthy and healing environments, do not harm the health of people or the health of the planet and create an inviting community for people to be a part of.

Conceptual contribution: Transition Pain

Next to alternative practices, this thesis also looks at transition dynamics by studying a process of organizational realignment. We study this process of realignment unfolding within a change-minded incumbent healthcare organization. The changing context in healthcare, in answer to landscape changes, requires organizational realignment of strategy, policies and work organization. When these are not aligned or even contradictory, this creates confusion and an organizational member can experience a sense of dissonance. In this study, we explore the use of a pain metaphor in organizational processes, perceiving an individual pain experience and pain symptoms such as tension or stress as a signal or call to action. We present a conceptualization of transition pain: pain experienced by organizational members related to processes of change in the context of disruptive external change (i.e., transition).

This incumbent perspective and how transitional periods are experienced by healthcare workers are explored in chapter 6. This case study done at a regional healthcare provider takes an organizational perspective on transition and the necessity to realign to a changing context. From this case, the concept of *Transition Pain* was developed as a signal of experienced dissonance when internal culture, structure and practices are not aligned. What is easily termed as resistance to change is here framed as a call for support and communication.

Using a pain discourse in relation to organizational behavior enriches the current discourse through awareness of pain experience and its functions. This supports practitioners in the interpretation of responses during a change process. With transition pains,

we offer a better understanding of behavior by approaching unwanted or unexpected responses as signals of experienced dissonance.

Recommendations

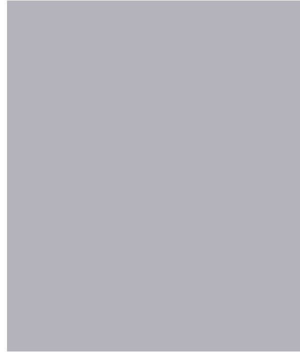
This explorative study makes a substantial contribution to mapping the developing transition in the Dutch healthcare system over the course of nearly a decade. The Dutch healthcare system is now actively seeking alternatives as patterns of destabilization and acceleration can be recognized. These patterns are visible in many subdomains as networks and coalitions of change-minded regime-actors, incumbents and niche-players are formed, transition agendas are developed and societal dialogue is growing. The phase of chaos and emergence seems, for the most part, yet to come, as dominant structures, patterns and routines are still in place. We are standing at crossroads with many possible directions. While we seem to have reached a tipping point, the playing field is still wide open and actors have to choose which way to go, what to keep, what to rearrange and what to let go of. In my opinion, this perfectly illustrates the current sentiment in Dutch healthcare and the different possible (joint) directions as we move into the 'messy middle' of transition dynamics.

Concerning transformative agency, the outcomes from the case studies in this thesis enforce earlier findings in transition studies about the relevance of developing new practices (experimenting), building a (new) common language, working with a coalition of the willing and doing, building support structures for people who are asked to change their practices, and stimulating niche-regime interaction.

Specific implications and recommendations for governance and policy include:

- encouragement of transition experiments that are based in niche-regime interaction;
- encouragement of transition experiments that integrate the different sustainability perspectives;
- development of different transition pathways that build on a shared vision of future healthcare and support acceleration by enforcing each other;
- encouraging revolutionary entrepreneurs directly targeting system change;
- investing (time) in dialogue with institutions and the people within;
- always keeping the triplet of culture, structure and practices in mind.

Future historians will be able to confirm if this thesis (accurately) caught the beginning of a sustainability transition in Dutch healthcare.



Samenvatting

SAMENVATTING

Gezonde Zorg

Verkenning van het ontwikkelende discours van duurzame zorg en de dynamiek van een transitie in gezondheid & zorg

Als we kijken naar de combinatie van vergrijzing, een afnemende beroepsbevolking en stijgende kosten van de gezondheidszorg, in combinatie met de bredere context van klimaatverandering, kunnen we ons afvragen hoe duurzaam het Nederlandse zorgstelsel in de huidige vorm is: kan het blijven functioneren in het licht van zulke kritieke uitdagingen?

De afgelopen tien jaar is duurzame zorg een belangrijk aandachtspunt geworden voor politici, beleidsmakers en zorgprofessionals: kunnen we toegankelijke, betaalbare en kwalitatief goede zorg blijven bieden? Meer recentelijk heeft de toenemende bezorgdheid over de ecologische voetafdruk van de gezondheidszorg, versterkt door de COVID-19 pandemie, de vraag opgeroepen of de sector binnen de planetaire grenzen kan blijven? Deze vragen, tezamen met de voortdurende discussies over de stijgende kosten van de zorgverlening, hebben geleid tot nieuwe belangstelling voor duurzame gezondheidszorg en de noodzaak van een fundamentele transformatie.

Onderzoek naar duurzaamheidstransities bestudeert complexe maatschappelijke problemen vanuit een systemisch perspectief. Het bestuderen van transitiedynamiek in maatschappelijke systemen levert ons kennis op over de aard van fundamentele verandering door te kijken naar verschuivingen in de manier van denken, doen en organiseren. Deze verschuivingen worden veroorzaakt door aanhoudende druk (persistente problemen) en afgedwongen door externe veranderingen en crises op macro- of landschapsniveau die kansen bieden voor verandering. De COVID-19-pandemie creëerde bijvoorbeeld plotseling kansen voor verandering, zoals werken op afstand en een bewustzijn van het probleem van ziekenhuisafval. De transitielens identificeert de onderliggende patronen die fundamentele verandering aandrijven als het samenspel tussen het zittende regime (of dominante manier van denken, doen en organiseren) en opkomende alternatieven (niches). Hiermee kan input worden verzameld voor een transformatieve (onderzoeks)agenda.

Dit proefschrift onderzoekt de transitiebeweging in de Nederlandse gezondheidszorg door het ontwikkelende discours rond duurzame zorg te belichten. Daarnaast worden

verschillende opkomende alternatieven bestudeerd. Deze alternatieven introduceren nieuwe culturen, structuren en praktijken en interageren met het zittende regime.

De centrale onderzoeksvraag luidt:

Hoe ontwikkelt zich de betekenis en het belang van duurzaamheid in de Nederlandse zorg?

Transities zijn processen van betekenisgeving in de samenleving waarin hardnekkige problemen worden onderkend en nieuwe praktijken, ideeën en concepten betekenis krijgen en aan belang toenemen. Onderzoek naar de betekenis die wordt toegekend aan het begrip duurzaamheid in de zorg is relevant om een vocabulaire op te bouwen dat actoren in de transitie kan ondersteunen. De onderzoeksvraag wordt verkend door het bestuderen van verschillende conceptualisaties van duurzame gezondheidszorg en het onderzoeken van empirische voorbeelden van nieuwkomers met een alternatieve propositie (niches). Daarnaast door te kijken naar transformatieve capaciteiten om te leren hoe experimenten, nieuwe praktijken en gericht beleid alternatieve manieren van denken, doen en organiseren kunnen ondersteunen.

De patronen en mechanismen die transities verklaren, zijn gericht op hoe gevestigde regimes zich ontwikkelen door optimalisatie en hoe macro-ontwikkelingen de druk om te veranderen kunnen vergroten. Transitiedynamiek illustreert hoe alternatieve ideeën, technologieën en praktijken (experimenten) transitieproces kunnen doorbreken versnellen terwijl het zittende regime destabiliseert. De fase van destabilisatie en versnelling wordt gevolgd door chaos en verlies van zekerheden terwijl de contouren van een nieuw regime zichtbaar worden. Nieuwe cultuur, structuren en praktijken worden dan geïnstitutionaliseerd terwijl oude worden uitgefaseerd.

Theoretische bijdrage: operationaliseren van duurzaamheid in het zorgdomein

Transitiestudies hebben hun wortels in socio-technische domeinen zoals energie of mobiliteit. Toepassing in de zorg en andere maatschappelijke domeinen is nog schaars. De operationalisering van (on)duurzaamheid in de zorg biedt inzicht in de transitiedynamiek in het socio-institutionele domein van de zorg, niet zozeer gedreven door technologische innovatie maar door institutionele, culturele en maatschappelijke vormen van innovatie.

De medische wetenschap heeft een groot aantal (infectie)ziekten effectief aangepakt. Dit medische model als conceptualisatie van gezondheid is gericht op de afwezigheid van ziekte of beperking. Dit perspectief heeft geleid tot een medische focus op 'reparatie'

of 'reparatie van het defecte onderdeel' (lichaam of geest) en heeft hiermee substantieel bijgedragen aan een toegenomen levensverwachting. De focus van het medische model komt tot uiting in de manier waarop het Nederlandse zorgstelsel is georganiseerd: medisch onderwijs, specialisatie, financieringsstructuren, een grote industrie voor geneesmiddelen en medische hulpmiddelen. Diagnostische mogelijkheden, behandeling in combinatie met de industrie voor geneesmiddelen en medische hulpmiddelen heeft geleid tot een uitgebreid aanbod in en van zorg. Technologische vooruitgang in combinatie met toegenomen welvaart en beschikbaarheid van zorg hebben zich ontwikkeld tot een vermeend 'recht' op gezondheidszorg en stuwen de vraag omhoog. Medische rationaliteit en de vraag naar (hoogwaardige) behandeling en zorg versterken zo elkaar, in zowel vraag als aanbod. Hierdoor is een te uitgebreid en onhoudbaar gezondheidszorgsysteem ontstaan.

Als het gaat om de koppeling van duurzaamheid en zorg zijn er meerdere overkoepelende perspectieven te onderscheiden:

- Systeem(on)duurzaamheid: landschapsontwikkelingen zoals vergrijzing, toename van chronische ziekten, technologische vooruitgang en een krimpende beroepsbevolking hebben de vraag naar zorg vergroot en de huidige organisatie van het systeem op het gebied van betaalbaarheid, kwaliteit en toegankelijkheid onder druk gezet.
- Mens perspectief: ontmenselijking van de zorg door focus op financiële prestaties en toenemende werkdruk.
- Nauw verwant is het perspectief dat pleit voor salutogenese (bevordering van gezondheid en welzijn) in plaats van pathogenese (ontwikkeling van ziekte): gezondheid als leidend principe in plaats van ziekte.
- Milieuperspectief: zou 'groene' zorg kunnen worden genoemd, gericht op (het verminderen van) het effect van gezondheidszorg op het milieu in termen van CO2 voetafdruk, circulariteit, afval, waterkwaliteit, gericht op klimaatverandering.
- Ecologisch perspectief: houdt zich bezig met de impact van klimaatverandering (en globalisering) op gezondheid en (wereldwijde) gezondheidssystemen die hierop niet zijn voorbereid, bijvoorbeeld pandemieën, oorlogen, migratie als gevolg van overstromingen.

De eerste vier perspectieven worden in dit proefschrift bestudeerd. Het meer grootschalige, ecologische perspectief is in deze studie niet uitgebreid verkend omdat de focus primair ligt op de (gelokaliseerde) Nederlandse gezondheidszorg.

Empirische bijdrage: transitiedynamiek in de zorg

Dit proefschrift verkent het onbekende gebied van transitie in de gezondheidszorg door initiatieven en experimenten op het gebied van de Nederlandse gezondheidszorg te onderzoeken. Dit proefschrift kijkt specifiek naar duurzaamheidsprogramma's, koplopers die alternatieven aanreiken, de ontwikkeling van een nieuwe taal en een nieuw paradigma, en de worsteling van gevestigde organisaties die belast zijn met de dagelijkse levering van gezondheidszorg. Aan de hand van drie casussen worden alternatieven voor de dominante manier van denken, doen en organiseren in de zorg en de niche-regime-interactie verkend:

- Expeditie duurzame zorg (hoofdstuk 3)
- Buurtzorg (hoofdstuk 4)
- Positieve Gezondheid (hoofdstuk 5)

De Expeditie duurzame zorg is ontwikkeld door het MVO Netwerk Zorg: een leerprogramma gericht op het creëren van koplopers in de zorgtransitie. Gedurende een periode van drie jaar zijn de acht deelnemende zorgorganisaties gevolgd om veranderingen in cultuur, structuur en praktijken te onderzoeken, evenals de resultaten en uitdagingen bij het verkrijgen en behouden van een koploperstatus. Dit hoofdstuk geeft een empirische beschrijving van een transitiemanagementproces.

Buurtzorg heeft een opmerkelijk ontwikkelingstraject doorgemaakt en wordt bestudeerd als voorbeeld van het leveren van zorg op een radicaal andere manier. Buurtzorg is ontstaan als alternatief voor de reguliere thuiszorg en deed als transitie-experiment mee aan het Transitieprogramma Langdurige Zorg dat liep in 2007-2009. In dit programma werd een transitie in de gezondheidszorg voorgesteld als "een fundamentele verandering naar een meer mensgericht, economisch volhoudbaar en maatschappelijk ingebed gezondheidszorgsysteem". Buurtzorg heeft als transitie-experiment gebruik kunnen maken van afgeschermde ruimte en transitieondersteuning in de vorm van financiële bescherming en gebruik gemaakt van transitiekennis van experts. In het onderzoek is gekeken naar de strategieën die Buurtzorg heeft toegepast om in relatief korte tijd momentum en invloed te krijgen. Deze strategieën zijn geanalyseerd vanuit verdieping, verbreding en opschaling. De snelle ontwikkeling van Buurtzorg wordt verklaard door het identificeren van hun strategische activiteiten, de afstemming van contextuele factoren en hun strategische positie als buitenstaander ten opzichte van het regime. We concluderen dat Buurtzorg een 'symbool' is geworden in een transformatieve beweging die kan bijdragen aan een toekomstige transitie in de zorg.

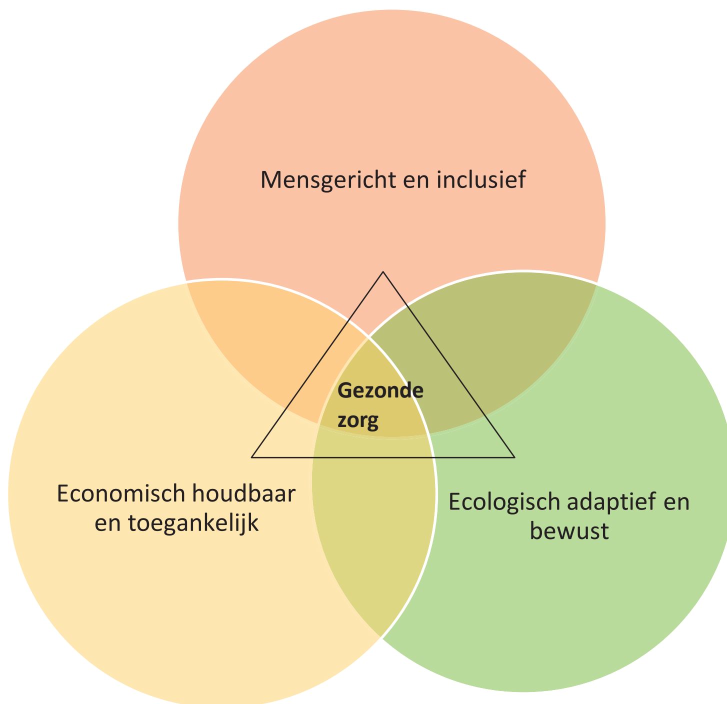
De casus Positieve Gezondheid is gericht op de wisselwerking tussen niche en regime, met name het perspectief van het beïnvloeden van beleidsontwikkeling in de

Nederlandse gezondheidszorg door het overnemen van een niche-discours. In de Nederlandse gezondheidszorg is een verschuiving in het discours zichtbaar waarbij de focus verschuift van 'ziekte en zorg' naar 'gezondheid en gedrag'. Middels een discoursanalyse gecombineerd met een transitieperspectief analyseren we deze verschuiving door de ontwikkeling en verspreiding van het concept Positieve Gezondheid, dat zich heeft ontwikkeld van niche-discours tot een belangrijk onderdeel van het nationale gezondheidsbeleid. Dit hoofdstuk reflecteert op deze succesvolle integratie in het overheidsbeleid en de toegepaste (discursieve) strategieën om legitimiteit voor Positieve Gezondheid te bewerkstelligen. Deze casus illustreert het diffusieproces, de acties en strategieën op verschillende niveaus en de faciliterende factoren en potentiële belemmeringen. Deze tracering van discours toont de groeiende (systemische) spanningen die gevoeld worden in de Nederlandse gezondheidszorg en de behoefte aan alternatieven.

Deze studie is een verkenning geweest van een transitie vanuit verschillende invalshoeken: transitie-interventie, discours, organisatieverandering, en als aanstichter van verstoringen, discussie en dialoog. De empirische casussen in dit onderzoek dragen stuk voor stuk bij aan de verkenning en acceptatie van het gezondheids- en welzijnsparadigma als belangrijk fundament voor een transitie in de Nederlandse zorg. De empirische casussen delen ook de uitdaging van (maatschappelijke) inbedding: het dominante 'reparatie'-systeem is nog steeds alomtegenwoordig. Toch is ook duidelijk dat er een sterke drive zit achter een mogelijke transitie naar Gezonde Zorg.

Conceptuele bijdrage: Gezonde Zorg

De perspectieven op duurzame zorg tezamen gaan in essentie over hoe we de zorg een gezonde toekomst kunnen geven. Ik doe de suggestie dat Gezonde Zorg kan functioneren als een verbindend concept dat de verschillende perspectieven op duurzame zorg met elkaar verbindt. Gezonde Zorg impliceert een gezondheids- en zorgsysteem gebaseerd op het ondersteunen van een gezonde bevolking en werknemers in een gezonde omgeving die betaalbaar en toegankelijk is. Gezonde Zorg bouwt voort op het gezondheidsparadigma om de verschillende perspectieven met elkaar te verbinden. Het doel is hier niet om een specifieke definitie te geven of te suggereren, maar om kenmerken van Gezonde Zorg als invulling van duurzame zorg te identificeren.



Figuur: Visualisatie van Gezonde Zorg

Op basis van dit onderzoek stel ik voor dat Gezonde Zorg de volgende kenmerken heeft:

- Gezondheidsparadigma als uitgangspunt: gezondheid en welzijn staan centraal evenals een oriëntatie op wat ons gezond maakt en houdt. Dit biedt de mogelijkheid om naar andere domeinen en levensgebieden te kijken bij vragen die in het medisch domein zijn gesteld, bijvoorbeeld geïntegreerde leefstijl interventies kunnen zinvoller zijn dan het voorschrijven van medicatie;
- Mensgericht en inclusief: compassievolle, holistische en geïntegreerde zorg. Deze eigenschap is gemeenschapsgericht en vraagt ook aandacht voor een gezonde en gelukkige werkplek voor zorgprofessionals en -medewerkers;
- Ecologisch adaptief en bewust: richt zich op de ziektelast en daarmee op zorgverlening die milieuvriendelijk en gericht is op het verkleinen van de ecologische voetafdruk als ook het creëren van gezonde en omgevingen (natuurpositief);
- Economisch houdbaar en toegankelijk: vraag en aanbod op een financieel betaalbare manier in balans brengen zonder andere waarden of domeinen in gevaar te brengen en realistisch omgaan met schaarste.

Gezonde Zorg impliceert cultuur, structuren en praktijken die zijn ontworpen om ziekte te voorkomen en een gezonde en helende omgeving te behouden, de gezondheid van

mensen of de planeet niet schaden en een uitnodigende gemeenschap vormen voor mensen om deel van uit te maken.

Conceptuele bijdrage: Transitiepijn

Naast alternatieve praktijken wordt in dit proefschrift ook gekeken naar transitiedynamiek door een proces van herinrichting te bestuderen dat zich ontvouwt binnen een veranderingsgezinde zorgorganisatie. De veranderende context in de gezondheidszorg, als antwoord op landschapsveranderingen, vereist een organisatorisch herontwerp van strategie, beleid en werkorganisatie. Wanneer deze niet op elkaar zijn afgestemd of zelfs tegenstrijdig zijn, ontstaat er verwarring en kan een organisatielid een gevoel van dissonantie ervaren. In deze studie onderzoeken we het gebruik van een pijnmetafoor in organisatieprocessen, waarbij we een individuele pijnervaring en pijnsymptomen zoals spanning of stress duiden als een signaal of oproep tot actie. We presenteren een conceptualisering van: pijn ervaren door leden van de organisatie gerelateerd aan veranderingsprocessen in de context van verstorende externe verandering (d.w.z. transitie).

Het opzetten van de bril van een gevestigde zorgaanbieder geeft inzicht in hoe overgangsperioden door zorgmedewerkers worden ervaren. Dit is nader onderzocht in hoofdstuk 6. Deze case studie, uitgevoerd bij een regionale zorgaanbieder, heeft een organisatorisch perspectief op transitie en de noodzaak tot aanpassing aan een veranderende context. Vanuit deze casus is het concept ontwikkeld als een signaal van ervaren dissonantie wanneer interne cultuur, structuur en praktijken niet op elkaar zijn afgestemd. Wat gemakkelijk weerstand tegen verandering wordt genoemd, wordt hier opgevat als een oproep tot ondersteuning en communicatie.

Het gebruik van een pijndiscours in relatie tot organisatiegedrag verrijkt het huidige discours door bewustzijn van pijnervaring en de functies hiervan. Dit ondersteunt bij de interpretatie van reacties tijdens een veranderingsproces. Met het vocabulaire van transitiepijn bieden we een beter begrip van gedrag door ongewenste of onverwachte reacties te benaderen als signalen van ervaren dissonantie.

Aanbevelingen

Deze verkennende studie levert een substantiële bijdrage aan het in kaart brengen van de zich ontwikkelende transitie in het Nederlandse zorgstelsel in het afgelopen decennium. Binnen het Nederlandse zorgstelsel is men nu actief op zoek naar alternatieven, en patronen van destabilisatie en versnelling zijn in veel subdomeinen te herkennen. In het bijzonder naarmate netwerken en coalities van veranderingsgezinde regime-actoren, gevestigde aanbieders, instituten en nichespelers worden gevormd, transitieagenda's worden ontwikkeld en de maatschappelijke dialoog wordt gevoerd. De fase van chaos

en emergentie lijkt voor het grootste deel nog te komen, aangezien dominante structuren, patronen en routines nog steeds aanwezig zijn. We staan op een kruispunt met veel mogelijke richtingen. Hoewel we een omslagpunt lijken te hebben bereikt, ligt het speelveld nog steeds wijd open en moeten actoren kiezen welke kant ze op gaan, wat ze behouden, wat ze herontwerpen en wat ze loslaten. Dit illustreert mijns inziens perfect het huidige sentiment in de Nederlandse zorg en de verschillende mogelijke (gezamenlijke) richtingen als we ons in het 'rommelige midden' van de transitiedynamiek begeven.

Met betrekking tot transformatieve capaciteiten versterken de uitkomsten van de case studies in dit proefschrift eerdere bevindingen uit transitiestudies over de relevantie van het ontwikkelen van nieuwe praktijken (experimenteren), het bouwen van een (nieuwe) gemeenschappelijke taal, het werken met een coalitie van bereidwilligen, het ontwikkelen van draagvlak en structuren voor mensen aan wie wordt gevraagd hun praktijken te veranderen, en het stimuleren van interactie tussen niche en regime.

Specifieke implicaties en aanbevelingen voor bestuur en beleid zijn onder meer:

- aanmoediging van transitie-experimenten die gebaseerd zijn op niche-regime-interactie;
- ontwikkeling van verschillende transitiepaden die bouwen op een gedeelde visie op toekomstige gezondheidszorg en versnelling stimuleren door elkaar onderling te versterken;
- aanmoediging van revolutionaire ondernemers die zich rechtstreeks richten op systeemverandering;
- (tijd) investeren in het veranderproces van instituties en de mensen daarbinnen;
- altijd rekening houden met de driepoot van cultuur, structuur en praktijken.

Toekomstige historici zullen kunnen bevestigen of dit proefschrift (nauwkeurig) het begin heeft weten te vatten van een duurzaamheidstransitie in de Nederlandse gezondheidszorg.

Shifting perspectives in healthcare

CHAPTER 1: SHIFTING PERSPECTIVES IN HEALTHCARE

1.1 The value and cost of (good) health

Ask people what they find most important in life and most will rank health in the top three (BMH, 2020; CBS, 2016b; Gfk, 2017; Kooiker, 2011). In the Netherlands, this has been the case consistently over the last decades. Health, or more specifically *good health*, enables us to pursue other priorities in life and health has been found to be the main indicator for happiness (Van Beuningen & Moonen, 2013). Compared to other European populations, Dutch people are among the healthiest, and the quality and accessibility of Dutch healthcare are considered high (OECD, 2018). This thesis starts off with different ways of looking at the value and cost of health: defining a health(care) system, healthcare demand and delivery in terms of expenditure and from the somewhat different perspective of planetary health.

1.1.1 Health system vs healthcare system

Concurrent with the importance placed on health, health (care) systems are designed to support individual and population health. According to the World Health Organization (WHO, 2003) a health *care* system refers to the institutions, people and resources involved in delivering healthcare to individuals. A *health system* [of a country or certain population] comprises all organizations, institutions and resources that produce actions whose primary purpose is to improve health (WHO, 2000). This definition of a health system thus implies a broader arrangement of actors and domains as health is improved by more than institutions delivering healthcare. For example, the quality of living conditions and amount of air pollution can strongly influence one's health but fall outside of the healthcare domain and healthcare system. In literature, the terms 'health system' and 'healthcare system' are often used as synonyms. In this thesis I mainly use the term 'healthcare system' for the purpose of simplicity. As will be argued in the course of this thesis, there is a significant difference between a health system designed to improve and maintain health and a healthcare system dedicated to delivering care and treatment based on a medical 'repair' paradigm. A health system crosses into other domains to improve and maintain health and this may prove an essential difference.

1.1.2 Healthcare expenditure

Delivering healthcare in a way that fits the current demand, available technology and driving medical and economic incentives, comes with increasing healthcare expenditure (CBS, 2021; OECD/European Union, 2022; RIVM, 2018; WRR, 2021). This is reflected in an increasing percentage of Gross Domestic Product (GDP) spent on healthcare (CBS, 2021; OESO, 2019). In the Netherlands, the healthcare expenditure was 13,2% of GDP in 2019 (CBS, 2021) and as such one of the highest in Europe. Recently, the Netherlands

was identified as the top European spender on healthcare per person in 2020 (OECD/ European Union, 2022). The expenditure on long-term care is among the highest in Europe (OESO, 2019).

The healthcare expenditure is expected to increase to as high as 20% of GDP by 2040 if nothing changes (WRR, 2021; Vonk et al., 2020). In the Integral Care Agreement, the Ministry of Health, Welfare and Sport together with sector organizations, announced that this expected increase in healthcare expenditure is neither realistic nor desirable (Integraal Zorg Akkoord, 2022). This expenditure supplants the expenditure in other domains such as education, culture, climate and defense (WRR, 2021). An increase in expenditure is also expected to result in increased costs for citizens through insurance premium, taxes and out-of-pocket expenses. A final argument is that unlimited growth of healthcare (expenditure) is undesirable due to a declining labor force, in general, but also specifically in relation to the demand in healthcare (WRR, 2021). The Dutch healthcare sector is acknowledging the limits to growth and the undesirability of expenditure growth in the healthcare domain only (WRR, 2021), despite the value we place on health.

1.1.3 Planetary health and climate change

Besides demand and expenditure, the value and cost of health can also be viewed from the perspective of planetary health. The idea of planetary health builds on the interdependence between the health and wellbeing of the earths (human) population and the health of the natural systems and the wellbeing of the planet itself (Horton et al., 2014; Horton & Lo, 2015). The health of people and the health of the planet are co-dependent (Beanland, 2017; WHO-HCWH, 2010). The effects of climate change caused by global warming are visible in health crises around the world. Examples include flooding and droughts leading to food insecurity and disease transmission, air pollution causing or contributing to a range of health problems (McDuffie et al., 2021, Watts et al., 2018) and rising temperatures increasing the occurrence of heat exhaustion and allergens (HCWH/ Arup, 2019). Subsequent climate migration may lead to mental health problems (IPCC, 2022). Increasingly, the climate crisis is equated with a health crisis (Romanello et al., 2021; Whitmee et al., 2015).

Recent research confirms that the healthcare sector is responsible for 7% of all CO2 emissions in the Netherlands (Gupta, 2019; Steenmeijer et al., 2022), quite above the global average of 4,4% (Pichler et al., 2019). Research has also shown a strong correlation between the climate footprint of a country's health sector and its health spending measured as a percentage of GDP: the higher the spending, the higher the per capita health care emissions (HCWH/Arup, 2019). As such, the (Dutch) healthcare sector has the

potential to make a significant contribution to the goal of reducing CO2-emissions by 49% in 2030 in the Netherlands (Klimaatakkoord, 2019).

The paradox here is that the healthcare sector, through CO2-emissions, waste and use of raw materials in their products and devices, is a large contributor to the climate crisis (figure 1.1), while the purpose of healthcare is to protect and promote health. A healthier way of delivering healthcare contributes to a healthier planet and healthier people.

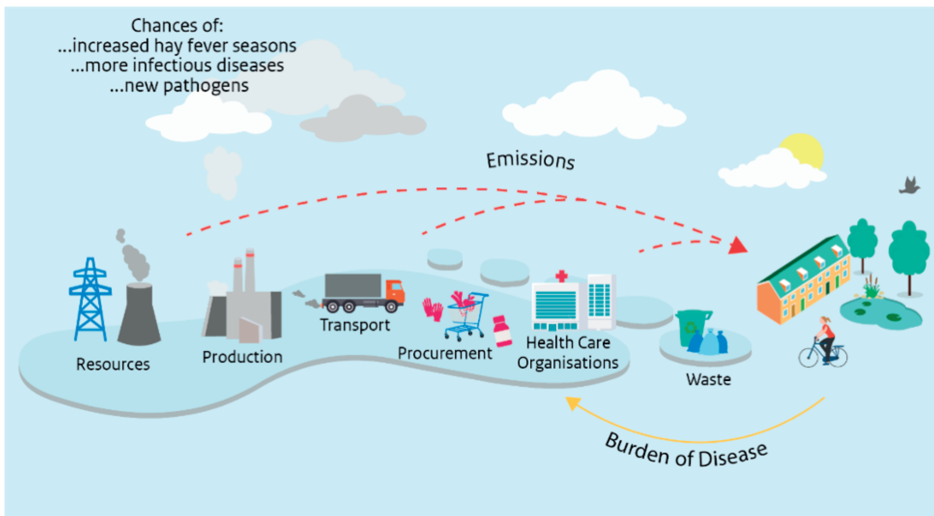


Figure 1.1 Diagram of the environmental footprint of a chain, with the self-reinforcing effects on public health and the living environment. Institutions and service providers in the healthcare sector are being confronted with the impacts of climate change on public health. Increased greenhouse gas emissions and fine particulates cause more heat to be retained in the atmosphere. This warming effect leads to climate change, which in turn causes increased heat stress, longer hay fever seasons, and the emergence of new diseases and pests. Source: Steenmeijer et al., 2022.

The value placed on health is reflected in the United Nations (UN) Sustainable Development Goals (SDG's) where number 3 is formulated as *Good health and well-being for all*. The SDG 2022 Report (United Nations, 2022) illustrates how the COVID-19 pandemic has disrupted essential health services worldwide and, among others, has triggered an increase in the prevalence of anxiety and depression. The COVID-19 pandemic has increased attention to the importance of addressing climate change and sustainability policies in healthcare. In the Netherlands, the COVID-19 pandemic raised attention to the importance of health and lifestyle (e.g., obesity means higher risk) and thus prevention, as well as the importance of work-life balance and a healthy (work) environment as work-related illness rates increased. For the elderly population in nursing homes the importance of quality of life over safety measures was highlighted. Very visible was the

large waste production that came with the pandemic policies. This large amount of hospital waste has become almost a symbol for the environmental footprint of healthcare in the Netherlands (figure 1.2). The excessive amount of hospital waste created by a high number of patients (e.g., through testing, occupancy rates) and pandemic policies focused on containing the spread of the virus by extensive use of disposables such as masks, gloves, aprons and other protective clothing. The amount of hospital waste became visible as waste collecting and disposal could not keep up with the amount of waste being produced. This led to specific research into hospital waste, in particular in Intensive Care Units (ICU's) and operating theaters. One example is the ICU at the Erasmus Medical Centre in Rotterdam where the research showed that the ICU produced 250.000 kilograms of waste per year.

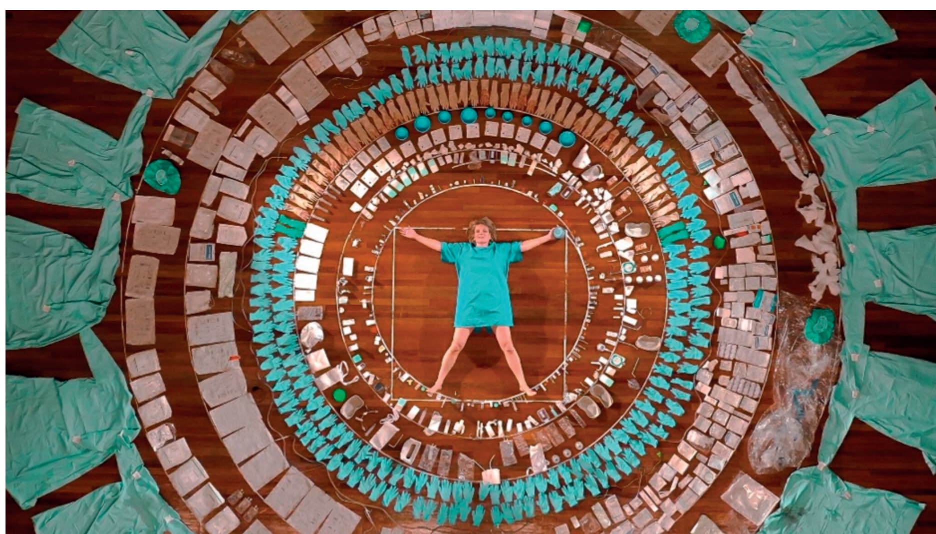


Figure 1.2 Art project made of operation waste by Maria Koijk (2021).

1.1.4 Healthcare fit for the future?

If we consider the combination of climate change, an ageing population, a declining labor force and rising costs of healthcare, we can ask whether or not the system in its current form is, literally, sustainable: can it continue to perform facing such persistent problems and critical challenges? This question arose for me as I observed a lack of attention in the sector in spite of these so obvious problems. Additionally, this question of sustainability seems closely connected to the quality dimension in healthcare (Connor & O'Donoghue, 2012), a subject that has always received a fair share of attention. Since setting out on this journey of discovery ten years ago sustainable healthcare has certainly become a favored topic of choice whether it be in the sense of tenability or

ecological sustainability. The COVID-19 pandemic, along with increasing concerns regardingthe climate footprint of healthcare and the ongoing discussions concerning rising costs of healthcare-delivery, constitute an important base for a newly developed interest in sustainable healthcare and the need for a fundamental transformation. This thesis explores this developing transition movement in healthcare by highlighting the changing discourse and several emerging alternatives.

1.2 Challenge: realigning to a changing context

1.2.1 Design of the Dutch healthcare system

Since the end of the 19th century our perception of health has seen several changes and these changes have been translated in the way healthcare is delivered. For example, the social hygiene movement developed with the growth of cities at the end of the 19th century (Helderman, 2007). This social hygiene movement introduced new notions relating to health such as the importance of clean water and the quality of food. This hygiene discourse contributed to a strong increase in the health of populations at the time and can be seen as the base for prevention and lifestyle approaches today. However, issues relating to preventative health and safety, ranging from the sewage system to food safety measures and from educational activities to pedestrian areas, are largely positioned and organized outside of what we consider to be the healthcare system today.

From the 1930s, scientific advancements in medical research and technological developments have increased opportunities for medical treatment and shifted the paradigm towards treatment of disease (curation). This advancement in medical science supported the rise of the medical profession of physician, hospitals as organizations where the medical profession is practiced and medical specialization (Van Raak, 2016). Together with the development of the welfare state after the Second World War this shaped the way healthcare is organized and financed today. The scope of Dutch healthcare has seen a large expansion leading to a myriad of general and specialized healthcare organizations, general and specialized healthcare workers (e.g., general physicians and specialists, nurses, physiotherapists), institutions (e.g., insurance companies, policy institutions, sector organizations) and suppliers (e.g., pharmaceutical companies). These examples illustrate the many subdomains that have emerged following specialization. The expansion of the healthcare domain into several echelons encompasses everything from pre-natal care to hospice care, in the form of public health(care), home care and institutionalized care.

The development of the current Dutch healthcare system can be described as being built up of constellations (Van Raak, 2010; Van Raak & De Haan, 2017) around healthcare

professions: primarily medical specialists who prescribe and perform medical treatments in hospitals that serve as supporting structures. A specific healthcare industry has developed in answer to this demand for medical treatment with pay-per-treatment financing, specialized medication and medical devices. Specialization is compartmentalized around specific groups of patients: mental healthcare, handicapped care, elderly care, youth care, maternity care. This compartmentalization is also recognizable in the division between general practitioners, home care and specialized hospitals (Mackenbach & Stronks, 2016). Increasingly, independent clinics also focused on specific treatments (NZA, 2007; Volmer, 2008). The discourse surrounding the focus on treatment of physical and mental medical problems, is known as the medical model.

1.2.2 The success and drawbacks of the medical model

So why is there such a high demand for healthcare, and why is this demand (and expenditure) expected to continue to rise? Paradoxically, the healthcare system seems to be a victim of its own success. The Dutch healthcare system, but similar in other Western countries, is designed to support the priority of (individual) health by focusing on diagnosis and treatment of medical 'problems'. It has done so very successfully as average life expectancy in the Netherlands has increased from 71.4 years in 1950 to 81.8 years in 2018 (CBS, 2019). Medical science has effectively dealt with a large number of (infectious) diseases: researching causes, developing medicines and curative treatments, supported by preventative measures such as vaccines. This medical model as a conceptualization of health (Larson, 1999) is focused towards *the absence of disease or disability*. This perspective has inspired a medical focus on 'repair' or 'fixing the malfunctioning part' (whether body or mind) and has been highly successful considering the increased life expectancy.

The dominant focus on diagnosing and curing ('repair') has arguably been the most successful feature of the medical model, reflected in how the Dutch healthcare system is organized: medical education, specialization, financing structures (fee-per-intervention based on diagnosis-treatment tariff combinations), a large industry for pharmaceuticals and medical devices. Add to that a population that, on average, demands whatever medical solution is available for their complaint and may turn to crowd-funding if not available through regular health-insurance. Research shows that this cultural driver of demand is strongly related to increasing prosperity (RIVM, 2018). Technological advances combined with increased prosperity and availability of care have developed into a believed 'right' to healthcare. In this way, medical rationality and the demand for (high quality) treatment and care have become self-reinforcing in both supply and demand, creating an overexpanded healthcare system.

The success of the medical model has influenced the demographic development reflected in the ageing of the population. More people live longer. The ageing of the population comes with an increase in chronic disease and comorbidity (RIVM, 2018); longer life, but not necessarily in good health. Chronic disease is often related to lifestyle. Obesity and smoking are well-known risk factors for cardiovascular and pulmonary diseases. The medical model is not as good of a fit for chronic disease as it is (or was) for acute or infectious disease. A more relevant approach to chronic disease consists of lifestyle interventions and prevention, such as a healthy diet, exercise, and managing (work) stress. However, the organization of the Dutch healthcare system and financing structures, are still mostly based on the medical model that pays more for treatment than for prevention (SER, 2020).

1.2.3 Gap between supply and demand

The previous paragraphs illustrate how the growing strain between the value placed on health and the cost of health(care), enhanced by healthcare delivery based on medical rationality, forms the basis for discussions on the tenability and sustainability of the Dutch healthcare system. The past decade has seen a large number of institutional reports (e.g., BMH, 2020; Nza/ZI, 2020; RVZ, 2010, 2014; SER, 2020; Taskforce JZJP, 2018; VWS, 2021; WRR, 2021) that conceptualize the tenability of the healthcare system as a gap between supply and demand.

The demographic of the ageing of the population and concurrent increase in chronic disease and multimorbidity has been previously highlighted. Another relevant demographic here is the decline of the work force and, simultaneously, the increasing need for more healthcare professionals following the rising demand for healthcare (WRR, 2021). This growing shortage in labor force is felt in almost all domains and adds to the 'competition' that healthcare has with other domains concerning expenditure. The gap between supply and demand is most visible in tensions that are experienced when the public values of quality and accessibility (WRR, 2021) are under pressure.

The pressure can be felt financially in the need for personnel. It can also be felt as societal pressure as characteristics such as solidarity are declining when it comes to contributing to the treatment of lifestyle related disease of others (WRR, 2021). Systemic tensions in the healthcare sector (Broerse & Bunders, 2010), are illustrated by symptoms such as waiting lists, gaps in nationwide coverage and provision of certain healthcare services, experienced lack of emotional support for patients due to work pressures, healthcare professionals who choose to work in another domain and leave healthcare and limited cross-domain collaboration (Neuteboom et al., 2009). The aforementioned large number of institutional reports all call for change and increasingly for this change to be trans-

formative in nature as previous healthcare reform has not been able to address these tensions effectively (IZA, 2022; Nza/ZI, 2020; Taskforce JZJP, 2018; WRR, 2021).

1.3 Need for a different approach

1.3.1 The danger of old remedies for current problems

The advances in medicine in the last century have been enormous and have all but eradicated infectious disease in Western countries[1]. The current Dutch healthcare system reflects this success, but the need has changed from a health perspective. Living longer with (multiple) chronic disease requires a different approach with more focus on healthy behavior and lifestyle, prevention, wellbeing, and a community approach, in addition to medical treatment when indicated. However, the characteristics of the current healthcare system are still mainly based on medical rationality (Grin, 2006; Schuitmaker, 2010). This leads to default solution pathways that are based on the successful features of the healthcare system as routines structure daily practices, discourse and decision-making by actors. The preferred way of doing things is generally executed on a subconscious level, but presents a bias towards solution pathways and oversight of alternative solutions (Broerse & Bunders, 2010). As long as the prevailing paradigm is based on medical rationality, solution pathways will reflect 'old' remedies of optimization e.g., cost-constraining strategies such as restructuring or controlled competition, focus on efficiency and efficacy, recruiting more personnel. These measures do not have to be made redundant as they have their worth to a certain point, however, in themselves they are not a sustainable solution for the tenability of the Dutch healthcare system (WRR, 2021).

1.3.2 Persistent nature of problems

The previous paragraphs have touched on characteristics of the current system that have supported its success in the past but are becoming a burden: the system is showing an undesirable resilience (Oliver et al., 2018). Schuitmaker (2010, 2013) has identified several embedded features of the (Dutch) healthcare system that all stem from the central role of medical rationality and the dominance of this paradigm focused on 'cure'. These strongholds or success factors have negative side effects that manifest in enduring problems. The main characteristic of enduring problems is that they are persistent in nature and cannot be solved as solutions become part of the problem. Features such as far-reaching specialization following a developing field of medical science are at the base of the success of the current system. Such a feature also obstructs an integral approach because of barriers between specializations and domains.

1 Although global pandemics such as COVID-19 are expected to be a recurring phenomenon (RIVM, 2020).

The embedded features Schuitmaker identifies and the associated challenges, are:

- Evidence-based medicine (EBM) as main approach to solving problems, building on randomized controlled trials (RCT). Other forms of evidence are generally rejected, but this approach is less fitting in times of crisis when quick decision-making is necessary.
- Standardization refers to a uniform approach, based on EBM, and emphasizing the professional domain, specifically when it comes to prescribing treatment such as medication as a preferred solution. Standardization and a uniform approach to a medical problem leave little room for alternative solutions, both inside and outside of the medical domain. There is limited capacity for personalized medicine that acknowledges individual traits and circumstances that may influence the standard treatment of choice.
- EBM and standardization are combined in clinical guidelines that dictate behavior of all actors in the healthcare system be it practitioners, patients, insurance companies, pharmaceutical companies, or policy institutes.
- Specialization has been a significant feature in furthering medical science. The downside is the development of compartmentalization that can act as a barrier to and can infringe on a transdisciplinary approach and/or alternative solutions.
- Protoprofessionalization refers to the use of medical discourse by lay people and how both patient and professional look for solutions in the medical discourse. This can drive up demand as patients request certain diagnostic procedures or specific treatment that they have read or heard about e.g., on the Internet.

Due to the embeddedness of these features they contribute to problems having a persistent nature and are labeled as unstructured (Hisschemöller & Hoppe, 1996) or wicked (Rittel & Webber, 1973). These are generally found in complex systems. In Dutch healthcare, for instance, the gap between supply and demand that has repeatedly led to restructuring and cost-containing strategies is not of recent years, but was already observed as early as the 1980s (Lagergren, 1985). So why are certain challenges, such as increasing healthcare expenditure or preference for (medical) treatment over alternatives such as lifestyle interventions, so persistent and why hasn't healthcare reform been able to solve these problems? The persistent nature of these problems is due to the main features of the healthcare system (based on past success factors) being embedded and therefore (re)produced by both the system and its actors (Loorbach, 2007). In other words, the challenges to the modern healthcare system are based on problems that are embedded in their foundational features (Broerse & Grin, 2017) and that build on an extremely successful model.

Pressures on the healthcare system increase as the context develops: an increasing population of care recipients and a decreasing workforce of care professionals and informal care givers, climate change, digitalization and a global pandemic require a different frame of mind. Solutions based on optimization may lead to a certain level of efficiency-gain and work-flow improvement for a certain time. These solutions do not address a fundamental change in the design of the healthcare system as a whole, necessary to realign with the changing context. These pressures can be felt as a call for change, but with a large amount of uncertainty concerning the 'right' direction and much to lose for incumbent actors that represent the dominant system. Proposed solutions for systemic pressures initially target symptoms instead of root causes e.g., restructuring budget distribution instead of targeting the demand for care. The landscape developments create a context for disruptive social change to solve persistent problems.

1.3.3 Diagnosis: care infarct

The analysis in the previous paragraphs emphasizes the unsustainability in the current way of doing things. In the current design, the Dutch healthcare system is unsustainable and optimization by following default solution pathways has reached is limits. Healthcare institutions, followed by media, have begun to refer to the rising tensions following scarcity as a (threatening) care infarct[2], specifically if no action is undertaken (IZA, 2022; NRC series of articles, 2022; Nza/ ZI, 2020; Taskforce JZJP, 2020; WRR, 2021). This tall pile of reports advocates the necessity to make choices regarding what healthcare services are made available and in which situations it is necessary to rely on one's own health capacities, informal care, traveling longer distances or choosing a digital option for specialized care. Every actor in the healthcare system, including patients or rather civilians, will need to adapt – this is the message of reports and critical articles. In the political arena it has proven difficult to really choose, and thus restrict, accessibility to healthcare services. This reserve is fueled by the aforementioned protoprofessionalization and the podium offered by television programs and other media. When considering the public voice, hardly any form of healthcare can be eliminated (NRC, 2022). On the other side of the spectrum, a declining solidarity can be identified when it comes to paying for healthcare services that are needed for lifestyle related (chronic) illness (WRR, 2021). Increasingly, the perceived unsustainability of the healthcare system is voiced. The following paragraph investigates the different sides of this (un)sustainability perspective.

2 Ironically, 'diagnosing' the systemic problems using this analogy of an infarct emphasizes the discourse of the medical model.

1.4 The sustainability perspective

1.4.1 Main perspectives on (un)sustainable healthcare

The level of healthcare in the Netherlands is considered high and many people are treated and supported by dedicated healthcare professionals. The previous paragraphs have illustrated that the current system is unsustainable in several areas and there is a growing sense of urgency for change. From the socio-economic perspective of tenability of the healthcare system (affordability, accessibility and realization of healthcare delivery), from a social perspective that advocates humanizing healthcare with a health and well-being paradigm instead of disease, and from an environmental/ ecological perspective that addresses the impact of healthcare on climate change and vice versa. The different perspectives put together very much resemble the Triple Bottom Line of social, environmental and economic impact (Elkington, 1994); also known as the Triple P of people, planet and profit (or prosperity).

In the most literal sense of the word, to sustain is the capacity to endure. The dictionary defines sustainability as *the ability to be sustained, supported, upheld, or confirmed* (dictionary.com). These definitions seem to describe a passive state, whereas sustainability in practice is actually more like continuous 'work in progress' and requires ongoing action. From this perspective, *sustainable development* as presented in the UN report Our Common Future (UN WECD, 1987), seems to be a better fit, also in healthcare.

Monissen & Akkerman (2011) identify these different definitions as the distinction between:

- sustainable healthcare as an undefined collectively used term;
- sustainability **in** healthcare representing an ecological or environmental perspective;
- sustainability **of** healthcare representing the tenability of the healthcare system building on a social and economic perspective on finance and capacity.

These distinctions seem to be used in separate fashions in Dutch healthcare, but at the same time can be presented as "sustainable healthcare", even though the interpretation is very different. The social perspective and the environmental perspective are the two main conceptualizations when combining sustainability and healthcare and these will be expanded on in the next two sections. The objective is not to suggest one overarching definition of sustainable healthcare, but to highlight different perspectives that in turn may influence transition pathways.

Since first exploring this subject for this study, sustainability and healthcare have increasingly been linked together. In 2009, one of the first publications on a sustainability transition in Dutch healthcare was published as part of the Transition Program for Long-term Care: in Dutch: Mensenzorg, een transitiebeweging (Neuteboom et al., 2009). With this program and publication, an analysis was made concerning the systemic problems in Dutch healthcare and a vision for the future presented. Sustainability in this conceptualization is a value underlying the systemic perspective and a way to describe the intended economic durability of the healthcare system. In 2010, a similar publication followed by Broerse & Bunders that explored the persistent problems in healthcare and how to deal with them.

In 2010, an invitational conference was organized by the Netwerkuniversiteit (part of the anthroposophical Bernard Lievegoed Fonds) on the topic of "building blocks for a sustainable healthcare". Many of the contributions to this conference were bundled in maybe the first comprehensive Dutch publication on sustainable healthcare (Van Gerven et al., 2011) and offered a list of specific action points. The first one being to put salutogenesis (what makes and keeps us healthy) above pathogenesis (what makes us ill and how to treat this). This line of thinking from the perspective of health rather than sickness was supported by the publication of a report by the Raad voor de Volksgezondheid (RVZ, 2010) concerning the paradigm shift from sickness to health (see also chapter 5) and advising a shift towards prevention. This call is still strong in current publications concerning the future of Dutch healthcare (e.g., Juiste Zorg op de Juiste Plek, 2018).

In 2011, there was the publication of a research report that focused solely on sustainability in healthcare and concluded a severe lack of vision and policy towards (environmental) sustainability in healthcare. At that time only 4% of healthcare providers actively engaged with sustainability (Knegt, 2011). This publication became an important starting point for the Dutch CSR network in healthcare (initiated in 2012, see chapter 3). The action points introduced by the 2011 publication (Van Gerven et al.) were copied by the Dutch CSR network for healthcare in their manifest for sustainable healthcare. Internationally, a comprehensive publication on sustainable healthcare became available in 2013 in the United Kingdom (Schroeder et al., 2013), covering both environmental sustainability and the sustainability of the healthcare system as a whole.

Since 2015, the Dutch Ministry for Health, Welfare and Sports has committed to sustainable healthcare by appointing an ambassador for sustainability and partnering in Green Deals for Sustainable Healthcare. The ministry of healthcare appointed this advocate for sustainable healthcare to acquire a support base at the executive level for sustainability in healthcare. An increasing number of healthcare organizations/ providers and institu-

tions underwrite the (third) Green Deal for Sustainable Healthcare 2023-2026. By 2023, the ministry of healthcare has a program team on this subject.

1.4.2 Social perspective: sustainable healthcare (system)

The social perspective pertains to both the socio-economic tenability of the system and aspects concerned with people and their behavior. This social perspective includes the call for humanizing healthcare by addressing the human interaction involved, the uniqueness of every individual's situation and their experience, as well as the emphasis place by several authors on the importance of community and care being embedded in society (De Blok & Pool, 2010; Huber et al., 2013; Neuteboom et al., 2009; Serra et al., 2018).

When considering the tenability of the system, we can identify that the main values of the Dutch healthcare system are under pressure: affordability, accessibility and quality (Essink et al., 2010; Toebes, 1999; WRR, 2021). These pressures have been visible since the 1990s and been attempted to solve, mainly at cost level e.g., by developing models for what is insured (Dunning's funnel: Dunning, 1991) and introducing regulated market mechanisms in the hope that competition will drive up quality and contain costs. These solutions have hardly been able to contain costs and by 2022 the urgency is felt very strongly as healthcare expenditure is competing with other important areas such as climate and education. The urgency for systemic change towards a more sustainable system is strongly felt (WRR, 2021).

Cost control and human-oriented healthcare are often presented as two sides of a coin, usually incompatible. Schroeder et al. (2013) call this the crisis of compassion: health professionals have become very busy, getting more done in less time. Meeting the human needs of those receiving care are potentially compromised, not helped by a medical model and financial structure that focuses primarily on targets and 'repair'. Ironically, as Schroeder et al. (2013) point out, compassion is a relatively unlimited and 'free' resource, but it is often not being used to full 'capacity'. Bringing the humanity back into healthcare (Neuteboom et al., 2009) reflects the shift from absolute health to well-being as a main goal to strive for. A focus on well-being can mean choosing not to operate, treat, repair or medicate, but to support an individual's personal goals of well-being which may have a more social or sense-giving character and need a community or spiritual approach (Huber et al., 2013). As formulated in the Integral Care Agreement (IZA, 2022): not every problem or question requires a medical response. This does not mean discarding all medical treatment, but implies critically considering medical interventions in the light of prevention, possible life style changes and support from the social domain.

These different approaches look to alternatives for the medical model to realize the goal of well-being, which in turn can support a person's feeling of healthiness, participation and a sense of belonging. This social perspective is relevant for understanding sustainable healthcare, as the main underlying idea is that all healthcare that is *not* given -because there was a fitting solution in another domain or because prevention kept a person healthy and medical intervention was not the preferred option- is ultimately the most sustainable.

1.4.3 Environmental perspective: sustainability in healthcare

Increasingly, the connections between healthcare and care for the environment are becoming more common. In the Netherlands, the first Green Deal for Sustainable Healthcare was launched in 2015(-2018), followed by a second in 2019(-2022) and recently a third Green Deal (2023-2026). A growing number of healthcare providers, sector organizations, suppliers and insurance companies have joined the consecutive Green Deals Sustainable Healthcare initiated by the Ministry for Health, Welfare and Sport and supported by other ministries. With the Green Deal comes acknowledgement that the delivery of healthcare draws on planetary resources and contributes to climate change.

The most recent Green Deal covers five themes: health promotion of patients, clients and employees, increasing awareness and knowledge on the impact of healthcare on the climate and vice versa, reducing the carbon footprint of healthcare, reducing primary resources and increasing circularity in healthcare, reducing environmental pressure caused by (use of) medication. Recent research (Gupta Strategists, 2022) suggests that the most positive impact towards reducing carbon emissions in healthcare can be attained through the energy use of buildings, travel movements of healthcare workers and patients, pharmaceutical industry primarily in the chain of production of medication and through medical devices. Other themes that are increasing in popularity are healthy eating, locally sourced ingredients, reduction of food waste and healing environments.

The ecological perspective pertains to the ecological stewardship in healthcare by healthcare(system) actors. In September 2021, editors of health journals worldwide, including the Lancet and The BMJ, simultaneously published a "call for emergency action to limit global temperature increases, restore biodiversity, and protect health" (Atwoli et al., 2021). This call to action refers to planetary health and the idea that if it is healthy for people, it is healthy for the planet (WHO, 2003). With this coordinated comment the editors call attention to the urgency for halting global temperature increase and consider the related effects on health worldwide. They call out to governments to "make fundamental changes to how our societies and economies are organized and how we live" (p.2). The commentary also addresses health professionals to "do all we

can to aid the transition to a sustainable, fairer, resilient, and healthier world" (p.2). The authors acknowledge that supporting the development of environmentally sustainable health systems will require changing clinical practice, although this topic is not further explored (Atwoli et al., 2021).

Of course, there is worldwide attention to all manner of sustainability and sustainable systems. From that perspective, healthcare is getting onboard with a broader trend where organizations are conscious of the impact they have on climate change and the health of the planet in the process of healthcare delivery.

1.4.4 Conceptualizations of sustainable healthcare

Ironically, both the social and environmental perspective on unsustainability can have a negative effect on people's health, something the system is designed to uphold as much as possible. Thus, in both views or perspectives the health and well-being of individuals and populations (in a preventive sense – before using healthcare services) is the key element: not disease being treated to become healthy again, but a healthy society that makes the use of the healthcare system less a necessity.

To summarize: in the linkages of sustainability and healthcare, several overarching perspectives can be identified:

- System (un)sustainability: landscape developments such as ageing of the population, increase in chronic disease, technological progress and a shrinking working population have increased demand and put pressure on the current organization of the system in terms of affordability, quality and accessibility.
- People perspective: dehumanization of healthcare as a result of focus on financial performance and increasing work pressures.
- Closely related is the perspective that advocates a preference for salutogenesis (promotion of health and well-being) rather than pathogenesis (development of disease): health as leading principle instead of sickness.
- Environmental perspective: could be called 'green' healthcare, concerned with (reducing) the effect of healthcare on the environment in terms of carbon footprint, circularity, waste, water quality, concerned with climate change.
- Ecological perspective: concerned with the impact of climate change (and globalization) on health and (global) health systems that are not prepared for this e.g., pandemics, wars, population movements caused by flooding. This, more large-scale, ecological perspective will not be explored extensively in the scope of this study as this study has its primary focus on (localized) Dutch health(care).

Besides these recurring themes, many publications showcase alternatives. Although they do not all specify these alternatives as sustainable, in description they underline the necessary transition in healthcare. Few publications explore the problems in the current healthcare system(s) and only signal the need to do it differently. These, seemingly diverging, views on sustainable healthcare beg the question of how a sustainability transition can come about, when the actors involved have a different understanding of the problem and the solution. Or can they exist side by side? Exploring the different meanings of sustainable healthcare and investigating dynamics of change in cases where alternatives are experimented with, is the main subject of this explorative study.

An acceleration of interest in sustainable healthcare is undeniable since initiating this research project in 2014. News and publications on sustainability (in all its forms and meanings) can now be found weekly in newsletters, articles, conferences, podcasts, awards, etc.. Additionally, new organizations are founded such as the Green Healthcare Alliance (in Dutch: Groene Zorg Alliantie, established in March 2021) and influential doctors, nurses and other healthcare care practitioners speak out for sustainable healthcare. As such, the amount of attention for sustainable healthcare has grown with an increasing societal interest and priority for sustainability in all areas and societal domains.

1.5 Developing perspectives on sustainable healthcare through transitions research

1.5.1 Sustainability transitions research

Healthcare has the specific characteristic of touching fundamental values and questions the way we live individually and together (Neuteboom et al., 2009). In society in general, there is a growing awareness of the necessity of becoming more sustainable in how we produce, consume and live. Health and healthcare have enormous impact: not only on our personal lives and on social relations and communities, but in terms of economic impact (e.g., GDP, workforce) and the impact on the planet (e.g., energy use, waste). The paradox here is that healthcare systems prevent, cure and manage health problems but can also create health problems by contributing to climate change through CO2 emissions, medicine in water and waste as well as claiming a large portion of resources. Additionally, the main business model in healthcare is based on delivery of treatment. As such, many healthcare actors have a financial interest in retaining a focus on disease and keeping up a certain level of production. A growing societal debate about the sustainability of the current healthcare system, based on the identification of persistent features, is necessary.

The challenges in healthcare as described in the previous paragraphs, have begun to fuel a sense of urgency, but require a more in depth understanding of the systemic characteristics that hold back change and specifically research into how fundamental change can be guided and accelerated. Sustainability transitions research (Grin et al., 2010; Loorbach et al., 2017) offers a perspective on the fundamental change of societal systems and how agency and action influence the course of transitions. This perspective can be used to analyze the current dynamics in healthcare and hypothesize about potential futures and what is necessary to move in a desired direction. Long-term systemic change in this context is defined as a a fundamental shift in the way of thinking, doing and organizing things throughout the system. In this study, this sustainability transitions perspective (further introduced in chapter 2) is used as the main lens to look at the developing meaning of sustainability and experimenting with alternatives in Dutch healthcare.

1.5.2 Outline

This first chapter has set the stage for a further outline of research aim and questions, theory and methods as well as the empirical research in the following chapters. After having introduced the sustainability transitions perspective in this chapter, chapter 2 presents the research aim and questions, the design of this explorative case study research and the theoretical grounding in transition studies. My research approach and journey frame the introduction to the empirical cases. Figure 1.3 visualizes the chapters in this thesis.

Chapter outline			
Chapter 1-2: Orientation			
Chapter 1 *Shifting perspectives in healthcare* Introduction and setting the stage		Chapter 2 *Studying transition dynamics in the field of healthcare* Theory and method Research aim and questions	
Chapter 3-6: Exploring the field in four empirical case studies			
Chapter 3 *Exploring a transition in Dutch healthcare*	Chapter 4 *The scaling-up of Neighborhood care: from experiment towards a transformative movement in healthcare*	Chapter 5 *Positive Health: from niche discourse to government jargon*	Chapter 6 *Transition Pains: recognizing effects of organizational realignment to a changing context*
Chapter 7 *Conclusions and recommendations*			

Figure 1.3 Overview of chapters in this thesis.

This thesis explores this uncharted territory of transition in healthcare by wandering around the field of Dutch healthcare and investigating sustainability programs, front-runners who offer alternatives, development of new language and a new paradigm, and the struggle of incumbents charged with everyday delivery of healthcare. The following chapters reflect a 10-year long journey, during which time *sustainable* healthcare and *green* healthcare have developed from relative unknowns to trending hashtags. Future historians will be able to confirm if this thesis (accurately) caught the beginning of a sustainability transition in Dutch healthcare.

The empirical chapters in this thesis (3-6) have been published or submitted as individual academic articles. This creates some overlap in the chapters concerning introduction of the transition perspective and description of dynamics.

Chapter 3 **Exploring a transition in Dutch healthcare** provides a first exploration of the literature on (un)sustainability in healthcare (as available in early 2018) and recognizes the embedded features of persistent problems in healthcare. Four types of unsustain-ability in healthcare are identified. The chapter also gives a further introduction of transi-tion, its focus on radical non-linear change and introduces the x-curve of transitions to help visualize the dynamics of transitions. Transition management is presented as a method of intervention and steering. This chapter then delves into the *Expedition to sustainable healthcare* as developed by the Dutch CSR Network for Healthcare. The eight participating healthcare organizations are followed during three years to investigate changes in culture, structure and practices as well as the results and challenges in sustaining a frontrunner status. This chapter illustrates the struggles of frontrunners in a transition, both for the Dutch CSR Network in Healthcare and the eight participating healthcare organizations.

In chapter 4 **The scaling-up of Neighborhood Care: From experiment towards a transformative movement in healthcare** the remarkable development of Neighbor-hood Care (in Dutch: Buurtzorg) is studied as example of an alternative way of delivering healthcare. Buurtzorg was initiated as an alternative for the standard homecare and participated as a *transition experiment* in the *Transition Program in Long-term Care* that ran as early as 2007-2009. As a transition experiment Buurtzorg was able to make use of shielded space and transition support. The chapter looks at the strategies that Buurtzorg applied to gain momentum and influence in a relative short period of time by analyzing these strategies in terms of deepening, broadening and scaling up. Additionally, this chapter explores the potential transition in Dutch (long-term) care by reflecting on (changing) dominant characteristics in terms of culture, structure and practices.

The niche-regime interplay that is introduced in chapter 4, is further explored in chapter 5 **Positive Health: from niche-discourse to government jargon** from the perspective of influencing policy development in Dutch healthcare. The concept of Positive Health is introduced as niche-discourse and its adoption in government policy is traced in this chapter. The chapter discusses the diffusion process, actions and strategies on different levels and enabling factors and potential barriers. This tracing of discourse displays the growing (systemic) tensions that are felt in Dutch healthcare as well as the need for alternatives. As this discourse analysis is based on tracing and analyzing (policy) documents that were written in Dutch, the analysis and description were also done in Dutch to avoid specific meaning being lost in translation. Therefore, chapter 5 is written and published in the Dutch language. An English summary is provided in the appendix.

In chapter 6 **Transition Pains: Recognizing Effects of Organizational Realignment to a Changing Context** the perspective shifts to incumbents and how transitional periods are experienced by healthcare workers. In this chapter the concept of transition pain is developed as a signal of experienced dissonance when internal culture, structure and practices are not aligned. What is easily termed as resistance to change is here framed as a call for support and communication.

The **conclusions** are presented and discussed in chapter 7. The research questions are revisited and the empirical cases in chapters 3 through 6 are discussed in terms of developing changes in culture, structure and practices, as well as diffusion strategies that support the development of niche-regimes. Implications for theory and practice are discussed and recommendations for an agenda for future research formulated.

2

Studying transition dynamics in the field of healthcare

CHAPTER 2 STUDYING TRANSITION DYNAMICS IN THE FIELD OF HEALTHCARE

2.1 Systemic perspective on fundamental change in healthcare

Transitions are defined as *fundamental* change, also described as *radical* change, in the dominant cultures, structures and practices (regime) of a societal subsystem that takes place on the long-term (decades) (Grin et al., 2010). Radical change can be distinguished from continuous change as being disruptive in nature (Weick & Quinn, 1999). The equilibrium of power is disturbed (Lewin, 1947) when a qualitative alteration of the rules of organizing takes place (Huy, 2002). Fundamental or radical change in a societal system refers to a change in underlying beliefs (culture) that is accompanied by a change in rules and regulations (structure) and daily practices. The foundations of the way things are done changes. These outcomes of a transition are not related to the pace of the change process. A fundamental or radical change can take place in incremental steps (Rotmans et al., 2001) over a long period of time. However, transition scholars posit that these steps are distinctly non-linear and shock wise in character (Rotmans & Loorbach, 2010).

Sustainability transitions research (Grin et al., 2010; Loorbach et al., 2017; Markard et al., 2012) offers frameworks to study fundamental non-linear change in societal systems by looking at shifts in the way of thinking, doing and organizing. These shifts are driven by persistent pressures and the impossibility to sustain an established state of the system, combined with external changes and crises. By understanding transitions as stemming from unsustainability, a key question in the transitions research field is what type of agency is needed to help navigate such societal subsystems in transitions towards sustainable future states. Transition dynamics (Geels, 2002; Geels & Schot, 2010; Hebinck et al., 2022; Loorbach et al., 2017; Rip & Kemp, 1998; Rotmans & Loorbach, 2010) identify the underlying patterns driving transitions as the interplay between the incumbent regime (or dominant way of doing things) and rising alternatives (niches). Where the latter showcase possible new ways of thinking, doing and organizing that are seen as potential parts of desired futures. This study investigates several of these rising alternatives and how they interact and develop with the incumbent regime.

This study has a specific focus on the transition dynamics in Dutch healthcare. Healthcare as an empirical setting is an interesting area of study as it is a societal system with an emerging transition context. Sustainability transitions research has, in the past, often focused on socio-technical regimes such as the energy transition or mobility. In healthcare, the transition context is much less dominated by technological develop-

ments, although very similar dynamics can be identified in terms of persistent problems, increasing tensions and emerging alternatives.

The use of a systemic perspective on (changes in) healthcare is generally acknowledged and also advocated as relevant and necessary (e.g., Braithwaite, 2018; Broerse & Bunders, 2010; Broerse & Grin, 2017; Plsek & Greenhalgh, 2001; Sturmberg & Martin, 2013). Greenhalgh et al. (2004) illustrate how the diffusion, dissemination and implementation of innovations in healthcare are influenced by the 'outer context', system readiness for innovation (e.g., tension) and system antecedents for innovations such as absorptive capacity for new knowledge, leadership and vision, and a receptive context for change. Braithwaite (2018) argues that healthcare is more complex than any other system considering the range and breadth of its numerous stakeholders, funding models, regulations, specialized professionals and number of actions, interventions and outcomes, for any person's needs. Therefore, a systemic perspective is necessary to understand the natural resilience of the healthcare system and support emergent properties of change that can arise from the interactions of individuals or groups (Braithwaite, 2018).

The prevailing improvement paradigm or 'blue print' logic in Dutch healthcare (Tuohy, 2012) has created a top-down oriented implementation method focused on (more) policy, regulation and restructuring (Braithwaite et al., 2018), whereas a learning system that adapts is much more useful in responding to a system characterized by complexity and uncertainty. A learning system is necessary to deal with new complex health problems, financial sustainability and organizing healthcare delivery effectively. Sturmberg (2016) illustrates how healthcare systems are remarkably stable: structurally open but organizationally closed and, as a system, self-organizing itself back into its shape despite disturbances. The overall structure and function are maintained. This illustrates the description of wicked or persistent problems in healthcare as introduced in chapter 1 and the need for a systemic approach to change the overarching common focus in healthcare.

This chapter introduces the specific aim and research questions that gave direction to the study and elaborates on the main concepts that make up the transition perspective that was applied. The research approach and the empirical cases that provided the data are then introduced. This chapter closes with an overview of my research journey and the case studies.

2.2 Aim and research questions

2.2.1 Research aim

This study investigates the tensions and pressures in the Dutch healthcare system and explores possible solution pathways, searching for what is strong and healthy in the healthcare system and exploring alternatives that can fuel the development towards a more sustainable healthcare system.

This research process has developed along the way, constantly adjusting to actuality and opportunity, and with a strong iterative character. However, the objectives of the research have remained constant:

- to make a theoretical contribution to the understanding of the concept and realization of sustainability in healthcare, by identifying the changes that are taking place within the Dutch healthcare system, from the perspective of transition studies, and exploring how and why these developments take shape;
- to contribute to knowledge of governance to support the development of a sustainability transition in healthcare by understanding the meaning and development of the concept of sustainability in healthcare as well as the necessary conditions to further development;
- to inspire practitioners by exploring rising alternatives in their role as frontrunner and to learn from their propositions and strategies;
- to identify potential barriers for practitioners from 'lessons learned' from frontrunners and lessons learned from change-minded incumbents attempting to align with a changing and challenging environment.

2.2.2 Building on earlier research

Transition studies have helped develop deeper theoretical insight into the patterns and mechanisms of transitions by introducing and finetuning transition dynamics through the multi-level perspective (Geels, 2002; Rip & Kemp, 1998), multi-phase S-curve and X-curve (Loorbach et al., 2017; Rotmans & Loorbach, 2010) and multi-pattern concept (De Haan, 2010; Van der Brugge, 2009). Additionally, transition theory was further developed through the study of transition management (Loorbach, 2007; Van Raak, 2016) by expanding on key elements such as problem structuring and envisioning (Sondeijker, 2009), coalitions and agenda's, transition experiments (Van den Bosch, 2010; Cramer, 2014) and governance of transitions (Loorbach, 2014) through reflexive monitoring (Beers et al., 2016). More recent studies have investigated agency in transitions, developing concepts such as power (Avelino, 2009) and justice (Van Steenbergen, 2020) in transitions.

Transitions in practice have been studied in historical perspective (Geels, 2002; Van Raak, 2016) and in empirical settings in different societal domains such as energy, mobility, urban development, agriculture and food. Transitions research has occasionally investigated the healthcare and social domains (Barsties et al., 2021; Broerse & Bunders, 2010; Broerse & Grin, 2017; Cramer, 2014; Essink, 2012; Loorbach & Rotmans, 2010; Rotmans 2012, 2014; Schuitmaker, 2013; Super et al., 2020; Van den Bosch, 2010; Van Raak, 2016; Van Steenbergen, 2020; Wittmayer, 2016). However, compared to domains like the energy sector the research on transition in the healthcare domain is scarce. Nevertheless, a growing interest for socio-institutional domains like healthcare (but also for example education) can be identified in transitions research (Super et al., 2020; Barsties et al., 2021) and these studies have broken new ground on the subject of transition in healthcare.

From the healthcare domain, there is an increase in studies on systemic problems that hinder healthcare reform (e.g., Braithwaite, 2018; Schuitmaker, 2013; Slaghuis, 2016; Sturmberg, 2016) and, from another perspective, studies on healthcare innovation and the role of change agents (Essink, 2012) and the governance of healthcare innovation (Janssen, 2016). The earlier research that this study builds on, shows a bias towards the Dutch transition research community and more in general the Western (European) sustainability challenges, building from developed modern societal systems (Loorbach et al., 2017). However, as this is the main context for this study in Dutch contemporary healthcare, the aim is not to be comprehensive in this manner.

2.2.3 Research questions

Building on the research already done in both transition studies and healthcare innovation, this research picks up the thread on transitions in practice with healthcare as the main empirical domain of study.

The main question guiding this exploration is:

*How does sustainability develop **meaning** and **significance** in Dutch healthcare?*

Sustainability in and/or of healthcare or (a) sustainable healthcare (system) are just a few ways to put a label on the meaning that is attributed to the combination of the words *sustainable* and *healthcare.* Investigating the meaning attributed to the concept of sustainability in healthcare is relevant to build a vocabulary that can support actors in the transition. The initial orientation for this study revealed how actors interpret sustainability in healthcare in different ways, as elaborated on in the previous chapter. Considering that a transition process is more about movement than about a pre-designed

destination, I do not aim to provide a specific definition of sustainable healthcare, but rather to illustrate the possible interpretations and how actors can make use of these interpretations and develop a common vocabulary. Practitioners may be able to recognize likeminded people or organizations, even if they use a seemingly different discourse.

Building on the main question two sub-questions are addressed:

How can ***sense-making*** *towards sustainable healthcare be explained in terms of (changing) culture, structure and practices?*

Sense-making is the process of people giving meaning to their experiences, communicated to and with others through words, symbols but also priorities. A sense-making lens helps to analyze a developing agenda setting towards sustainable healthcare and is combined with the transition perspective. A simple and understandable definition of a transition is: a fundamental change in structure, culture and practices (Loorbach & Rotmans, 2006; Rotmans & Loorbach, 2010, in Grin et al., 2010 p. 109). This lens is used to look at the developing sense-making around sustainability in and of healthcare. This triad makes a recurring appearance throughout this study and helps to understand how a transition in healthcare can take form and how structure, culture and practices are all required to sustain long-term and fundamental change. Exploring changing structure, culture and practices can inspire practitioners and illustrates the systemic nature required in realizing a transition.

How can an increase in ***significance*** *of sustainable healthcare be explained in terms of transformative agency?*

Transition Management (TM) builds on the normative assumption that a sustainable society or subdomain is preferred over one that is currently dysfunctional. Transition governance is concerned with trying to direct transition dynamics in a preferred direction. At the same time, a transition is known to develop over at least a generation (25 years) or several decades and to be unpredictable with shock-wise development. The *M(anagement)* in TM therefore adheres to *steering, influencing* and *creating favorable conditions* for transitions. This idea forms the foundation of this sub-question that addresses how lessons learned from experiments, new practices, activities by frontrunners and focused policy can support alternative ways of thinking, doing and organizing.

In this thesis, the term 'healthcare system' refers to the arrangement of organizations, institutions, professions, structures, rules and regulations, beliefs, values and daily practices that share the common goal to improve health of individuals and populations

by providing healthcare. This description implies that systemic change involves redesigning the structure, culture and practices that make up this whole 'arrangement'. This study aims to look at several viewpoints relating to different actors and elements that make up the arrangement of the healthcare system. Therefore, this study mainly makes use of case studies. These case studies represent experiments and interventions, involving both frontrunners (or newcomers) and change-minded incumbents. The results and 'lessons learned' can contribute to formulating possible solution pathways to a more sustainable healthcare system. Figure 2.1 shows the design and the exploration in this study.

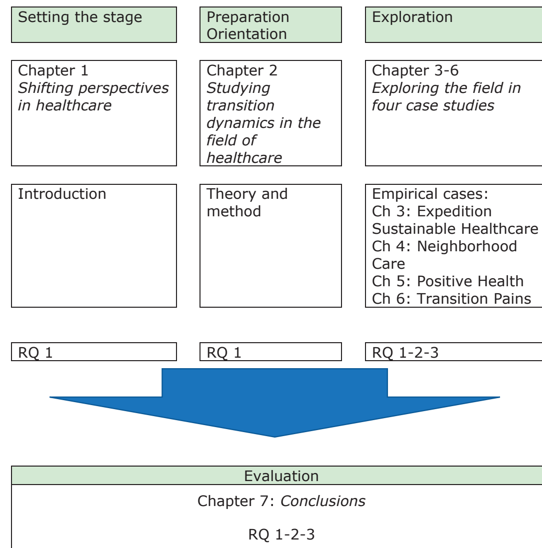


Figure 2.1 Study design

2.3 The transition perspective

2.3.1 Transition studies

The research in this thesis builds on several concepts and models from the field of transition studies and transition management. In this section I introduce the main concepts from transition studies from which we have explored the healthcare transition and identify how and where they were used in the research. In table 2.2 the use of specific theoretical models and concepts in relation to the case studies is summarized.

2.3.2 Multi-Level Perspective (MLP)

The Multi-Level Perspective (MLP) was developed in the field of socio-technical systems (STS) studies and understands a transition as a long-term multiple-level process. The MLP argues that transitions come about through the interactions between processes at different levels (Geels & Schot, 2010 p. 24). The interplay between different levels, specifically (dis)alignment between levels, highlights the dynamics of transitions, especially when talking about (de)stabilization. The MLP distinguishes three levels (or scales):

- landscape: exogenous long-term developments, trends, major crises that can function as drivers for systemic change (e.g., globalization, individualization, changes in the political arena);
- regime (Rip, 1995): includes elements such as rules, regulations, user practices, infrastructure, technology, shared values, powerful actor configurations and institutions. Rotmans & Loorbach (2010) understand the regime as the dominant set of structure (institutional and physical setting), culture (prevailing perspective) and practices (rules, routines and habits);
- niche: where radical innovations (novelties) (can) emerge as seeds of transition.

Rotmans & Loorbach (2010) understand the macro, meso and micro level of the MLP as functional scale levels, arguing that they represent functional relationships between regime- and niche-actors, each with their own structure, culture and practices. A niche that scales up to regime level can become part of the regime (or as Loorbach (2007) puts is: a patchwork of regimes) through e.g., substitution, reconfiguration, assimilation or adaptation. Often the novelty or alternative from the niche interacts with the regime level and is not necessarily a disruptive force. As this interplay between niche and regime is where most of the action takes place, Rotmans & Loorbach (in Grin et al., 2010) propose an additional category to the MLP: the niche-regime level that represents empowered niches (Haxeltine et al., 2008) forming a new regime out of the incumbent and emerging ones.

In Chapter 4 the MLP is used to conceptualize scaling-up as moving from the niche-level to the regime (or mainstream) level, making use of the dynamics that are influenced by landscape developments. This framework of deepening, broadening and scaling-up (Raven et al., 2010; Rotmans & Loorbach, 2008; Van den Bosch, 2010; Van den Bosch & Rotmans, 2008; Van den Bosch & Taanman, 2006), derived from the MLP, is tested in practice and expanded to include specific strategies to realize scaling-up to regime level.

2.3.3 Transition dynamics

Understanding how regimes fundamentally transform, is the focal point of transition studies. The patterns and mechanisms (dynamics) that explain transitions include how

established regimes develop path-dependently through optimization, how landscape changes can increase pressure and how alternative ideas, technologies and practices are being experimented with, sometimes finding the right window of opportunity to break through (based on Loorbach et al., 2017). Transition dynamics describe how landscape developments interact with system-level (regime) development and developments in niches (alternatives to the dominant way of doing things). The Multi-Level Perspective (MLP), (Geels, 2002, Rip & Kemp, 1998; Geels & Schot, 2010) and the X-curve framework (Loorbach et al., 2017; Hebinck et al., 2022) illustrate these interactions in terms of pressure build-up, optimization, experimentation, chaos, phase-out and acceleration. The selection and broader diffusion of novelties in niches depends on alignments with regime and landscape levels (Geels & Schot, 2010 p.19) and can be understood as different pathways of change (Geels & Schot, 2010; De Haan, 2010; Loorbach, 2014). Destabilization of the regime creates windows of opportunity for alternatives that introduce or are based on new ways of thinking, doing and organizing.

Transitions have been identified as having multiple phases where changes happen in a shock-wise and nonlinear fashion, represented by an S-curve (Rotmans et al., 2001). This S-curve (recognizable in the later developed X-curve) introduced four phases that show different paces of change, long stable periods alternated with periods of change. The S-curve with the phases of predevelopment, take-off, acceleration (breakthrough) and stabilization are still recognizable in the more comprehensive X-curve in terms of experimentation, acceleration, emergence, institutionalization and stabilization. With the formulation of the S-curve, additional alternative curves can be identified that illustrate lock in, backlash or system breakdown, all of these curves moving downward after take-off or acceleration. The later developed X-curve of transitions (Loorbach et al., 2017) shows the dynamics in both the emerging niche(-regime) and the declining incumbent regime, illustrated in figure 2.2. The representation of the X-curve is ideal typical. However, the X-curve can take on many different forms, as visualized by Loorbach (2014) in different (mainly undesirable) curves.

From the MLP and X-curve, patterns and pathways of change can be distinguished (e.g., Geels & Schot, 2010; De Haan, 2010; De Haan & Rotmans, 2011). Identifying patterns and mechanisms of change helps to determine how to best influence the process (Rotmans & Loorbach, 2009). In this sense, the X-curve can serve as an analytical tool for actors in transitions to help design interventions, transition instruments and experiments and simultaneously be aware of the influence of power, politics and (vested and/or diverging) interests. Understanding dynamics is necessary to attempt any kind of steering or governance and interventions need to be shaped on the basis of the dynamic state of

the (sub)system. In Chapters 3, 4 and 5 this interplay between landscape, regime and niches is illustrated in the different empirical cases.

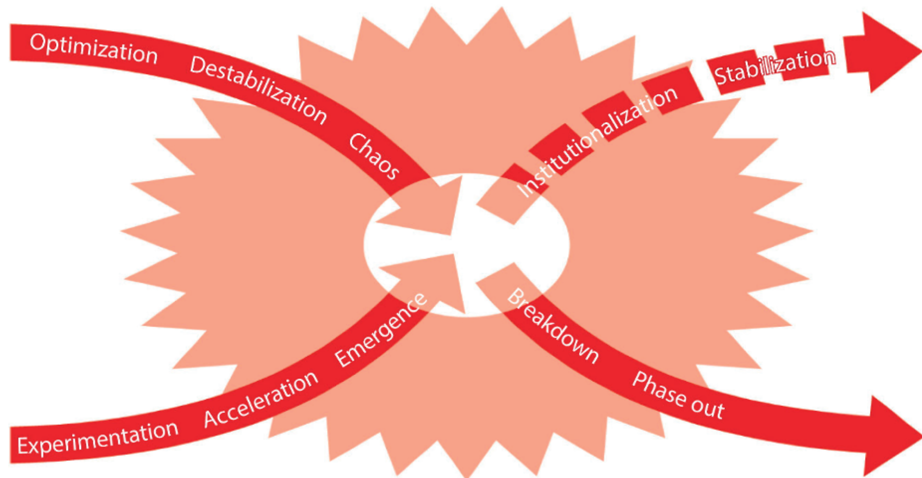


Figure 2.2 The X-curve of sustainability transitions: dynamics of transitions as iterative processes of build-up and breakdown over a period of decades (Source: Loorbach et al., 2017)

Landscape changes can lead to the buildup of tension or pressures as optimization efforts are no longer effective in a previously stable societal system. Als alternatives present themselves, either developing in protected space or as grassroots experiments, and find more and more windows of opportunity to engage in interaction with incumbents in the regime, the dominant way of thinking, doing, and organizing, is questioned. This can potentially lead to destabilization and chaos in which incumbents, niches and niche-regimes search (in co-production or competition) for a new equilibrium, deciding which elements need to be broken down or phased out and which elements have emerged that need to be supported in structures, cultures and daily practices to develop into the new, more sustainable, dominant way of doing things. The two curves (ascending and descending) that make up the X-curve illustrate how different phases of build-up and breakdown are connected and where regime and niche-players interact. In the X-curve, reading from left to right, five different phases can be identified. The phases are not mutually exclusive. Activities can be identified to be happening in different phases at the same time. Typical niche-regime dynamics and interactions are illustrated as they can be identified in a transition process. Table 2.1 provides a further description of the dynamics in the different phases of the X-curve.

Phase	Description (adapted from Lodder et al., 2017 and Hebinck et al., 2022)	Characteristics
Optimization-Experimentation	Improving the existing ways of thinking, doing and organizing. Simultaneously, experimentation in niches where radical new practices and new thinking are developed.	Unconnected initiatives. Individual motivation.
Destabilization-Acceleration	Acceleration is achieved through the connection of different experiments and alternatives, creating a movement. Alternatives are visible and accessible to a broader public. Opportunities are created as the pressure on the regime increases when existing ways of thinking, doing and organizing prove to be insufficient to adequately address persistent problems. Incidents may spur a sense of urgency for change. Fundamental discussions on the desired direction are conducted.	Connecting alternatives. (Public) discussions on the desired future. Incidents are connected to discussion: increasing sense of urgency.
Chaos-Emergence	New structures become visible and the need for a new system is broadly acknowledged as a sense of urgency is frequently voiced. With the need for change broadly acknowledged, (opposing) interests become more visible, possibly creating conflict. While the need for change is felt, the contours of a new system are not yet fully developed. This creates chaos and uncertainty.	Sudden loss of security, collapse of stable institutions and established organisations, and profound political interventions or acute crises. Old 'rules' don't apply anymore but new 'rules' are not yet (fully) formed.
Institutionalization-Breakdown	The emerging new system is institutionalized through the development and solidification of new structures, policies, practices and discourse (the new normal). The institutionalization goes together with the breakdown of (elements of) the old system: disabling old laws, financial structures, policies and even institutions while new ones are formed.	Regime actors start to engage with alternative practices to develop new structures.
Stabilization-Phase-out	During the stabilization of a new regime the tweaking and optimization begins. While new ways of thinking and doing stabilize, old ways are phased out. This comes with saying goodbye and dealing with loss.	Further developments are mostly concerned with details and phase-out of remaining original elements of the regime that are not useful.

Table 2.1 Connected phases of build-up and breakdown.

2.3.4 Characterizing the regime in a triplet of Culture-Structure-Practices

In this thesis I build upon the understanding of a societal regime as "the dominant structures, cultures and practices" (Rotmans & Loorbach, 2010). In this conceptualization:

- *culture* refers to the collective set of values, norms, perspective (in terms of coherent, shared orientation) and paradigm;

- *structure* refers to the physical, economic and institutional infrastructure (including rules, regulations and collective actors);
- *practice* refers to routines, behavior, ways of handling and implementation at the individual level (including self-reflection and reflexive dialogue).

This triplet of culture, structure and practice characterizes the dominant way of doing, thinking and organizing, as represented by the regime in the MLP.

In the early development of transition theory, the elements of culture, structure and practices were introduced as part of the clovermodel by Frantzeskaki & De Haan (2009) and further developed by Van Raak (2016). The triplet concept of cohesive change of culture, structures and practices to realize transition builds on Giddens' theory of structuration (1984). Culture, structures and practices can be seen as a system of generative rules and resources that can be drawn upon (mediate interaction) to provide meaning, exercise power, evaluate conduct, legitimize actions and in this way produce and reproduce social interaction. In this way, social structures are both constituted by social practices (enabled by human agency) and can contain human agency or action at the same time. This duality of structure (Giddens, 1984) helps explain why persistent problems are produced and reproduced as embedded features of a system itself. And also why, to realize a fundamental change, it is necessary to fundamentally change all three elements of culture, structure and practice (CSP). Bosman (2022) argues that this conceptualization of the regime puts more emphasis on the cultural or discursive elements as well as the practices and behavior of actors. As such, this conceptualization is best fitting to frame the cases in this study.

The cases studied in this thesis have a strong focus on the aspect of transformative innovations that influence culture, practices as well as structures. Therefore, the conceptualizations of a regime as the dominant CSP, a niche as an alternative that challenges the dominant CSP, and a transition as a fundamental change in CSP, are best fitting to serve as a stepping stone in this thesis. The relevance of social-practice theory and approaches (e.g., work by Spaargaren, Mommaas) has been identified and acknowledged (Grin et al., 2010) from the start but never fully integrated. This thesis aims to explore the triplet of culture, structure *and* practices, based on the hypothesis that a fundamental change in all three elements (or at all three levels of structuration) are necessary to address persistent problems and support a transition. And not only changes on all three elements/ levels, but also "mutually coherent changes" (Grin et al., 2010) to transform the deep structure of a system (Rotmans & Loorbach, 2010) and realize a trajectory that somewhat resembles the ideal typical X-curve.

In the course of this research, this triplet of culture, structure, practice has proven the connecting thread between transition in theory and transition in practice. This conceptualization of the regime in dominant culture, structure and practices represents the socio-institutional approach in transitions (Loorbach et al., 2017). This socio-institutional approach is distinguishable from the socio-technical and socio-ecological approaches in that it puts institutionalized cultures, structures, and practices at the core of a transition. The focus is on how incumbent routines, powers, interests, discourses, and regulations create path dependencies and how these are challenged by (transformative) social innovations" (Loorbach et al., 2017 p. 610).

2.3.5 Socio-technical vs socio-institutional

Transition studies have their roots in socio-technical fields and application in healthcare and other social domains is still scarce. The socio-technical approach has been dominant in (sustainability) transition studies. A social domain such as healthcare is therefore quite understudied in transition studies. However, the *socio* in socio-technical adheres to the relevance of human agency and interactions that determine the meaning and use of technology as well as more general production and consumption. In this way, I believe healthcare has not been given sufficient attention (so far) in sustainability transition studies and research. Healthcare (in Western countries at least) is both a very technological domain and a domain that has the potential for transformative social innovation: fundamental changes in social relations and interactions that are accompanied by alternative ways of thinking, organizing and doing (Pel et al., 2020). I therefore align with the socio-institutional approach to transitions that focuses on functional systems and emphasizes institutional, cultural and social forms of innovation as drivers (and levers) of societal transitions (Loorbach et al., 2017).

Simultaneously, technological innovation obviously still plays and (increasingly) important role in the healthcare domain. For example, related to waste in healthcare such as medicine remains in water, (reducing) waste materials from operations or use of circular materials in buildings and such). This more technical (and ecological/ environmental) orientation is the base for the Green Deal Sustainable Healthcare initiated by the ministry of health. In this way, the character of the health(care) transition can be conceptualized as a (transformative) social innovation with ecological and technological features.

2.3.6 Transition Management and transformative agency

Transition Management is the attempt to influence governance activities in such a way that they lead to accelerated change directed into a more sustainable direction (Kemp, Loorbach & Rotmans, 2007; Loorbach, 2007), ultimately resolving the persistent problems involved, by exploring promising future options and directions. Managing transi-

tions therefore implies searching, learning and experimenting (Rotmans & Loorbach, 2010). Also, investigating ways to influence and support actors and their activities in such a way that they can develop into a potential competitor for dominant actors and practices that form the incumbent regime.

Transition Management researchers have developed a multitude of governance tools to support activities such as (transition) experiments, host transition dialogues, support coalition building, vision development, reflexive monitoring and evaluation. These tools and activities have been derived from conceptual models, some of which have been investigated, used and sometimes amended to in the cases in this research. The chapters provide a more detailed account of the use of:

- Elements and main principles of Transition Management (Loorbach, 2007; Loorbach & Rotmans, 2009) in Chapter 3.
- Development mechanisms of transformative innovation (Loorbach, et al., 2020) in Chapter 5.

In this research, several alternatives with possible transformative innovations are studied to explore their potential as frontrunners or leading examples and learn from applied strategies for scaling up or diffusing. Loorbach et al. (2020), (building on Avelino et al., 2019, 2020 and Haxeltine et al., 2017) define transformative innovations as *shared activities, ideas and objects across locally rooted sustainability initiatives that explore and develop alternatives to incumbent and (perceived) unsustainable regimes that they seek to challenge, alter or replace.* The transformative power of an innovation can only be judged in hindsight. In this study, potential transformative innovations and their activities and development are studied as they interact with incumbent institutions. In the case of Positive Health (chapter 5), specifically development mechanisms of transformative innovation (Loorbach et al., 2020) are studied to identify key activities that have contributed to the (rapid) adaptation of Positive Health. These development mechanisms are: growing, replicating, partnering, instrumentalizing and embedding. These mechanisms show a similarity to the analysis of another transformative innovation, studied in chapter 4 (Buurtzorg), by using the framework of deepening, broadening and scaling-up (Van den Bosch, 2010; Van den Bosch & Rotmans, 2008).

Each chapter (chapters 3-6) has its own, more detailed, theoretical account that draws on specific literature and/or conceptual model or framework concerning the chosen perspective. At the same time, the chapters share a largely similar or overlapping introduction to the challenges and persistent problems in healthcare as these chapters were published in different journals. This necessitated repetition in introducing the use of the transition perspective in the study of healthcare (innovation).

2.4 Research approach

Transition studies, as a research paradigm, look to explore societal developments where complexity, uncertainty and ambiguity frame the main context. Academic knowledge development goes hand in hand with experimental application in practice. Exploring transitions together with practitioners is a distinctive characteristic of transition research (Loorbach, 2014; Wittmayer, 2016). Robson (2011) refers to this as 'real world' research: social research about seeking answers to questions about problems that are faced in people-related fields (rather than ones concerned primarily with advancing an academic discipline). It takes place in complex and sometimes ambiguous situations, characterized by uncertainty, where conclusions are necessarily tentative. This thesis is based on this type of 'real world' or practice-oriented research in the social domain of healthcare.

Considering that the focus is on human beings in social situations (e.g., interactions) and the general aim is 'understanding' a qualitative approach is best fitting. A qualitative research approach provides the opportunity to study context and focus on meanings to be able to understand phenomena in their setting, both retrospective and explorative in real-time. Interviews and participatory observation allow for acquiring multiple perspectives. From the beginning, a defining characteristic of transition studies has been the advocacy of a transdisciplinary approach (Loorbach et al., 2017), engaging with other (research) disciplines, but particularly a diverse range of actors in the field. At the same time, there are as many realities as there are participants, including the researcher. The task of the researcher is to understand the multiple social constructions of meaning and knowledge. This notwithstanding the fact that transition research has a distinct normative character (Loorbach, 2014) as there is generally some type of norm concerning the direction of change (i.e., towards a sustainable system of some sort). At the same time, this leaves room for acknowledging that values of the researcher and others exist and subjectivity is an integral part of the research. And in this aspect differs greatly from the randomized controlled trial (RCT) that is popular in medical research. Experimental exploration of interventions in transitions is a characteristic approach for studying (agency in) transitions, next to theorizing and analyzing governance and evaluating formal transition or innovation-based policy in transitions (Loorbach et al., 2017) and in this way has strongly influenced the direction and chosen cases in this research.

The overall research design is based on a multiple case study approach (Yin, 2009) with an emergent and flexible design. A multiple case study approach offers the opportunity of investigating developments and presented alternatives in different subdomains of Dutch healthcare as well as investigating different cases as they emerge at different

times during the research period. Studying different cases and using a different lens in every case-study, offered the opportunity of learning about transition dynamics from several different perspectives. The research method and cases were not fixed in advance as the empirical examples were also developing as part of a transformative movement during the period of the research. The research focus was adapted as time and the research progressed. As mentioned above, the main research method for data collection is qualitative in nature, combining different methods in every case-study.

2.5 Research journey: exploring transition dynamics in practice

This research journey has been nothing like I imagined when I started out in 2014. The research questions, the cases, the overarching transition perspective, the time it would take me to finish this thesis, all very different than I would have thought beforehand. One thing has remained a constant: my lasting interest in the subject and possibilities of sustainable healthcare. What has changed is that sustainable healthcare has become a mainstream concept although interpretation differs as this study will show. Indeed, my own interpretation of sustainable healthcare has changed in the course of this process.

My original perspective on sustainability in healthcare was rooted in the field of quality management as my area of expertise at the time. A special issue on corporate social responsibility (CSR) in a Dutch journal for quality management set me on a path to learn more on the subject of sustainable healthcare. This study has always been largely explorative, iterative and abductive in nature: looking for direction, going fast and going slow, distracted by options in a field wide open and turning back around. As a quality management consultant my starting point for researching sustainability in healthcare were available quality standards and certificates on CSR (e.g., MVO-ladder, ISO 26000, integrated reporting). This orientation led me to the Dutch CSR Network on Healthcare who were pioneering with an Expedition Sustainable Healthcare where they combined insights from ISO 26000 and Transition Management. The 'expedition' provided a rich site for learning about sustainability, perspectives on sustainable healthcare, motivators and barriers encountered by frontrunners pursuing acceleration of sustainable healthcare and thus the perfect first case to explore the field. The case, for me, was a rich illustration of the non-linear character of transitions, possible changes in culture, structure and practices, and the tenacity of the dominant regime. This case gave me insight into the struggles of frontrunners in a transition, both for the Dutch CSR Network in Healthcare and the eight participating healthcare organizations.

Through the expedition I was introduced to the small community of healthcare transition researchers and was invited to collaborate with Suzanne van den Bosch on a follow-up research project on the scaling-up of Neighborhood Care (Buurtzorg). With this case,

the research perspective shifted to an early success story of a transition experiment that developed from a niche to mainstream. This case strengthened my theoretical base with transition experiments and the model of deepening, broadening and scaling up (Van den Bosch, 2010). In this research we developed the model by adding strategies.

These two 'early' cases can be recognized as alternatives in reaction to the ongoing optimization in the regime that is creating tension as persistent problems are not being solved. These alternatives aim(ed) to destabilize the regime and accelerate a different way of doing things. While exploring the 'early' cases, I was employed at an incumbent healthcare organization. In this organization, the director at the time was very much eager and motivated to fuel a transformation (and also out of necessity because of regime changes), but struggling to maintain changes. Unexpectedly, this became my third case as I became interested in the dynamics that seem to maintain the status quo. At regime level but specifically within organizations. In this case the apparent barriers of dominant logics supported the hypothesis that culture, structure and practices need to change together, and in a *mutually cohesive* (Grin et al., 2010) fashion. This case illustrates destabilization and chaos as experienced by employees, but also how old patterns and structures require active attention to phase out. The results from the interviews were illustrative of struggle, both at the organizational level and at a personal level. Again, this research turned an unexpected corner as sustainable care took on the meaning of taking care of people in healthcare organizations to maintain a motivated and resilient workforce. This case resulted in the conceptualization of *transition pain* to give vocabulary to experiences of organizational members of incumbent healthcare providers.

From the beginning, the structure element in the form of supporting policy and financial structures from the incumbent regime (e.g., ministry of healthcare, insurance companies) appeared to be a large source of obstruction. From the first case, I had wondered if Positive Health might be a gamechanger in this process of transition in Dutch healthcare and I was excited when hearing about the prominent role that was given to Positive Health in the National Memorandum on Health Policy 2020-2024 (VWS, 2020). I decided that for my final case I would study this 'rise to fame' of Positive Health that seemingly represents emergence and even institutionalization. This case investigates niche-regime interplay, bringing together several elements introduced in the early cases and chapters. The findings in the case of Positive Health reflect the results from the earlier case of Neighborhood Care when looking at strategies and enabling factors such as leadership built on a personal story. This case brought me back to the question of how meaning is constructed around the concepts of health and care. Focusing on the language of health connected me once again to the concept of healing environments and in that way bringing the research outcomes together. As the case study of Positive Health has

a strong resemblance to the case study of Neighborhood Care, I have positioned these cases as consecutive chapters (4 and 5) in this thesis.

Looking back, I moved from standards to storytelling in the early stages of this research and with this study have tried to build a narrative of sustainable healthcare that can inform future explorations in this field. The X-curve (Loorbach et al., 2017) has been a helpful analytical tool to put a case in context of both the dominant regime and its lifespan, as well as what is happening and what needs to be done 'outside' of the case (enabling factors and potential barriers). In figure 2.3 the cases have been plotted on the X-curve.

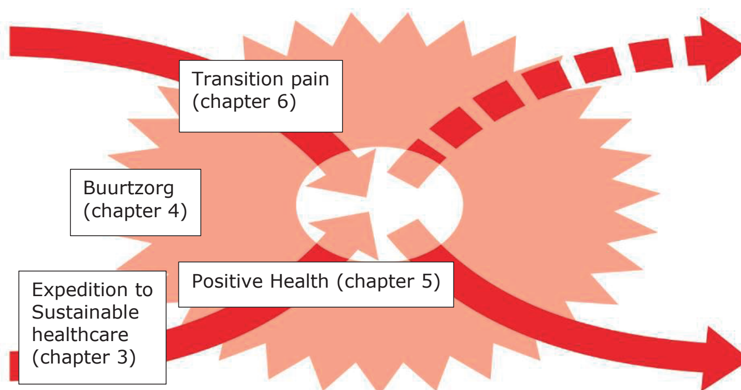


Figure 2.3 Plotting cases on X-curve

The Expedition to Sustainable Healthcare illustrates the context of individually motivated change agents aiming to realize an acceleration in transition and encountering a lack of concern at the regime level. At the regime level the focus is still on optimization. The Neighborhood Care case explores experimenting with radical new thinking, doing and organizing and also causing a small measure of destabilization in the regime by creating a large number of followers. The case on Positive Health shows the connection between sense of urgency for change and possible alternatives: an emergent perspective for future healthcare. Specific attention is paid to the connection of alternatives through the use and changing of discourse. The case on Transition Pain (CASE) illustrates the chaos and feeling of uncertainty that can be felt when new structures emerge but are not yet fully developed. This positioning of cases is specifically related to the research focus in this thesis and may shift over time and/or depending on one's perspective.

In section 2.4 I wrote that sustainability transitions research is said to have a distinct normative character. This research project has been a journey of sense-making for me

as a researcher, healthcare professional and as somebody who has struggled with normativity, and to a lesser extent subjectivity, throughout this research. As a practitioner I have developed a tendency toward pragmatism and action. Building up a nuanced and objective argument was not my forte and has taken, and still takes, practice. In my daily work, both as a consultant and as a company secretary, it has been part of my job description to have an opinion. Working on this thesis I have had to learn how to translate that opinion into a question, an analysis of different viewpoints or a discussion. The feedback and discussions with my supervisors, Derk Loorbach and Annemiek Stoopendaal, have been extremely helpful in pointing out and questioning my opinionated statements of all that is good and bad in Dutch healthcare. Additionally, engaging with healthcare professionals on a day-to-day basis and specifically when talking about my research has helped me find a path in practicing normativity. Reflections of researchers at DRIFT and ESHPM as well as reflections of reviewers at journals have been very helpful in building my narrative. A narrative that is clearly oriented towards exploring desired futures, but in a validated, peer-reviewed and reflexive way. Several DRIFT working projects served as enriching examples to sharpen my perspective even further in the very final stages of this journey.

2.6 Case study overview

This thesis is based on four cases that illustrate transition dynamics in different contexts in the Dutch healthcare domain. These different contexts concern the subsector of the healthcare domain, the type of organization from an actor role perspective and the type of case e.g., transition experiment or intervention. The choice for different contexts within the healthcare domain (and also slightly touching other societal domains in places), different actor roles and perspectives, ties in with the explorative nature of this study. These cases provide a diverse base for exploring transition in a domain that is understudied in this field of research. The cases were (consecutively) identified based on the following criteria:

- Current development (at the time of the research) related to experiencing persistent problems in the Dutch healthcare system (e.g., niche development as a response to the regime).
- Highlighting different perspectives (e.g., sector, type of organization, actor role in transition) and adding to perspectives that were already included.
- Sufficient access to data was available.

The research for the Expedition to Sustainable Healthcare case is based on an embedded case study (Yin, 2009) with longitudinal design. The method for data-collection primarily consists of qualitative interviews: background interviews, supporting interviews and interviews with representatives from the participating organizations (the embedded

cases). The interviews with the participants were conducted during three consecutive years following the completion of the expedition. The data-collection from the interviews was supplemented with document analysis and participatory observations through participating in several expedition sessions as well as related activities such as network sessions organized by the CSR Network.

The research for the Neighborhood Care (Buurtzorg) case primarily consisted of in-depth desk research i.e., document analysis. The documents studied contained a variety of resources e.g., interviews with founder Jos de Blok, public policy plans from the Dutch Ministry of Health and related institutions, news articles and academic research publications on Neighborhood Care. The research builds on earlier academic research where Neighborhood Care was selected as a transition experiment.

The research for the Positive Health case is based on a discourse analysis. The main data sources for the discourse analysis were internal documents from the institute for Positive Health, public policy documents from the Ministry of Health, academic publications as well as grey literature on Positive Health, (public) strategy and policy documents and reports from (leading) institutions and organizations in Dutch healthcare. Several supplemental interviews were conducted to verify and elaborate on the findings of the discourse analysis.

The research for the case study at CASE was of an exploratory nature focused on identifying organizational dynamics in a transition context. The extended case study builds on document analysis through desk research and (semi-structured) interviews as main method of data-collection.

Table 2.2 gives an overview of the research design as multiple case study and the applied methods for data-collection. The case study chapters (chapters 3-6) contain more detailed method sections. The outcomes of the four case studies combined were synthesized to answer the research questions. The three primary topics from the research questions serve as the common thread to analyze the outcomes: meaning attributed to sustainability in healthcare, changes in culture, structure and practices, and ways to facilitate or support a transition (e.g., by learning from successful (strategic) activities of frontrunners).

Chapter & Case	Article	Sector	Perspective	Actor role	Theoretical concepts	Method	RQ
Chapter 3: Expedition to Sustainable healthcare by Dutch CSR Network	Johansen, Loorbach & Stoopendaal (2018). **Exploring a transition in Dutch healthcare.** Published in: Journal of Health Organization & Management	Across the healthcare domain, but mainly secondary care (hospitals) and social care (e.g., homes for elderly or handicapped)	Intervention/ experiment at niche level	Third Sector/ Bridging organization (participants were potential frontrunners)	MLP/ CSP Transition Management	Longitudinal embedded case study with 8 participating healthcare organizations -Desk research -Semi-structured interviews -Participatory observation	1-2
Chapter 4: Neighborhood Care (in Dutch: Buurtzorg)	Johansen & Van den Bosch (2017). **The scaling-up of Neighborhood care: From experiment towards a transformative movement in healthcare.** Published in: Futures	Home care	Transition experiment/ Niche to mainstream development	Frontrunner, entrepreneur	MLP/ CSP Deepening, broadening, scaling-up framework Strategic activities	Case study -Desk research -Corroborative interviews	2-3
Chapter 5: Positive Health	Johansen, Loorbach & Stoopendaal (2023). **Positieve Gezondheid: Verandering van taal in de gezondheidszorg.** Published in: Beleid en Maatschappij	Across the healthcare domain, with origins in primary care	Niche-discourse influencing regime policy	Developing niche	MLP/ CSP Transformative social innovation	Case study -Desk research -Corroborative interviews	1-3
Chapter 6: Incumbent healthcare organization (CASE)	Johansen, Loorbach & Stoopendaal (forthcoming). **Transition Pains: Recognizing Effects of Organizational Realignment to a Changing Context.** In revision for: Journal of Applied Behavioral Science	Mental healthcare/ social domain	Organizational development following regime tensions	Incumbent	MLP/ CSP Dissonance Incumbent struggle	Longitudinal case study -Desk research -Semi-structured interviews -Participatory observation	2-3

Table 2.2 Overview of cases

3

Exploring a transition in Dutch healthcare

Published as: Johansen, F., Loorbach, D., & Stoopendaal, A. (2018). Exploring a transition in Dutch healthcare. *Journal of health organization and management*, *32*(7), 875-890.

CHAPTER 3 EXPLORING A TRANSITION IN DUTCH HEALTHCARE

3.1 Introduction

Healthcare systems in developed countries, such as the Netherlands, are increasingly identified to be unsustainable in their current design and seemingly immune to reform (e.g., Broerse & Bunders, 2010; Broerse & Grin, 2017; Dickinson & Pierre, 2016; Fineberg, 2012; Plesk & Greenhalgh, 2001; Neuteboom et al., 2009). The rising costs that come with technological progress in the context of an ageing population and a highly specialized and fragmented domain lead to increasing pressures for transformational change. The problems that seemingly defy reform are rooted deeply in the existing system, they are systematically (re)produced and therefore they have a persistent nature (Loorbach, 2007; Schuitmaker, 2013). These persistent problems come in many shapes and forms, illustrative examples are provided in Broerse & Bunders (2010) and Broerse & Grin (2017), but are inherently all concerned with the key features of the current health system such as a dependency on medical rationalization, specialization and standardization. It has proven difficult to alleviate tensions in the system by addressing problems through increasing efficiency or other types of optimizations (e.g., cost control and quality management). Persistent problems become visible through these kinds of interventions, clashing with the existing default solution pathways and remaining unsolved (Broerse & Bunders, 2010; Schuitmaker, 2013). Several authors (e.g., Broerse & Grin, 2017; Schroeder et al., 2013) point out the necessity of an integral transformation of the whole system, even though it is unclear what a future system would look like (Charlesworth et al. 2015).

The literature on healthcare identifies four main dimensions of persistent unsustainability. Firstly, system concerns related to affordability and accessibility due to rising demand caused by ageing populations, increase in chronic disease and possibilities of medical technologies (e.g., Broerse & Bunders, 2010; Fineberg, 2012). Secondly, dehumanization of healthcare related to a focus on financial performance, medicalization and standardization (e.g., Neuteboom et al., 2009; Youngson & Blennerhasset, 2016). Thirdly, the impact current healthcare design and institutions have on the environment (e.g., Knegt, 2011; WHO & HCWH, 2009). And finally, the impact of climate change on health (e.g., Costello et al., 2009; WHO, 2014). Even though these dimensions are frequently described separately, they are interlinked and all relate to a certain unbalance in the system. These dimensions, as well as the (un)balance, can be recognized in Elkington's Triple P bottom line: balancing people, planet, profit (Elkington, 1994), commonly used as a base definition of sustainability. Essink et al. (2010) identify that a sustainable state in healthcare is similar to that of any other system in that it is characterized by a balance between social and economic development on the one hand and protection of

the environment on the other. The Sustainable Development Unit of the NHS (United Kingdom) specifies that "a sustainable health and care system is achieved by delivering high quality care and improved public health without exhausting natural resources and causing severe ecological damage".

Every attempt to define characteristics, themes, elements or criteria for sustainable healthcare differs. However, in all cases the need for *radical* change is agreed upon. This foreseen systemic change primarily relates to the dominant structures, cultures and practices (Chreim et al., 2012; Essink, 2012; Van Raak, 2016; Johansen & Van den Bosch, 2017) and seeks to deal with the persistency and path-dependency that has been created and is being reproduced in the current system. Such a fundamental change in any system can be identified as a transition.

A transition is defined as a 'process of radical non-linear change in societal sub-systems as a response to a number of persistent problems confronting contemporary modern societies' (Grin et al., 2010; Loorbach et al., 2017). Even though the change itself is radical on the long term, transitions unfold over a period of decades and take place in incremental steps on the short term (Rotmans et al., 2001). Transition Management (Loorbach, 2007) specifically looks at these long term changes in the context of a complex and uncertain environment. Transition Management is essentially a method of intervention that looks at agency mechanisms that have the ability to influence transitions both within incumbent structures (regimes) as well as from emerging alternatives (niches). Transition Management scholars develop and experimentally test and refine interventions to accelerate transitions through action research (Wittmayer, 2016), producing both actual impact on transitions, deeper insight into transition dynamics in specific domains and better understanding of transition management.

One such an experimental transition intervention has been developed by the Dutch CSR (Corporate Social Responsibility) Network for Healthcare. Founded at CSR the Netherlands in 2012, this network aims to stimulate the further development of sustainable healthcare. 'Sustainable healthcare' is the term the network uses as an umbrella term for activities directed at realizing change towards a value-based healthcare system and can include a range of activities varying from adapting the service delivery model to reducing waste. When we use the term 'sustainable healthcare' in this article, we refer to this usage by the network.

One of the network's main goals is to create and support a group of healthcare organizations that can take on the role of frontrunners by actively taking up the challenge of changing regular ways of thinking and doing in their own organization, thereby influ-

encing others in the sector. The assumption of the network is that eventually the group of frontrunners will be large enough to influence system change. Healthcare organizations are invited to participate in an 'Expedition to Sustainable Healthcare'. This article analyzes the development of the first eight healthcare organizations that participated in the 'Expedition': are they (becoming) the frontrunners that were envisioned by the network? We conceptualize the Expedition to Sustainable Healthcare as an intervention aimed to contribute to a process of transition and explore the development of these first eight healthcare organizations. This article has a dual focus:

- Analyzing the process of the expedition and drawing lessons regarding its value in terms of transition management.
- Exploring a potential transition in (Dutch) healthcare to deal with persistent problems as well as how the expedition could contribute to this transition.

In this article we first take a closer look at transitions and Transition Management. We then give a further description of the CSR Network for Healthcare and the results of the Expedition to Sustainable Healthcare. The results of the expedition are then discussed in the light of the transitions framework. This article does not aim to give an exact description or definition of sustainable healthcare as for instance can be found with Neuteboom et al. (2009) or Schroeder et al. (2013). The focal point is not so much attaining 'sustainability' but the capacity of healthcare organizations to instigate a change in culture, structure and practices within their own organization and, possibly, to address persistent problems in the system.

3.2 Transitions and Transition Management

During the 1990s, (sustainability) transitions developed as a new research concept focusing on large-scale and long-term societal change. Transition research has primarily addressed socio-technical systems e.g., energy, mobility, water or waste. However, research into socio-institutional systems, such as healthcare, is gaining terrain. It is becoming clear that healthcare is an equally complex system facing the necessity of radical change to deal with persistent problems.

Transitions imply deep systemic change unfolding over a period of decades but with a distinctively non-linear and chaotic pattern in which accelerated and accumulated incremental changes take place. These changes are chaotic and non-linear as dominant cultures, structures and practices develop path-dependent and resist changes that fundamentally challenge the status quo. Ultimately, path-dependencies lead to reduction of diversity and adaptive capacities while alternatives become increasingly attractive, often driven by a broader societal acknowledgement of persistent problems and the

need to go beyond optimization. While alternatives become more attractive at the same time the incumbent system destabilizes, as shown in figure 3.1.

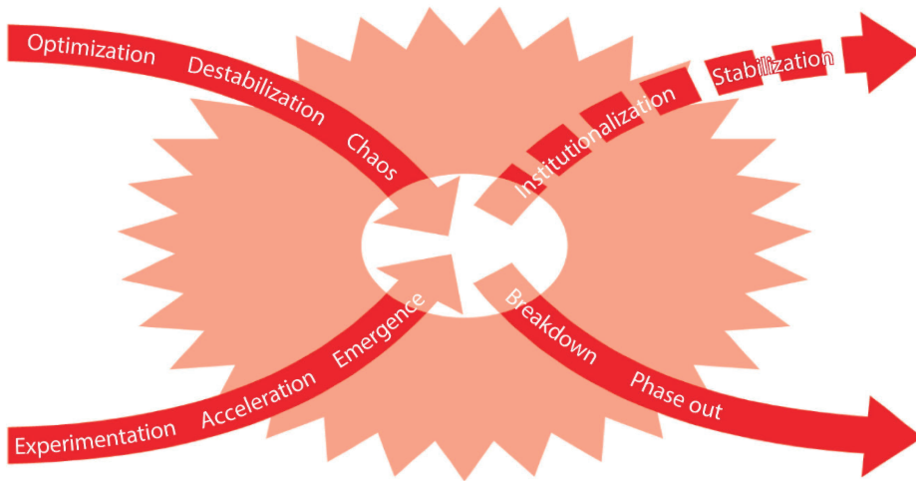


Figure 3.1 The X-curve of a transition: dynamics of transitions as iterative processes of build-up and breakdown over a period of decades (Loorbach et al., 2017)

The status quo (optimization phase) in a system or regime slowly starts to change as experiments (niches) challenge the existing regime. A system destabilizes when a process of change accelerates and develops into emerging and visible structural changes. This can be seen as a cycle: a new system develops and stabilizes, and after a period of optimization (often a generation or more) can possibly destabilize again. The X-curve illustrates how acceleration and destabilization are two sides of a coin. A stable regime is unresponsive to change and therefore unable to deal with persistent problems, hence, unsustainable in the long-term. The strain caused by the persistent problems can create room for alternatives and experiments (niches) that can contribute to destabilizing a regime. In this perspective, a transition is a multi-level long-term process of change affecting dominant structures, culture and practices (Frantzeskaki & De Haan, 2009; Rotmans & Loorbach, 2010):

- *structure* refers to the physical, economic and institutional infrastructure (including rules, regulations and collective actors);
- *culture* refers to the collective set of values, norms, perspective (in terms of coherent, shared orientation) and paradigm;

- *practice* refers to routines, behavior, ways of handling and implementation at the individual level.

Within transitions research, Transition Management (TM) has developed as a governance approach to explore, understand, operationalize, guide and accelerate transitions with networks of change agents (Loorbach et al., 2017; Wittmayer, 2016). TM looks to influence the changes taking place in the course of a transition, supporting actors to steer transitions in the intended direction as well as reflecting on these processes. TM aims to influence transitions through the creation of space for actors to explore and build alternatives (e.g., ideas, practices, and social relations), as well as to challenge and change the status quo through experimentation and learning (Grin et al., 2010; Loorbach, 2007, 2010; Wittmayer, 2016). In this context, transition scholars identify a need for a more strategic process of connecting niches and proactive regime actors, develop shared new perspectives and support systemic experimentation that can disturb the status quo. Essink (2012) indicates that the outcome of such a process can support the development of a shared change agenda and mobilize actors. The main elements of TM are summarized in table 3.1.

Element of TM	Description
Selective participation and multi-actor dynamics	Selection of frontrunners and bringing them together with actors from various backgrounds such as the existing regime and other domains. The main focus is connecting niche and regime.
Problem structuring	Development of a shared sense of persistent problems that define the need for systemic change through a transition analysis with participants. This growing consciousness of the unsustainability of a system can initiate destabilization on a small scale.
Envisioning	The creation of images of alternative futures and their underlying values to inspire and direct innovation and experimentation in a collective direction.
Developing a shared discourse	Both the collective problem structuring and envisioning support the development of a shared discourse among actors involved, both niche and regime.
Transition agenda and pathways	The envisioning of transition images and transition goals support the development of a transition agenda with objectives and various transition pathways to be explored. This aids a general sense of direction and perspective for practice.
Experimenting	A transition needs experiments as part of a systematic innovation program to learn how to adapt, change and transform existing dominant ways.
Learning	Learning-by-doing in the form of experiments as well as (reflexive) evaluation and monitoring provide information that can be translated back into the transition process in a cycle of continuous learning and adapting.

Table 3.1 Main elements of Transition Management.

To transition scholars, the transition in healthcare is about realizing human-centered healthcare that is economically viable and adds value to society, and is also connected to the rest of society (Neuteboom et al., 2009; Van Raak, 2016). In this view, sustainable healthcare is the result of changes in culture, structure and practices that support these principles. TM focuses on the process of evolutionary societal change by working experimentally towards future healthcare systems.

In the case of the 'Expedition to Sustainable Healthcare' a learning program was designed based on several TM principles to support the participants in becoming frontrunners in a healthcare transition, focused more on realizing change (in a common direction) than on realizing a specific result e.g., a predefined concept of sustainable healthcare.

3.3 Method

This paper is based on an experimental transition process involving frontrunner organizations in the healthcare domain in the Netherlands: the 'Expedition to Sustainable Healthcare'. The data was collected in a longitudinal study by examining the activities and development of eight Dutch healthcare organizations participating in the expedition and following the impact three years beyond the scope of the actual program (2014).

During this three-year period, yearly semi-structured interviews were conducted with the main project managers at the network as well as representatives from the eight healthcare organizations participating in the expedition, totaling 33 interviews. On average, the interviews lasted 1 to 1,5 hours. The interviews were transcribed verbatim. At two of the participating healthcare organizations there was a change in representatives during the three-year period. The group of main representatives held very different positions e.g., sustainability officer, company secretary or strategic advisor. In one case a merger has taken place during the research period and several participating organizations have seen a change at the CEO level. Additional desk research was conducted reviewing internal documents from the network and the participating healthcare organizations (e.g., strategic plans, yearly reports, internal communications and use of social media) as well as external data such as news items and articles. In addition to the desk research and interviews, the first author attended and observed various types of meetings in 2014 and 2015: an expedition meeting, a meeting organized by the network for directors of healthcare organizations with system players such as a bank and a healthcare insurer, two regular network meetings, and the final conference. The researcher was also included in the online community created for the participants of the expedition (Yammer).

We analyze the main changes as well as key issues from the perspective of the healthcare organizations and the network in the three years after the expedition and identify resulting changes in culture, structure and practices. The impact or influence of the expedition was studied in terms of new ways of thinking and doing within these organizations. The identification of key issues in these change processes as well as emerging results was aided by using labels (both theoretical and practice-based) while analyzing the material. The findings were checked in the yearly interviews. The focal point of the analysis was the influence of the expedition as a specific impulse in a larger transition process.

3.4 Dutch CSR Network for Healthcare

3.4.1 Establishment and development

The CSR Network for Healthcare was established in 2012 as one of the sector specific networks that are part of CSR the Netherlands. The initiation of the network followed up on research into the state of affairs concerning sustainability (policy) in Dutch healthcare (Knegt, 2011) and the outcome of a round table conference with healthcare directors discussing these outcomes. The general conclusion of the round table conference was that healthcare directors primarily have a short-term focus which does not take into account the impact healthcare has on the planet as well as on people's lives. The general view was: given the impact they have, healthcare organizations have a responsibility to address their added value to society and to develop a long-term vision to guide the development of the healthcare system.

The network looks to inspire, motivate and bring together all parties in the healthcare system to develop a vision and corresponding activities towards sustainable healthcare. The activities include periodic thematic meetings and initiating icon projects. For example, an icon project was set up to develop professional attire for healthcare workers that met several sustainability criteria e.g., ergonomic support, renewable bio-based material (long-lasting), 'clean' supply chain. The network brought together a variety of partners such as healthcare organizations, textile companies, students and international supply chain experts to realize this sustainable professional attire. An important focal point in the activities of the network is a cross-sector approach, not only targeting healthcare providers but including policy makers, healthcare insurers, banks, suppliers and educational and research institutes. By the end of 2017 the network had 57 members including 22 healthcare providers.

3.4.2 Expedition to Sustainable Healthcare

In the start-up period of the network, the project manager of the network conducted a round of interviews among healthcare directors. Most of these directors did not have

a clear idea about the concept of sustainability in healthcare, the relationship between climate change and health(care), nor were they familiar with related ideas such as circular economy. It became clear to the project manager that it was important to target these directors and higher management as the main decision makers and provide them with knowledge of sustainability concepts and alternatives to make an informed choice in their strategy. These ideas became the base for a year-long learning experience, targeted at directors and managers of healthcare organizations as well as a large group of employees from these organizations: Expedition to Sustainable Healthcare.

Figure 3.2 Core themes from the Expedition to Sustainable Healthcare, based on ISO 26000.

The expedition was designed around seven themes (figure 3.2), based on the ISO 26000 Guidance Standard for Social Responsibility and adapted to healthcare. This translation of social responsibility to healthcare has become the network's overview of the elements of sustainable healthcare. The expedition was designed session by session in an action learning setting using insights from Transition Management. The themes from the ISO guideline provided the content for the sessions. The way the sessions were conducted was inspired by notions from Transition Management: introducing and exploring a problem, inviting inspirational speakers to envision a possible future,

developing a shared discourse in discussion and learning from each other. The aim was to create awareness by providing participants with theoretical perspectives as well as a new mind-set to enable them to further the development of sustainability within their own organizations. Sharing ideas and learning from other participants was an important part of the design as well as positioning the development of individual organizations in the larger perspective of a transition in healthcare.

Rewards	Achieved through	Illustration (quote)
Inspiration, awareness and internal engagement	-Visionary speakers. -Active discussion of presented ideas during session to help translation to own organizational context. -Active involvement of the executive and management level (mandatory to participate). -Sessions attended by a large and varied group of employees.	*It was a good way to introduce colleagues to how sustainability in his or her field could be interpreted. In this way, many people have had the opportunity to become acquainted with visionary speakers (…), that helps our ambition to become sustainable to the core.* (Staff sustainability officer) *An extra impulse to focus and involve more people and to let the realization develop that we really have to continue with this. And that has happened. (…) The main goal was to bring the board of directors a step further and that was successful. They are now saying "we are a large organization and we have to seriously consider sustainability". That is an important statement.* (Chairwoman sustainability committee)
Knowledge and perspective (a broader view on sustainability)	-Session contents and speakers covered a range of topics and viewpoints on sustainable healthcare, surpassing environmental sustainability. -Stimulating participants to develop long-term goals (20-30 years into the future). -Focus on gaining a transformational perspective instead of optimization.	*The expedition has led to another way of thinking, really further, higher, deeper.* (Project manager sustainability) *And awareness, we already thought that sustainability went beyond electricity, energy and those kinds of things, and we had also already added lifestyle, but we didn't know that sustainability is also reflected in governance, finance and those kinds of things.* (Vice-director)
Shared discourse	-Participants hearing the same terms spoken by a variety of speakers. -Participants learning to use this language during the sessions.	(…) *and what you also hear back is that the fact that they are sitting at the table and hearing the same language, for example an inspirational speaker, and then get to work and that way learn to speak the same language concerning CSR, sustainability and all changes and the system. Yes, that surely eases things. Language is so important.* (Project team member)

Table 3.2 Rewards experienced by the participants of the expedition.

Besides the thematic meetings each participating organization followed an individual program with support from one of the consultants attached to the expedition team. The individual support generally consisted of a quick-scan comparing the strategy and policies of the organization to the ISO 26000 guideline. Additionally, consultants supported individual organizational development by aiding internal steering groups, writing

sustainability reports or helping to create visions of a sustainable future. The expedition was concluded with an open conference sharing the insights and best-practices. These were also published in a so-called learning history.

3.5 Results

In 2014, the first eight healthcare organizations participated in the expedition. These organizations included academic and regular hospitals as well as institutions for mental healthcare, elderly care and handicapped care from around the Netherlands. They were approached by the network as frontrunners in Dutch healthcare and were actively invited to become participants in the expedition. The network had identified these organizations through early involvement in the network, prominent placement in hospital rankings and visible activities towards sustainability. In most cases the organizations were already affiliated with the network.

3.5.1 Rewards

Participants identified several rewards gained from joining the expedition, presented in table 3.2. The results indicate that the expedition has aided capacity building among participants, in particular among participants who attended multiple meetings. These capacities may be instrumental for initiating change, both within the own organization and within the (local) system. Awareness, inspiration, knowledge and a shared discourse are rewards supportive of envisioning activities that prepare for experimentation and learning.

3.5.2 Positive Health

In the expedition session that centered around the theme 'Patient and Client Care' (figure 3.2) the participants were introduced to the concept of 'Positive Health'. The concept of Positive Health refers to a shift away from a healthcare paradigm that is focused on illness and disease towards a paradigm based on health defined in terms of resilience and the ability to adapt and self-manage (Huber, 2014). The participants are in general agreement that the introduction to Positive Health was one of the most valuable rewards they collected in the expedition:

> *Our organization has drawn up a new strategic vision (…), and during the expedition we were introduced to the vision on health by Machteld Huber. Before that, we had never heard of it, that was really new to us and has especially inspired us for that strategic vision.* (Chairwoman board of directors)

> *Thanks to the expedition to sustainable healthcare, we were introduced to Machteld Huber, that is extremely valuable. We have immediately incorporated this in our strat-*

egy. That can be hard to calculate in numbers, but it is very helpful in the sustainability story: what do you stand for? (Staff sustainability advisor)

This enthusiasm for Positive Health has since spread in Dutch healthcare in general. The focus on quality of life rather than the currently dominant focus on curing disease has proved to be inspiring. From a transition point of view, Positive Health is a concept that potentially has the capacity to instigate change at the system level. By changing the paradigm from disease to health (culture) there is potential to change structure and practices as well, e.g., developing (financial) structures and practices towards prevention, changing the design of hospitals to support a healthier and healing environment, reducing the use of pharmaceuticals and developing the curriculum for healthcare professionals to include subjects such as nutrition. However, critics point out that this collective embracing of Positive Health in Dutch healthcare ("as if it were the holy grail") hasn't left much room for a critical debate on the (moral) implications of Positive Health (Van Staa et al., 2017). Focus on Positive Health and its relation to well-being and happiness widens the boundary of healthcare considerably and may even further support medicalization (one of the persistent problems identified by Schuitmaker, 2013). Another issue raised by critics is that resilience and self-management are not attainable for everybody because it requires a certain amount of strength that is not a given. Full accountability for your own health mixes up health and behavior. In many ways, Positive Health seems to speak to a large group of practitioners and policymakers, however, it is equally clear that the concept needs further development.

3.5.3 Changes in structure, culture and practices

A shift in paradigm, although embraced by participants, takes time to develop. In the third-year interviews the participants identified that the real 'harvesting' was just beginning. Table 3.3 describes a variety of changes observed during the research period. Most changes are described by the participants as projects with a focus on changing behavior by changing structure. Many projects have yet to show actual changes in practice. Most changes can be identified as a form of optimization (e.g., decreasing environmental impact) rather than transformation. A number of smaller experiments, covering a range of activities but connected to a changing vision and strategy, seem to pave the way for larger experiments, even though larger more transformational organizational changes were not (yet) realized during the research period.

Looking at these examples of change in structure, culture and practices from the perspective of the X-curve, we can identify the growing room for experimentation. This experimentation was encouraged by the expedition. The X-curve shows us that the build-up process needs to be accompanied by a process of breakdown in the 'old'

system. However, this was not an explicit part of the expedition and is not mentioned in any of the interviews.

Structure	Sustainability as a designated responsibility at top management level Use of specific goals focused on sustainability (e.g., lowering carbon footprint, enlarging social footprint, energy neutrality, zero waste) Developments in infrastructure towards supporting outpatient care Solar panels and energy programs for employees Developing healing environments Programs to reduce food waste and increase healthy meals Sustainable procurement (sustainability as main criterion instead of price) and new types of relationships with suppliers working together to develop sustainable products and supply chains
Culture	Positive Health introduced as a new paradigm, introducing different values related more to health and prevention than to sickness and care/cure Sustainable development in partnerships: large scale changes can be realized when working together with others outside to healthcare (e.g., university, municipality, water management company) Campaign 'Act with awareness' to promote a broad awareness of sustainability beyond the daily work focus
Practices	Active encouragement of healthy lifestyle for both patients/ clients and employees e.g., Meatless Monday at the hospital restaurant Engaging clients with mental of psychiatric disability in regular work activities Lectures for upcoming physicians are given by patients Increasing use of circular and biodegradable materials Use of electric bicycle instead of car between locations Plastic recycling in the operating room Change in supplier relations: negotiations become conversations based on reciprocity and working together towards sustainable products

Table 3.3 Examples of changing structure, culture and practices in participating organizations.

3.5.4 Challenges

Although participants agree that the expedition has offered them a great deal in terms of inspiration, knowledge, awareness to instigate their own strategy and goals towards sustainability, there have also been challenges along the way. The challenges encountered are diverse (as were the participants' organizations), but mostly relate to an unsupportive structure, unfocussed strategy and lack of leadership. The main examples are: a change in top level management or key figures, lack of connection between general organizational strategy and long-term vision on the future of healthcare, lack of structured responsibility to forward internal change and difficulty crossing domains within the organization. Participants that encounter these challenges experience a lack of uniform direction that leaves room for different priorities. These challenges are recognizable in most organizational change literature. The challenge that stands out is

the difficulty in translating the broad social perspective offered by the expedition to the organizational context.

The expedition has provided the participants, especially the coordinators, with a view on sustainability that can be translated to every aspect of organization, be it facilities, financial management, governance, employees or clients/ patients (see also figure 3.2). However, several participants experience difficulties in passing on this broad view within their own organization, precisely because it is very broad and can relate to most organizational processes when approached from a value-based perspective.

> *We are also very conscious of, we don't speak of sustainability but of sustainable care, for our clients, the parents/ relatives and employees. Because sustainability was for many people about energy and gas and so on, but it is so much more. (…) So, we keep saying: sustainability is not just about the environment, it's also about people and the added value to society.* (Company secretary)

> *It's about everything really. (…) In our strategy we have said we want to realize a breakthrough in sustainability in our primary activities (…) and then it touches everything you do in a hospital. And then it is so extensive that you don't know where to begin. (…) Then we say sustainability is about sustainable research, but also about food wastage and about vitality, and then people are already confused.* (Staff sustainability advisor)

> *And my general findings are that the first associations with sustainability are mostly related to waste and energy. So, if you ask people: what do you want to do, it is mostly at that level: sustainable buying, better separation of waste, no more use of paper, those kinds of things. And what develops during conversation is the realization that sustainability is more. It's not only about waste and energy, it's also about sustaining the workforce, (…), it's about effective care, sustainable education, sustainable research, doing the right research in the right way.* (Staff sustainability advisor)

Basically, the proposition introduced by the expedition was to look at the value of the healthcare organization to society. In practice, the development of a long-term vision and strategy were not always sufficient to guide further developments and many participants have had to make choices concerning specific projects to direct their focus. These projects are generally related to the more recognizable areas of sustainability such as energy and waste as these are easily communicated with healthcare workers. Despite all emphasis on a broader meaning of sustainable healthcare, it is narrowed to the classic interpretation concerning the environment.

Of course, this focus on environmental issues is very relevant and there is still much ground to cover in healthcare. However, participants agree that this is not the main challenge:

> *What you see (…) if you look at the planet side: waste, energy, buildings. Those are not the complicated issues; a lot is already happening. I find that the challenge, at least in our organization and I think nationwide, is to realize actual sustainable patient care, and research and education. That is a much larger challenge.* (Staff sustainability advisor)

The expedition has tried to inspire a change in culture, structure and practices in the way healthcare is organized and produced by raising questions about the primary goals of healthcare and the value of healthcare to society beyond the traditional environmental sustainability. The main challenge therefore lies in creating awareness that sustainable healthcare is much more about changing the way we do things through a different approach to the care for patients and less about 'green' hospitals. The term 'sustainable healthcare' may not be the most appropriate term as it inadvertently focusses more on a result than on the process of change.

3.5.5 Frontrunners in the making?

One of the main aims of the expedition was to create a group of frontrunners to support the acceleration of a transition in healthcare, assuming circa 50 healthcare organizations would follow the expedition over a period of several years. Following the first national expedition and a second regional expedition, there have not been similar expeditions. Several potential participants declined because of issues related to time or money. In addition, the evaluation of the first two expeditions by the network indicated that local or regional expeditions organized around the specific issues of the local participants provided better support for participants. The efforts of the CSR Network for Healthcare have therefore not (yet) yielded a large group of frontrunners as foreseen and the results show that frontrunners cannot simply be created through participating in an expedition.

Nevertheless, among the participants several frontrunners can be identified. What characterizes these organizations is an integral approach towards sustainability, balancing economic, sociocultural and ecological values. A few participants of the expedition have set high ambitions, reaching far beyond solar panels and electric cars, viewing a healthy living environment in and around the healthcare facilities as part of their responsibility. They reflect on their role as healthcare provider in (local or regional) society. Consequently, they look to forge partnerships with other organizations at the local or regional level aimed at developing sustainable alternatives. These frontrunners maintain that

partnerships are essential. Additionally, these organizations actively participate in public debate about the future of Dutch healthcare thus supporting a growing undercurrent of alternatives.

The main success factor appears to be the ability to engage stakeholders inside and outside the organization, across domains, making connections that support changes on different levels and bring niche and regime closer together. Supported by factors such as nurturing inspiration and ambition, visibility, and ambassadors at the top level, the frontrunners have made visible how the concept of sustainability can be a stepping stone for transition.

3.6 Discussion

In this section, the design and results of the expedition are discussed from the perspective of Transition Management (TM). Additionally, this section looks at the contribution of the expedition towards a transition in Dutch healthcare.

3.6.1 Examining the 'Expedition' as a transition process

From the perspective of TM, the 'Expedition to Sustainable Healthcare' can be conceptualized as a deliberate intervention to explore a desired transition in Dutch healthcare and the way it might influence the speed and direction of such a transition. The expedition resembles the transition arena (Loorbach, 2007): a (virtual) space where actors use social learning processes to acquire new knowledge and new perspectives. It is important to note that the main goal for the network was to further 'sustainable healthcare', not to solve persistent problems. In the design of the expedition the network made use of concepts from TM, primarily envisioning and learning.

<u>Problem structuring</u>

An important base for every TM process is a system analysis and the development of a shared understanding of persistent problems in a system (Rotmans & Loorbach, 2009). This problem analysis was not part of the expedition or its preparation. This had implications for the selection (already known frontrunners in the existing regime), scope (changing the current system rather than exploring radically new futures) and process design (emphasis on concrete action rather than new discourse). A thematic design was chosen based on the ISO 26000 Guidance Standard for Social Responsibility (figure 3.2). The chosen approach was not legitimized by a critical transition analysis with participants, making the expedition less demand-oriented. In this way, the expedition may not have fully touched on the heart of the unsustainability and persistent problems in the healthcare system. This lack of shared problem analysis may have influenced the experienced lack of common ground among participants as well as the organizational

focus of most participants, and possibly influenced the recruitment of new participants for further expeditions.

Selective participation

Participants were invited based upon their frontrunner status, but on an organizational level. In TM, selection is based upon realizing a specific diversity of perspectives, positions and capacities but always as individuals. As the expedition focused on already acknowledged organizations they were often already known to the network and not selected based on specific competencies. The (first) expedition as an arena also lacked active support from political actors and regime powers. This changed in the second expedition by inviting local and regional regime players (e.g., government, bank and insurance company). Participants in the expedition were joined by visionary speakers. However, the speakers joined on a thematic base, not as regular participants, reducing the opportunity to deepen the discussion on their ideas. The expedition tried to facilitate and stimulate niche-regime interaction, but did not fully succeed. The lack of problem structuring may have also been instrumental in the lack of attention paid to interaction with the regime by participants; they were mostly focused on their own organization (with a few exceptions).

Envisioning

Envisioning was an important part of the expedition. Through the collective sessions with visionary speakers, participants gathered (personal) inspiration and images towards sustainable healthcare. In the individual sessions with consultants several participants developed visions of sustainable healthcare for their own organization. Overall, the expedition led to a very enthusiastic reception and diffusion of the concept of Positive Health. This transformative vision for an ageing society, in which quality of life is a central foundation rather than the currently dominant 'repair system', became part of the shared guiding orientation.

An important result of the expedition was the development of a common vocabulary provided by the speakers and subsequent exploration during the sessions by participants. A common vocabulary should become a primary aim in the transition process instigated by the expedition as it can lay the foundations for future problem structuring and a confrontation of perspectives. A common vocabulary can support mutual understanding and collaboration.

Transition agenda and pathways

The transition agenda and pathways are tools for collective strategy building. While the expedition supported the development of visions of sustainable healthcare, less atten-

tion was paid towards translating vision into practice in the form of transition pathways as a perspective for practice. This may explain the difficulty expressed by participants concerning an integral approach towards sustainable healthcare and the challenge of translating the inspiring vision within the organization and simultaneously avoiding the risk of focusing solely on environmental issues. In turn, this can be related to the identified lack of shared problem analysis.

Experimenting and learning

The initiation of specific experiments was not an explicit part of the expedition program. The expedition was focused more on stimulating participants to seek room to experiment, especially in dialogue with regime players. Room for experimentation was explored by participants, mostly within the own organization and less in dialogue with regime players. This resulted in initiatives for circular clothing, sustainable building measures, exploring new healthcare concepts, etc..

The expedition in itself was in constant state of monitoring, evaluating and learning-by-doing as the program was developed session by session, translating lessons learned into a next session. The process within organizations was mostly monitored by a steering group. However, following the completion of the expedition the participants were 'on their own' for the most part. The network did not have the resources to facilitate follow-up monitoring and support other than regular network meetings.

3.6.2 Healthcare in transition?

The expedition was a journey of exploration in the sense that the participants, together with the expedition designers, searched for the meaning and form of the desired change labelled as sustainable healthcare. In this exploration they developed a shared discourse and the envisioning of alternative futures in healthcare. Through the collective and individual learning process the participants acquired new knowledge and perspectives to support the development of their own vision and strategy. This exploration and developing discourse aids not only the participants but has spread to a wider audience through the communication of participants, through the interaction with key speakers, through the final conference and publication of a learning history, and of course through the network itself. Thus, the discourse on sustainable healthcare is not limited to the expedition but slowly developing further on its own in the healthcare sector. Furthermore, the expedition has affected the awareness of sustainability in healthcare through the invitation of key note speakers. In this manner, the expedition has tied influencers to the theme of sustainability in healthcare. Both influencers in healthcare who have linked their story to sustainability, as well as influencers on sustainability who have taken up healthcare as a relevant sector to support development.

Looking back at the X-curve (figure 3.1) the expedition (so far) has been supportive of the undercurrent that yields experiments and alternatives, but has not been able to reach enough healthcare organizations and institutions to push for acceleration. Additionally, the interactions between experiments (niches) and the healthcare regime are few. Nonetheless, the CSR Network for Healthcare and the expedition stimulate a transdisciplinary approach, the development of multi-actor participatory networks, a focus on learning by doing and alignment between niches and regimes to facilitate the change process. These characteristics are in line with the findings of Essink (2012) as being ingredients for a successful strategy for scaling up innovations in healthcare. Thus, implying that the potential for the network and the expeditions has not been fully reached yet.

It can be argued that developing awareness in society towards sustainability has led to more awareness in the healthcare sector and frontrunners have also emerged outside of the expedition. Maybe not surprisingly, the acceleration of changes in the healthcare system can mainly be found in the 'classic' sustainability themes, what you might call the edges of healthcare: energy, buildings, waste and food. The core business of healthcare and the accompanying persistent problems, system and structures are still largely untouched.

3.7 Conclusions and recommendations

Transitions are concerned with radical change over a long period of time. In practice, such transitions are highly complex, incremental and unpredictable. In our paper we have followed the developments in the Dutch healthcare sector during a period of three years and have looked specifically at the 'Expedition to Sustainable Healthcare'. This expedition helped to explore the potential future direction and dynamics of a transition in Dutch healthcare. Such a transition, according to both research and the participants in the expedition is both likely and desirable. At the same time this expedition has only been a very small-scale intervention with at least on the surface so far, a marginal effect on the Dutch healthcare system. Nevertheless, the outcomes suggest that there is the need for a more strategic and focused effort to guide and accelerate certain transition pathways as well as that the approach of the expedition is a promising way to operationalize transition management principles.

The output of the expedition seems to suggest increasing pressures for change and growing transition potential in the Dutch healthcare system. Even though healthcare organizations experience strains in the system and participants of the expedition in general are inspired to reinvent healthcare as a sustainable system, very few examples of disruptive innovations can be identified. One main example in Dutch healthcare,

Buurtzorg (Johansen & Van den Bosch, 2017), has not been followed by similar disruptive innovations focused on the core business of healthcare. In this way, innovation remains largely institutionalized. A sense of urgency is still limited to a small group of frontrunners and has not yet found its way in any visible destabilization of the system. However, critical thought has been stimulated and will most likely continue to develop as alternatives are becoming more known and new perspectives are generated. Expeditions like this one can certainly support this development of increasing awareness and be even more effective as a nurturing place for experiments.

From the perspective of Transition Management, the expedition did not pay enough attention to the problem analysis of the unsustainability of the current system (the persistent problems) and was not able to realize many niche-regime connections to support the scaling up of experiments and breaking down of old pathways. However, these niche-regime connections may arise in the coming years as the participants in the expedition were primarily focused on their own organizations in the first years following the expedition and their focus is starting to turn outward.

The value of the expedition as a transition instrument lies in the sharing of ideas about different futures in healthcare and stimulating a changing discourse. Future expeditions could focus more on addressing the persistent problems and exploring the pathways that can lead to radical changes in the healthcare system. This case shows that 'classic' (environmental) sustainability is sufficiently institutionalized to be adopted in a rapid fashion in healthcare. Changing ways of thinking and doing in healthcare to break the pattern in persistent problems requires many more transition experiments such as this expedition and based more in niche-regime interaction. The transition in healthcare can be supported by a systematic development of expeditions where every expedition learns from the other ones to support the development of new pathways in the healthcare system as a whole. Further research into transition pathways could support healthcare organizations in translating visions of alternative futures in healthcare from a broad societal perspective to day-to-day culture, structure and practices that inspire and motivate healthcare professionals.

4

The scaling-up of Neighborhood Care: from experiment towards a transformative movement in healthcare

Published as: Johansen, F., & Van den Bosch, S. (2017). The scaling-up of Neighbourhood Care: From experiment towards a transformative movement in healthcare. *Futures*, *89*, 60-73.

CHAPTER 4 THE SCALING-UP OF NEIGHBORHOOD CARE: FROM EXPERIMENT TOWARDS A TRANSFORMATIVE MOVEMENT IN HEALTHCARE

4.1 Introduction

Healthcare systems in developed countries are facing a number of challenges, including demographic changes such as the ageing of the population and related increase in chronic diseases, increasing healthcare costs and increasing demands of society regarding the quality of healthcare. Lagergren (1985) foresaw these challenges and the need for structural changes in public healthcare more than 30 years ago. In the past decades, different actors in the Netherlands have tried to meet these challenges by optimizing the existing healthcare system by means of policy reforms, cost control and incremental innovation. Different authors describe how the boundaries of this optimization in healthcare are being reached, illustrating that the current healthcare system is not sustainable or 'fit for the future' (Broerse & Bunders, 2010; Hancock, 1999; Neuteboom et al., 2009; Plsek & Greenhalgh, 2001). 'Healthcare sustainability' refers to the balance between the demand for care and the capacity to deliver it (Janssen & Moors, 2013). The current Dutch system for long-term care does not have long-term viability in terms of quality, affordability, accessibility and acceptability (Schuitmaker, 2013). It has not yet been able to adapt to ongoing changes and is therefore not a resilient system: it is unsustainable in the current design.

However, in the past decade, a transformative movement in the Dutch long-term care sector has been changing the dominant way of thinking and working in healthcare. A frontrunner in this movement is 'Neighborhood Care', which is referred to in this article by their Dutch designation 'Buurtzorg'. Buurtzorg is formed by a network of nurses who work in small-scale, self-managed teams to provide homecare in neighborhoods. When they started in 2006, their approach was radically new because it had fundamentally different characteristics from the dominant approach in healthcare: Buurtzorg aimed to empower both nurses and patients, create meaningful relationships between nurses, patients and their social network and support self-reliance in patients. Laloux (2015) refers to Buurtzorg as an example of an organization with a new business model, following an emerging worldview, based on 'self-management', wholeness and evolutionary purpose (a 'teal' organization). Buurtzorg introduced Self-Management as a fundamentally different organizational model in healthcare, erasing all management layers. Hence, the existing literature has mainly studied Buurtzorg from a managerial and organizational perspective (Laloux, 2015; Nandram, 2015; Van Dalen 2010, 2012). However, the development of Buurtzorg, from a local experiment with one team of 4 nurses in 2006 to an (international) network of more than 800 teams in different domains of long-term

care, raises questions about *how* Buurtzorg was able to rapidly scale up and become the frontrunner of a transformative movement in healthcare.

In this paper we look at the development of Buurtzorg from the perspective of transition studies (Grin et al., 2010; Markard et al., 2012; Rotmans et al., 2001) and specifically the approach of Transition Management (Loorbach, 2007). A transition can be defined as a 'radical transformation towards a sustainable society as a response to a number of persistent problems confronting contemporary modern societies' (Grin et al., 2010). From this perspective Buurtzorg can be seen as a response to the persistent problems and challenges in the Dutch long-term care system. Within Transition Management literature Buurtzorg is considered as a key example of one of the 'transition experiments' that were part of the Transition Program in Long-term Care (Loorbach & Rotmans, 2010; Van den Bosch, 2010; Van Raak, 2016). The aim of our case study of Buurtzorg is to add to this literature by providing insight into how a radically new practice in healthcare could rapidly scale up and impact the long-term care system.

Several authors have criticized existing transition literature for being overly focused on socio-technological domains (Lawhon & Murphy, 2011; Markard et al., 2012). Healthcare as well as other social domains such as welfare and education are arguably faced with similar challenges to develop new ways of 'production and consumption'. Partly, this gap has been filled by focusing on how daily routines change in *social practice* studies (e.g., Shove and Walker, 2010; Spaargaren, 2011). However, empirical studies that focus on transitions in social domains are still scarce. Lawhon & Murphy (2011) also identify the need for "more understanding of the dynamics through which communities, industries, countries, and/or regions transition into more sustainable forms." Our case study of Buurtzorg adds to this literature by looking at the dynamics and ongoing changes in the long-term care sector in the Netherlands. The main research questions guiding our case study are: "how can we understand and explain the rapid development of Buurtzorg (between 2006 and 2016) from a transition experiment towards a transformative movement in the Dutch long-term care system?" and "what strategic activities for surpassing the experimental phase, and moving from niche(s) to mainstream can be identified based on the case of Buurtzorg?".

Our conceptual framework is introduced in section 2, building upon transition literature and focusing on strategic activities for scaling up. In section 3 we explain our research method. In section 4 we further introduce Buurtzorg and contextualize the case, including the developments in the Dutch long-term care sector that have enabled the take-off and growth of Buurtzorg. In section 5 we analyze the scaling up of Buurtzorg, identifying key strategic activities and synthesizing this in our conceptual framework. In

section 6 we reflect on the ongoing changes in the dominant way of thinking, doing and organizing in long-term care and the contributions of Buurtzorg to this transformative movement. We end with the conclusions and discussion in section 7.

4.2 Transition perspective on scaling-up

4.2.1 Transition experiments as instrument of transition management

The term 'transition experiment' is a key concept in our case study as Buurtzorg was selected as one of the transition experiments of the Transition Program in Long-term Care. Contrary to other types of experimental projects such as 'niche-experiments' (Kemp et al., 1998) and 'bounded socio-technical experiments' (Brown et al., 2003; Brown & Vergragt, 2008), 'transition experiments' do not necessarily feature technological change or environmental sustainability (Sengers et al., 2016). The concept builds upon the Brundtland definition of sustainability (UN WCED, 1987) that emphasizes the importance of meeting the needs of the present without compromising the ability of future generations to meet their own needs. Hence, transition experiments are defined as 'innovation projects that explore radically new ways of meeting societal needs and solving persistent societal problems' (Van den Bosch & Rotmans, 2008). In the Transition Program in Long-term Care transition experiments were applied as one of the key instruments of the governance approach of Transition Management (Loorbach, 2007) (see section 4.4.2). Cramer (2014) has shown that there were many barriers to empowering 'niche-innovations' in long-term care, and most transition experiments that were supported by the Transition Program were not successful in scaling up.

4.2.2 Conceptualizing 'scaling-up'

We understand 'scaling-up' as the process in which radically new approaches, starting out as experiment, become mainstream or 'normal'. Within transition literature this phenomenon has been conceptualized in various ways: as the societal embedding of experiments (Deuten et al., 1997; Kivisaari et al., 2004), as the aggregation of learning experiences in local projects to a global niche level (Geels & Deuten, 2006; Geels & Raven, 2006), as the translation of sustainable practices in niches to mainstream practices in the regime (Smith, 2007) or as the trajectory from 'novelty to normality' (Shove, 2012). We use the general term 'scaling-up' to explicitly refer to the 'scales' or different levels of the Multi-Level Perspective on transitions (Geels, 2002; Rip & Kemp, 1998; Schot, 1998). A basic notion in this perspective is that "*niches* provide the locus for the generation of radical novelties, but the selection and broader diffusion of these novelties depends on alignments with *regime* and *landscape* levels" (Geels & Schot, 2010 p.19). The landscape concept can be used to describe long-term developments, trends and major crises that are exogenous and can be important drivers for system change. The regime concept

(Rip, 1995) has been mainly used to understand the stability of socio-technical systems and to study (historical) socio-technological change. The regime includes elements such as rules and regulations, user practices, infrastructure, technology, shared values and powerful actor configurations and institutions.

Since transition experiments do not necessarily feature technological change, we do not use the concept of 'socio-technical regimes'. We use a broader notion of the regime concept that refers to the dominant structure, culture and practices in a 'societal system', which can be understood as a system evolved to meet societal needs, for example a sector or industry such as energy supply, education or healthcare (De Haan & Rotmans, 2011). When a transition in a societal system takes place, this can be conceptualized as a "fundamental change in structure, culture and practices" (Rotmans & Loorbach, 2010 p.109):

- *structure* refers to the physical, economic and institutional infrastructure (including rules, regulations and collective actors);
- *culture* refers to the collective set of values, norms, perspective (in terms of coherent, shared orientation) and paradigm;
- *practice* refers to routines, behavior, ways of handling and implementation at the individual level (including self-reflection and reflexive dialogue).

In our case study of Buurtzorg these concepts are applied to understand the ongoing changes in the context of the Dutch long-term care system.

4.2.3 Focus on strategic activities

In order to develop innovative practices beyond a niche into the mainstream the strategies and actions of individual actors and groups of actors are crucial (Elzen, 2012; Hermans et al., 2016; Smith & Raven, 2012). Farla et al. (2012) emphasize the need to better understand the actor-perspective in sustainability transitions and to identify the strategies and conditions under which different types of sustainability transition challenges can be addressed. From an actor-perspective Buurtzorg could be characterized as a "niche-entrepreneur" (Pesch, 2015) who initiated a broader movement by transferring learning-by-doing experiences beyond the niche context (Smith et al., 2010). Entrepreneurs are acknowledged to be able to make significant contributions towards sustainability transitions (e.g., Exton, 2008; Janssen & Moors, 2013). The literature on entrepreneurs shows a wide variety of entrepreneurial strategies depending on the research perspective and context. Janssen & Moors (2013) have identified 19 strategies applied by healthcare entrepreneurs in the context of sustainable innovations. However, these strategies are not mapped in a conceptual framework that can also be applied by other researchers or practitioners. Their typology of sustainable healthcare entre-

preneurs (revolutionary, evolutionary, innovative, isolated) does provide a first step in developing a sector-specific framework around entrepreneurs in healthcare transitions. Based on this framework, Buurtzorg could be seen as an example of a "revolutionary entrepreneur" who aims to structurally change the system context, not just their own sustainable innovation (Janssen & Moors, 2013). Building upon transition literature, our case study of Buurtzorg focusses on identifying the key *strategic activities* that enabled them to rapidly transcend the level of experimentation and build up a new mainstream model for delivering and organizing long-term care.

4.2.4 Framework of deepening, broadening and scaling-up

To understand the rapid scaling up of Buurtzorg, and to identify their strategic activities, we apply and further develop the framework of 'deepening, broadening and scaling-up' (Raven et al., 2010; Rotmans & Loorbach, 2008; Van den Bosch & Rotmans, 2008; Van den Bosch & Taanman, 2006). This framework was developed and applied in practice as part of action research during the Transition Program in Long-term Care (Van den Bosch, 2010), which was also the start-up period of Buurtzorg.

The first type of strategy is *deepening* which refers to learning activities through which actors learn as much as possible within a specific local context. Deepening builds upon the notion of 'niches' (Kemp et al., 1998; Schot & Geels, 2007) that provide a context for experimenting and learning about radical novelties that are deviant from 'business as usual' or the 'regime'. The second type of strategy is *broadening*, which refers to repeating and connecting radically new approaches in different contexts, either within or outside the initial domain of application. A general notion in the literature on innovation and transitions is that before an innovation breaks through to the mainstream context, it needs to be developed in a variety of contexts (Geels & Raven, 2006; Levinthal, 1998; Nooteboom, 1999; Rogers, 1995; Rotmans & Loorbach, 2008). As a result of broadening the innovation becomes adapted to different contexts. Another important aspect of the strategy of broadening is connecting the various experiments in different contexts in order to build up a network with increasing influence and stability. The third type of strategy is *scaling-up*, which can be defined as "embedding a radically new approach in the dominant practices, structure and culture of a societal system" (Van den Bosch, 2010). The strategy of scaling-up is thus aimed at influencing the way societal needs are fulfilled by "actively trying to exert influence on society" (Rip, 1995). The outcome of scaling-up is that a radically new approach, which was initially deviant or unusual, gets embedded in the societal system and thus becomes 'mainstream'. Our definition of scaling up also relates to the definition of Hermans et al. (2016) in which 'upscaling' is concerned with "identifying opportunities and barriers within institutional structures to properly embed an innovation and the actions that niche actors employ to achieve

that, such as (…) advocacy and lobbying, mobilizing powerful 'patrons', and creating alternative visions, framings and discourses." In our case study of Buurtzorg we aim to identify these types of concrete strategic actions and integrate this in the framework of deepening, broadening, scaling-up in order to provide both researchers and practitioners with a framework that can be used to identify strategic activities for (future) transition experiments.

An important notion in this conceptual framework is that the strategies of *deepening* and *broadening* should be integrated with the strategy of *scaling-up* in order to exert influence and create new standards or models. This integration of strategies can also be recognized in the work of Geels & Deuten (2006) who describe how learning in local projects and learning *between* and *across projects* can lead to general lessons and rules by dedicated 'aggregation activities' (such as standardization, model building, writing of handbooks, formulation of best practices). Figure 4.1 illustrates how the strategies of deepening, broadening and scaling up can be related to the scales in the Multi-Level Perspective.

4.3 Method

We have conducted a case study because this enables an in-depth empirical study of how Buurtzorg could rapidly develop from 'transition experiment' towards a transformative movement in healthcare and to identify their strategic activities to move from 'niche to mainstream'. Based on Yin's definition of a case study as "an empirical inquiry that investigates a contemporary phenomenon within its real-life context" (Yin, 2003 p.13), we also aim to understand the context of Buurtzorg, which is the Dutch system for long-term care. We look at the development of Buurtzorg from 2006 to 2016, which provides a complete overview of the period in which Buurtzorg was started up and rapidly scaled up. The reports and meetings with Buurtzorg as part of the Transition Program in Long-term Care (2007-2009) are used as an important knowledge base. The Dutch Research Institute for Transitions was a member of the program team that selected Buurtzorg as a transition experiment, and as such supported all transition experiments with writing reports, organizing learning sessions to share their experiences and monitoring their activities. We have analyzed the start-up and follow-up activities of Buurtzorg by means of desk research (including internal documents, news articles and internet sources about long-term care and Buurtzorg, interviews with founder Jos de Blok and Buurtzorg nurses, research books and articles about Buurtzorg). Based on this data, we identify the variety of strategic activities that have contributed to the rapid scaling up of Buurtzorg and conceptualize these strategies in an adjustment of the existing framework of deepening, broadening and scaling-up in order to formulate a fitting explanation for the development of Buurtzorg. In addition, we use this data to make

more general observations on the ongoing changes in Dutch long-term care in terms of structure, culture and practices.

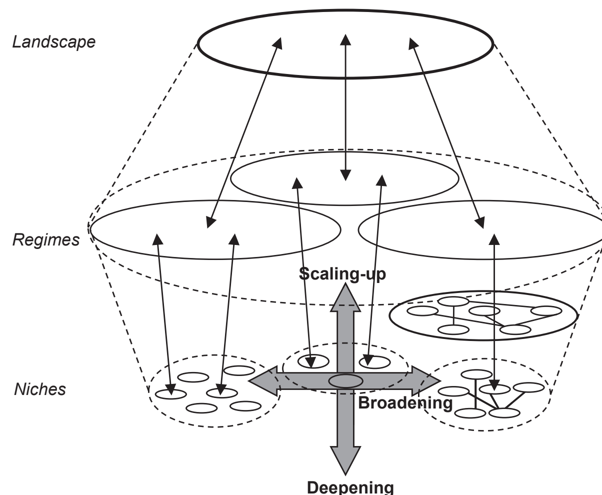


Figure 4.1 Deepening, broadening & scaling up transition experiments (based on Van den Bosch, 2010) in relation to the multi-level perspective (based on Geels, 2002).

4.4 Buurtzorg and the Dutch system for long-term care

4.4.1 The Dutch system for long-term care

The Dutch sector for long-term care includes elderly care, homecare, mental healthcare, and care for physically or mentally disabled persons. The incumbent healthcare regime is under pressure to meet the societal need for high-quality long-term care, while responding to landscape developments such as the ageing of the population and the increase of chronic disease and simultaneously bending the cost curve. Between 2004 and 2014, the expenditure in long-term care increased by 40% (CBS, 2014). The long-term care system needs to overcome 'persistent problems', which can be understood as the systemically reproduced negative side effects of success factors of the current system (Schuitmaker, 2013). One of the persistent problems in healthcare is the financing mechanism based on delivering different 'care products', which stimulates increasing production instead of prevention (Neuteboom et al., 2009). In homecare, this has resulted in a myriad of different 'products' that are related to different care tasks. This can also be regarded as a negative side effect of increasing standardization and specialization, since standardized care tasks are performed by different types of care professionals, who are supervised by

a large number of managers. Due to this neo-Taylorist[3] separation between the planning and execution of work, neighborhood nurses in homecare can experience a fragmented sense of self and occupation (Oldenhof, 2015). Since the beginning of 2000, several crises in the Dutch long-term care sector have been identified, including major problems concerning the quality and cost control in homecare. Exemplary is the bankruptcy of the largest Dutch homecare organization (Meavita) in 2009. With hindsight this can be considered as a turning point in the sector because it added to the general feeling of unease and hence provided a context for new approaches such as Buurtzorg to take off (illustrated in figures 4.2 and 4.3).

4.4.2 Transition Management approach in long-term care

To overcome the persistent problems, a Transition Management approach (Loorbach, 2007) was implemented in the long-term care sector, with support from the Dutch Ministry of Health, Welfare and Sports and the Dutch care sector associations. In 2005 they agreed to cooperate to improve the long-term care sector and provide additional incentives for innovation (in total 80 million euros), leading to the Transition Program in Long-term Care (Loorbach & Rotmans, 2010; Van den Bosch & Neuteboom, 2017). The Transition Management approach was intended to address persistent problems by changing the care sector from within by supporting small-scale shielded experiments, combining visionary thinking and practical acting, in small steps with a long-term focus, aimed at creating a societal movement. As part of this approach, a 'Transition Arena Care' was established. This transition arena consisted of a group of frontrunners from different backgrounds related to long-term care who developed a shared problem analysis and long-term vision on care. Their problem analysis proclaimed the problem of incompatible underlying values: the conflict between the values of the healthcare system (cost-effectiveness, efficiency, productivity, profit) and human values such as attention, compassion, time and trust (Neuteboom et al., 2009; also identified by Youngson & Blennerhassett, 2016). Based on their analysis the transition arena developed a sustainability vision entitled: Human(s) Care (in Dutch *Mensenzorg*), which envisioned long-term care as being "human oriented, economically sustainable and societally embedded". This refers to a focus on the meaningful relationship between client and professional, a change in paradigm towards the long-term rewards of prevention and health and not just the short-term costs, and acting on the relationship between long-term care and the other domains of society.

3 'Taylorism' is a theory of management that aims to improve economic efficiency, especially labor productivity.

Another part of the Transition Management approach was to facilitate two rounds of 26 transition experiments (Van den Bosch, 2010) that applied this vision in practice by developing radically new approaches that could contribute to a transition. The experiments in the program were selected because they contained possible solutions for perceived persistent problems in the sector on a small-scale. Theoretically stated, they each formed 'scale model systems' for possible future subsystems (Loorbach & Rotmans, 2010). Buurtzorg was one of the transition experiments in the first round, which received support and funding between 2007 and 2009. Buurtzorg matched the selection criteria of the Transition Program including: a connection to persistent problems, a high motivation (personal drive of an entrepreneur and own investment) and an ambition to share learning experiences. Buurtzorg differed from the other selected transition experiments because it was the only experiment that was initiated by an entrepreneur instead of an incumbent care provider. This positioned Buurtzorg more clearly as an 'outsider to the regime', being more flexible and independent (Van den Bosch, 2010).

4.4.3 Introduction to Buurtzorg

Buurtzorg was founded by entrepreneur Jos de Blok, a former community nurse and manager in homecare. Dissatisfied with the bureaucracy-driven healthcare, in 2006 De Blok and his wife started the foundation "*Buurtzorg Nederland"*, striving for "an organizational model that focuses on meaningful relationships and no hierarchy" (De Blok in Nandram, 2015). Their idea of starting Buurtzorg was born from the conviction that *"a more humane or humanistic approach is needed in management so that people can be the owner of their daily work, can enjoy their results, and can contribute to society with meaningfulness"* (De Blok in Nandram, 2015*)*. Buurtzorg aims to meet the societal need for high-quality care at low costs by working with small-scale autonomous teams of nurses, focusing on the direct contact between client and professional (Buurtzorg, 2008). The teams of nurses work towards self-reliance in clients by helping them to become more embedded in their local network of neighbors and family members and assessing their capabilities, hence empowering them to become independent. The teams consist of a maximum of twelve nurses and are self-managed entities. As such, nurses are challenged to organize and manage their own work.

Whenever the team grows beyond twelve nurses, a new team is formed to maintain the small-scale structure. This organizational model is called the Self-Managed team approach. The first concept of self-managed teams was introduced in the late 1940s and 1950s by the Tavistock Institute of Human Relations and has since developed into a variety of different teamwork models (Tjepkema, 2003). In the Netherlands Buurtzorg can be seen as the main frontrunner in introducing and furthering the concept of self-management in long-term care.

Figure 4.2 shows the development of Buurtzorg in number of teams. When Buurtzorg was selected as a transition experiment, at the end of 2006, there were 5 teams of nurses. By the end of the Transition Program in 2009, this number had increased to 100 teams. As explained in section 4.1, the year 2009 can also be regarded as a 'turning point' in the long- term care sector and signaling the take-off of Buurtzorg growing by 150 teams a year.

Figure 4.2 shows that since 2014 the growth in the number of Buurtzorg teams has slowed down, which could be related to the fact that at the end of 2013 the Dutch Care Offices (health insurers) announced that they would no longer finance "overproduction" of care in comparison to the care that was delivered in the previous year (the unpaid "overproduction" of Buurtzorg in 2013 was 9.5 million euros). Currently Buurtzorg is a network organization consisting of about 800 teams, totaling more than 9000 community nurses and nurse assistants in 2015. The teams provided homecare to almost 25,000 clients in 2015 (Buurtzorg, 2015), circa 10% of the 255,000 clients in homecare in 2015 (CBS, 2016a). The teams are supported by 18 regional coaches and a small central office of about 30 supporting staffmembers.

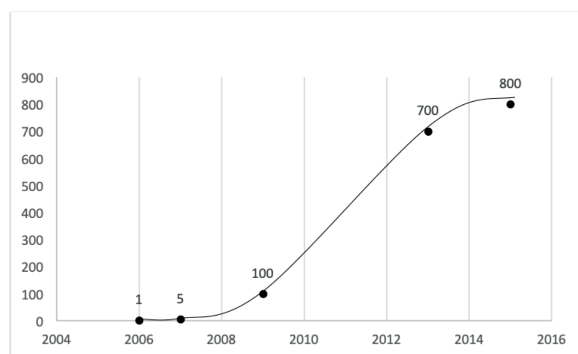


Figure 4.2 Growth in number of Buurtzorg teams.

The timeline in figure 4.3 summarizes the milestones in the development and scaling up of Buurtzorg, visualizing important events at the niche-, regime- and landscape-level. Since 2010, Buurtzorg has also spread out from homecare into other care domains such as welfare (Buurt-services), mental healthcare (Buurtzorg T), youth care (Buurtzorg Youth) and maternity care. Furthermore, since 2011 the Buurtzorg model has internationally expanded to countries such as Sweden, Belgium, Japan and the USA. For its influence on clients, employees, the Dutch healthcare sector and society at large Buurtzorg and

founder Jos de Blok have received both national and international recognition (e.g., the Albert Medal in 2014).

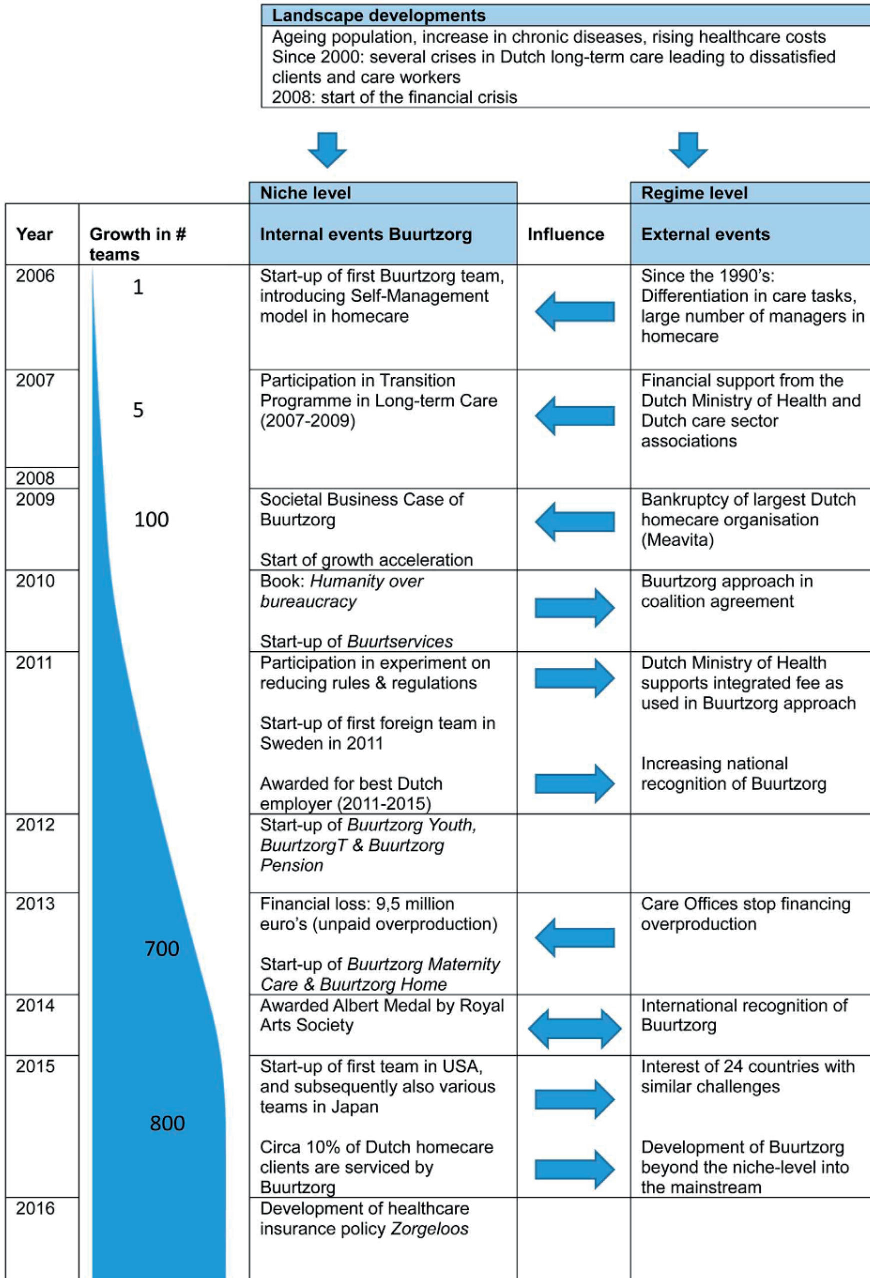


Figure 4.3 Multi-level event timeline of the development of Buurtzorg indicating influential events on the niche- and regime level, in the context of landscape developments.

4.5 Strategic activities of Buurtzorg

4.5.1 Deepening: Learning and experimenting

The development of Buurtzorg can be characterized as a strategy of *learning-by-doing or trial-and-error:* the first Buurtzorg team at the end of 2006 was quickly followed up by new teams at various locations and they developed the "Buurtzorg approach" as they went along. In this way they could experience in practice how their approach worked effectively and under what circumstances it did not. Following his own entrepreneurial orientation (taking initiative, open to risks and innovative) (Nandram, 2015), the founder of Buurtzorg *created space for entrepreneurship and ownership* within the Buurtzorg teams. This means that the teams receive a large measure of freedom to be entrepreneurs and to make their own choices about how to organize their team (including hiring employees, hiring office space, recruiting clients, etc.). All Buurtzorg teams are supported and connected by a smart ICT infrastructure, which was developed in cooperation with an ICT innovator, a *creative outsider* (Van de Poel, 2000) to the healthcare domain. The teams can share their experiences by way of the internal web, which functions as an important communication and learning tool. In the first years the learning process in the teams was guided by two *coaches, who translated the lessons learned* into written instructions on the internal website and in booklets about the principles of Self-Managed Teams.

The support from the Transition Program in Long-term Care provided additional space for *experimenting, research, reflection and sharing lessons learned* (Loorbach & Rotmans, 2010). Based on the Strategic Niche Management approach (Kemp et al., 1998) this support from the Transition Program can be characterized as a niche or 'partly protected space' that is important for articulating visions, heterogeneous learning and building social networks. This partly protected space was provided by means of a financial grant that enabled further developing their radically new approach and sharing lessons learned. The Transition Program also provided additional knowledge and support from experts in other domains as well as the commitment of the Ministry of Health. In 2011 Buurtzorg also received 'regulatory space' by entering into a Ministry program on reducing rules and regulations in healthcare organizations.

With support of the Transition Program, Buurtzorg developed a *Societal Business Case* in which the societal costs and benefits of the Buurtzorg approach were estimated and shared with the sector (Ernst & Young, 2009). In the following years research was done on how Buurtzorg organized their homecare approach that deviated from the incumbent healthcare system (Van Dalen, 2010, 2012). A study by KPMG (2015) calculated that Buurtzorg is saving 3,000 euros per patient, when only the costs for long-term care are calculated, and the total costs for healthcare provided to Buurtzorg clients are below the

average. It was also calculated that Buurtzorg is spending 35% less hours per patient a year, in comparison to the Dutch average, which demonstrated that clients can be more self-reliant (making patients more independent from formal healthcare). Despite of the lower number of hours per patient Buurtzorg regularly has the highest satisfaction rates among patients in homecare (Nivel, 2009). The Nivel report also studied if there were differences between Buurtzorg clients and clients of other homecare organizations. They found no differences between age, gender or living arrangements. The main difference appeared in a higher level of education of Buurtzorg clients. These *research publications* have provided further insight into the workings of Buurtzorg and aided the debate about the development of homecare.

4.5.2 Broadening: Repeating and connecting

The strategy of *repeating* the Buurtzorg approach was a bottom-up process in which groups of community nurses, who shared the Buurtzorg vision, could apply to *set up new teams at new locations*. Often these nurses experienced the same unfulfillment as founder De Blok with working at existing homecare organizations. As such, the general dissatisfaction among healthcare workers provided an important base for the fast growth of Buurtzorg. A new team could share in the experiences, knowledge and ideas that Buurtzorg had gained, but were also given freedom to propose their own ideas to make improvements. Each team was strongly embedded in the local community and created or reinforced their local networks by connecting with essential partners and stakeholders (e.g., general practitioners, hospitals, health insurers, voluntary organizations). By *connecting to the local community,* Buurtzorg team were also able to attract new clients.

New Buurtzorg teams were provided with plans of action and ICT-support, aimed at ensuring high-quality care by providing general guidelines, though not hampering team freedom. The importance of *ongoing adaptation* is illustrated with a quote from the founder of Buurtzorg: "Traditional processes of changes often fail because it's an illusion to develop new ideas in isolation, after which they are broadly implemented. I think you should do a lot more in the context of where things are happening. …It is about adaptive innovation, in which change is an organic process" (Dallinga et al., 2011, our translation).

The support by the Transition Program in Long-term Care also enabled *connecting to other transition experiments* that explored radically new practices in different domains of healthcare. Since the start of Buurtzorg, the founder had *transformative ambitions at a national, and even international level*, to "reform the healthcare industry" (Nandram, 2015). He connected with people from other healthcare domains who recognized his

ambition, which enabled repeating the Buurtzorg approach in domains such as mental healthcare or youth care. In Dutch healthcare the different domains are typically 'worlds apart'. This *expansion into other domains* therefore required a lot of cooperation with experts and entrepreneurs from other domains in order to adapt the Buurtzorg approach to different contexts. Buurtzorg has succeeded in broadening its approach to the domains of mental healthcare, welfare, youth care, maternity care and temporary care in pensions. However, these are all small-scale initiatives that need more time to develop and mature. For example, 'Buurtzorg youth care' currently consists of 8 teams and is working in relatively large geographical areas for clients with more complex problems and backgrounds. These could be barriers to an effective use of the community-based approach of Buurtzorg (Van Hattem, 2014).

Many existing healthcare organizations have also tried to 'copy' the Buurtzorg model of self-managed teams of nurses. In the early years of Buurtzorg, Jos de Blok presented his ideas to *existing healthcare organizations* in order to support their implementation of the Buurtzorg approach. As the requests for information increased, Buurtzorg published two books (De Blok & Pool, 2010; Pool & Mast, 2011) about the Buurtzorg vision, how care is organized in self-managed teams, the choices that were made and the added value for other organizations and professionals in the public sector. The books were quickly followed by a popular manual on self-managed teams (Vermeer & Wenting, 2014). However, a barrier in traditional organizations for long-term care is that the average level of education of nurses and nurse assistants is generally lower than the level of education of the community nurses that work at Buurtzorg. Especially institutional care homes work with lower educated employees who often do not choose to work in self-managed teams (as the Buurtzorg nurses do). Therefore, this can be regarded as a 'top-down' way to implement the Buurtzorg approach, which has been less successful than the bottom-up way of setting up new teams with motivated groups of nurses.

The efforts of the founder of Buurtzorg to spread his ideas and explain about the Buurtzorg vision and experiences have also led to the *international expansion* of the Buurtzorg model. Japan was one of the first countries with interest in the Buurtzorg model since this country wants to make a shift from hospital-based care to homecare. In 2014 it was announced that about 500 Buurtzorg teams will be implemented in Japan. At the end of 2011 the first Buurtzorg team started in Sweden and in 2015 the first "Buurtzorg Neighbourhood nursing" team in the USA was established.

4.5.3 Scaling-up: societal embedding

The scaling-up strategy of Buurtzorg can be characterized as a continuous effort of the founder of Buurtzorg to actively try to influence the existing healthcare system or

'regime'. Since the start of Buurtzorg, the founder *envisioned and anticipated necessary changes in the regime:* the dominant culture, structure and practices of the healthcare system. He seems to possess essential entrepreneurial skills for guiding the scaling up from local experiment to a broader movement, including "the capacity to anticipate, enterprise, allure, network and lobby" (Andringa & Weterings, 2008; Moore & Westley, 2011). He brought the vision of Buurtzorg to the attention of *regime actors*, such as key politicians at the Ministry of Health, Welfare and Sports and political parties 'from left to right'. This resulted in embedding the community care approach in the Coalition Agreement of 2010, recognizing Buurtzorg as the *representation of a new standard* for providing long-term care. Other strategic activities of Buurtzorg were constantly *repeating the vision to create awareness* by generating comprehensive media attention and building up personal contacts with key persons in the regime. Buurtzorg continuously has to make *agreements with other powerful actors* in the healthcare regime, such as the regional Care Offices that are responsible for contracting and financing care providers. However, the continuous growth of Buurtzorg does not fit into the existing rules of the healthcare regime, since contracts are based on the production of the previous year and do not support growth. This is an ongoing struggle for Buurtzorg as the general rules and regulations often do not support innovation. Buurtzorg therefore had to take large financial risks because they did not want to turn clients away due to the production rules. They choose to make this public to stimulate the debate about the existing healthcare regime.

Buurtzorg also influenced the way community nurses are financed; as a result, the traditional fragmented financial structure with different fees for different care 'products' was integrated in one average fee in which all 'products' or services are grouped together. Buurtzorg has always worked like that within their own organization, and later this was acknowledged by the Dutch Ministry of Health as part of their program on less rules and regulations in healthcare.

One barrier that Buurtzorg encounters while further scaling up is the difficulty to find new employees, who are driven by the Buurtzorg vision, as the pool of motivated and skilled nurses seems to be decreasing. This also reflects one of the critical notes that Buurtzorg has encountered during their scaling-up process: their success has been criticized of "cherry picking", because they draw on the limited pool of well educated, motivated nurses (De Blok & Pool, 2010). However, the system barriers in the current education system (e.g., Rotmans, 2014) may impede an adequate development and training of competent nurses. Buurtzorg recognizes a shortage of community nurses and is trying to establish nursing education according to the principles of Buurtzorg. This shows how Buurtzorg draws on human resources, provided by the existing healthcare system and

related education system, and at the same time it is trying to change elements of these systems (Farla et al., 2012). A very recent development is an initiative of the founder of Buurtzorg and two other frontrunners in Dutch healthcare, to develop a radically new healthcare insurance policy (www.zorgeloos.care). With these initiatives Buurtzorg demonstrates the importance of *addressing different system elements* to strengthen its impact and influence on the healthcare regime.

4.5.4 Reflection on scaling-up and key strategies of Buurtzorg

The rapid scaling up of Buurtzorg, from niche to mainstream can partly be explained by applying the Multi-Level Perspective to gain insight into the contextual factors that have played an important role in the development of Buurtzorg (as shown in figure 4.3). Buurtzorg started out at the 'right' time, when the tensions in the healthcare regime created a general sense of uneasiness and dissatisfaction. Buurtzorg provided an answer to the increasing gap between peoples' needs and the way the long-term care system was organized. Hence, the development of Buurtzorg can partly be explained as the alignment of developments at the level of the regime, landscape and niches: the general sense of uneasiness that was felt about long-term care, the demographic and economic pressure to realize change, and the room for experimentation and development provided by the Transition Program. Buurtzorg is therefore a key example of making use of the available 'windows of opportunity'. At that specific moment in time, in the specific context of long-term healthcare, Buurtzorg provided the 'right' answer. The scaling up of Buurtzorg also had an effect on the 'destabilization' of the long-term care regime. This effect was clearly visible in the large 'migration' of nurses to Buurtzorg, leaving incumbent healthcare providers with a shortage of qualified professionals. Furthermore, by making use of available 'regulatory space' provided by the Ministry of Health, Buurtzorg realized a simplification in the way homecare was financed, reducing the large amount of 'product codes' for home care into a single product code for Buurtzorg (VWS, 2016). Another visible effect is that in 2015 circa 10% of all the people that receive homecare in the Netherlands were a client of Buurtzorg. This shows that Buurtzorg has gained in size, stability and influence and has thus successfully scaled up from a niche (in which "social networks are small, unstable and precarious", Geels & Schot, 2010) to a mainstream approach in long-term care. This influence of Buurtzorg on the healthcare system is still increasing, as Buurtzorg is expanding to other healthcare domains and also influences the educational system for nurses and recently introduced an alternative for the healthcare insurance system.

In order to get insight into *how* Buurtzorg could rapidly scale up and influence the long-term care regime, the previous section has described their *strategic activities* to "move from niche to mainstream". Examples of these strategic activities are constantly repeat-

ing their vision to create awareness, influencing public opinion and policy, proactively participating in the public debate and sharing lessons learned. For the specific literature on Transition Management, or more general literature on entrepreneurial strategies, not all of these strategic activities for '*niche-mainstreaming*' are novel. However, what this paper adds to this literature is the further theoretical and empirical grounding of the conceptual framework for *deepening* (learning and experimenting), *broadening* (repeating and connecting) and *scaling-up* (societal embedding). Our case study of Buurtzorg shows that the general strategies of deepening, broadening and scaling up are not followed in a linear way or a step-by-step order, but rather require an integrated approach: putting multiple strategies into effect at different moments in time. For example, when Buurtzorg received support from the Transition Program they could intensify their learning and research activities *(deepening)*, while they also followed a strategy of setting up as many new teams as possible *(broadening)* and also pro-actively worked on their *scaling up* by embedding their approach in existing healthcare organizations.

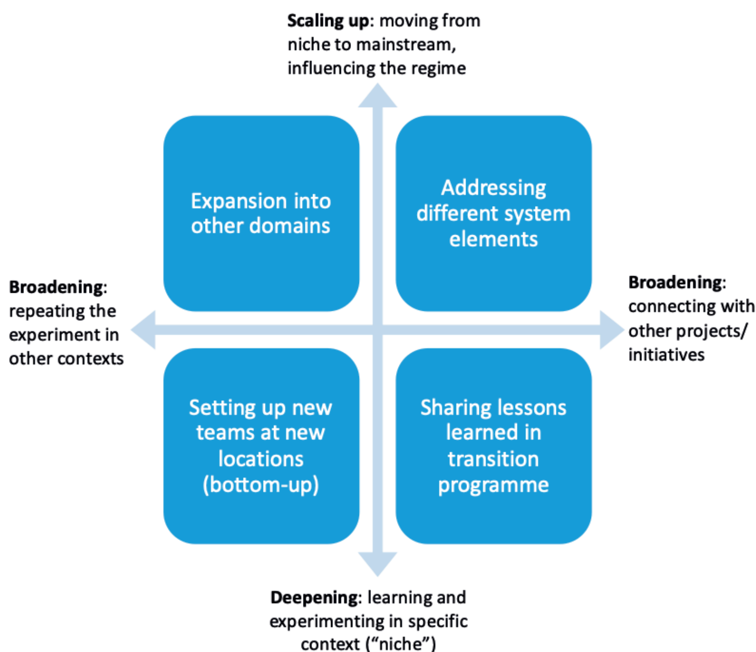


Figure 4.4 Key strategic activities to deepen, broaden and scale-up Buurtzorg.

In figure 4.4 we have adapted the visualization of this conceptual framework, in order to identify and map four key strategic activities of Buurtzorg that each combine two di-

mensions of the original framework. First experiences of applying this figure in practice (in the context of the Transition Academy in the Netherlands) indicate that this can also provide a general framework for practitioners, in order to support them with identifying and visualizing strategic activities to scale up their own transition experiment.

In table 4.1 we analyze these four key strategies of Buurtzorg, relating them to their other strategic activities, the actors involved, the results and reflecting on the success of each strategy. We would like to emphasize that in each strategy Buurtzorg interacted with many different actors, temporarily in the Transition Program for Long-term Care and continuously with politicians, policy makers, healthcare insurers, other healthcare organizations and creative outsiders.

4.6 Towards a transformative movement in Dutch healthcare

In the past decade the persistent problems, challenges and crises have led to a movement that deviates from the dominant characteristics of Dutch long-term care (15 years ago). This 'transformative movement' can be indicated by ongoing changes in the culture, structure and practices of the system for long-term care. Our observations suggest that Buurtzorg has made significant contributions to these changes (table 4.2).

The challenges in Dutch healthcare have led to new ways of thinking about health and healthcare. These new ideas are impacting the Dutch long-term care system in which fragmented ways of thinking about cost-efficient care are increasingly moving towards a holistic way of thinking based on human values. This in itself is not a radically novel idea, but this way of thinking has largely been lost and is now (re)introduced as a new paradigm: from a healthcare paradigm that focused on illness and disease to a paradigm based on health, defined in terms of resilience and the ability to self-adapt (Huber, 2014). Key concepts in this way of thinking are 'quality of life', 'self-reliance', 'being part of a community', and 'being in control of your own health(care) process'. This paradigm shift has consequences for the relationship between people or patients and health professionals such as doctors and nurses: from a hierarchical relationship between professional and patient to a decision-making process between equals. Youngson & Blennerhassett (2016) add compassion as a critical value towards humanizing healthcare.

The organizational and institutional structures are also seeing the first significant changes, moving from a hierarchical top-down way of organizing, in which doctors and managers exert their influence, to a 'self-managed' bottom-up structure in which people themselves and their direct care providers are in control. Direct care leaves out the overload of risk control measures, management layers and protocols and the decisions are made in the interaction between professional and client (Loorbach, 2014). A

fundamental change in structure that relates to self-organization is the rise of health cooperatives and neighborhood cooperatives (Van Beest, 2014). These cooperatives are made up of citizens who together organize healthcare and/or other services in their neighborhood or town. In this way the cooperative decides what is needed for its members and the community and does not rely on healthcare organizations or healthcare insurers. In terms of the 'financial structure' of long-term care the Dutch government has decreased budgets for providing institutional healthcare and has decentralized long-term care responsibilities and budgets to local governments that are better able to support prevention and health.

Key strategies	Related strategic activities	Actors	Result	Reflection
Sharing lessons learned (combination of deepening and broadening/ connecting)	Creating space for experimenting, research & reflection Connecting to local community Cooperating with other outsiders Research publications	Program managers, policy makers, researchers and other project leaders in transition program; local stakeholders and outsiders to healthcare domain	Learning	Partly successful strategy; because Buurtzorg was a frontrunner, the sharing of lessons learned in Transition Program was not 'bidirectional' (the other experiments mainly learned from Buurtzorg).
Setting up new teams at new locations (combination of deepening and broadening/ repeating)	Creating space for entrepreneurship and ownership Translating lessons learned and guidance by coaches Learning by doing/ trial-and-error	Nurses, clients of homecare and coaches in different places in the Netherlands	Ongoing adaptation	Successful strategy; bottom-up process in which groups of nurses were intrinsically motivated by the vision of Buurtzorg and were given space to start up their own Buurtzorg team.
Addressing different system elements to strengthen impact (combination of scaling-up and broadening/ connecting)	Envisioning and anticipating changes in the regime Bringing vision to attention of regime Representing a new standard Agreements with powerful actors	Existing healthcare organizations, policy makers and other powerful actors in long-term care	Changing dominant structure, culture and practices	Partly successful and partly failed strategy; top-down implementation in existing healthcare organizations failed but successful in changing financial structure, management paradigm and practices of nurses.
Expansion into other domains (combination of scaling-up and broadening/ repeating)	Repeating the vision to create awareness Transformative ambitions at (inter) national level	Experts, practitioners and clients in other care domains and countries	(Inter)national expansion	Partly successful strategy; (inter)national recognition of Buurtzorg vision but success in other domains and countries needs further research.

Table 4.1 Analysis and reflection on key strategies.

The new ideas about healthcare and more specifically the changing relationship between healthcare professionals and patients are increasingly influencing the way practices are shaped. We observe that practices focused on production and efficiency, such as timeslots, checklists and division of labor, are losing importance. They are gradually being replaced by practices that focus on the well-being of patients, such as attention to the specific needs of a patient in relation to the social network and stimulating self-reliance. The general practice in Dutch long-term care has long been 'supply driven' and is switching to 'demand driven' i.e., investigating what patients want and need first and adjusting to that. In existing healthcare organizations, we observe an active search for new practices stemming from the changes in paradigm. However, transforming the long-established practices in the day-to-day work and routines within incumbent healthcare organizations is proving to be resistant.

Table 4.2 gives an overview of the ongoing changes in Dutch long-term care and the most significant contributions that Buurtzorg has made to these changes. However, it is still too early to draw conclusions regarding a (future) transition in healthcare. Therefore, we argue that Buurtzorg is contributing to a 'transformative movement' that can have a potential impact on fundamentally changing the characteristics of future healthcare systems.

4.7 Discussion and conclusion

This article has looked at Buurtzorg from the perspective of transition studies, highlighting that Buurtzorg was started with the ambition to transform the healthcare system and has successfully scaled up a radically new approach that is contributing to a transformative movement in healthcare. Consistent with Laloux (2015) our case study of Buurtzorg shows the effect of vision and purpose, transparency, and evolutionary and organic development. However, while Laloux focusses on the internal organizational structure, culture and practices of Buurtzorg, our case study focusses on their strategic activities that were externally oriented towards the healthcare system and have supported the development of Buurtzorg beyond a niche into the mainstream.

We conclude that Buurtzorg became a 'symbol' in a transformative movement that can contribute to a future transition in healthcare, representing not only a new standard in providing long-term care, but also a more fundamental change or a change in paradigm (Janssen, 2016). This transformative movement is indicated by ongoing changes in the Dutch system for long-term care, including a new culture (discourse, paradigm) and new structures and practices that are closely related to that of Buurtzorg, e.g., self-managing teams, empowering both patients and professionals, and supporting self-reliance. According to the founder of Buurtzorg the success of their approach is also based on

Dominant characteristics of Dutch long-term care 15 years ago:	Current movement towards fundamentally new characteristics:	Contributions of Buurtzorg to these changes:
Culture		
Focus on disease or disability (within the domain of healthcare)	Focus on health or resilience (quality of life across the domains)	Vision based on a holistic way of thinking and a meaningful relationship between nurses, patients and their social network
Taylorism as management paradigm: hierarchy, management layers, top-down, focus on efficiency and standardization	Paradigm based on self-management: stimulating bottom-up problem-solving skills, ownership and creativity in professionals in small autonomous teams	Introducing the Self-Management paradigm
Structure		
Financial structure that supports 'production' of care	Financial structure that supports prevention and health	Buurtzorg way of financing community nurses: one average fee in which all products or services are grouped together
Lack of societal integration (e.g., with other societal domains in which care needs can also be addressed or prevented)	Integrating long-term care in the local community (e.g., by social neighborhood teams in which multiple organizations participate)	Connecting to the neighborhood, working together with other domains
Practices		
Focus on rules, regulations and procedures: bureaucracy driven	Focus on well-being of patient: demand driven	Empowerment of patients and professionals in self-managed teams
Fragmentation: task differentiation and multiple care professionals for one patient; lack of cooperation between healthcare providers	Integration: patient-oriented performance of care tasks by a small number of highly educated care professionals; patients' best interest are base for collaboration between healthcare providers	Integrated care delivered by community nurses, who build up meaningful relationship with patients and their social network

Table 4.2 Contribution of Buurtzorg to ongoing changes in Dutch long-term care.

'simplifying' the long-term care system, for example by reducing the number of different care 'products' into one integrated product, working with generalists instead of specialists and by working without managers. We argue that aiming for more 'simplicity' could be a general guideline for transforming complex healthcare systems. However, the development of Buurtzorg should also be understood within the context of the Dutch homecare domain, which is relatively simple in comparison to other healthcare domains. This relatively low level of complexity (in terms of the variety in care problems, care services and care professionals, and the interactions between them) may have been an important success factor for the rapid development of Buurtzorg. We observe a significantly slower growth of Buurtzorg teams in more complex care domains such as youth care, which needs to be explained in follow-up research.

With regard to our first research question on the rapid development of Buurtzorg from a transition experiment towards a transformative movement, our findings show that this can partially be explained by the Multi-Level Perspective (Geels, 2002) i.e., the favorable alignment of contextual factors. We have added an actor-perspective, characterizing Buurtzorg as a 'revolutionary entrepreneur' (Janssen & Moors, 2013) that applies strategies aimed at inducing system change directly. Our findings confirm the importance of this type of entrepreneurial orientation towards system change. We observed that the founder of Buurtzorg and the self-managed teams of nurses have continuously positioned Buurtzorg as an 'outsider' to the existing healthcare regime. The founder made use of many opportunities to express his vision on transforming the healthcare system, continuously using the media and confronting 'regime actors' such as policy makers, politicians and healthcare institutions. This vision was recognized by a large number of nurses, who consciously left other healthcare providers to start their own self-managed Buurtzorg team. This large-scale 'migration' had a direct effect on the destabilization of the incumbent healthcare providers. Other examples of the direct influence of Buurtzorg are their introduction of the Self-Management paradigm and their attained influence on policy, health insurance and public opinion.

In comparison to the other transition experiments in the Transition Program, the strategic position of Buurtzorg as an 'outsider' to the regime created more room, or even freedom, to develop and scale up their radically new healthcare approach. According to Cramer (2014) the incumbent healthcare organizations in the Transition Program faced more restrictions when attempting to scale up their radically new practices. Our case study therefore suggests the importance of selecting transition experiments that are initiated by entrepreneurs instead of incumbent organizations.

In addition to the alignment of contextual factors and their strategic position, the rapid development of Buurtzorg can also be explained by the *strategic activities* of the founder and the teams of nurses in interaction with other actors. In our second research question we therefore focused on identifying the specific strategic activities of Buurtzorg that have supported moving their radically new practice from niche to mainstream. We have identified these strategies, by applying and further developing the conceptual framework of 'deepening, broadening and scaling up' transition experiments. Our empirical findings support these general strategies and show that Buurtzorg continuously created room for learning and experimenting in a local context (*deepening*), while repeating their approach at new locations and in new domains of healthcare and abroad (*broadening*) and continuously tried to confront the healthcare 'regime' to influence the mainstream way of thinking, working and organizing healthcare (*scaling up*). The case study of Buurtzorg has also led to an adjustment of the original conceptual framework

(visualized in figure 4.4), emphasizing the non-linear character of the three strategies and the integrated use of different types of strategies at the same time. Based on this, we have identified four key strategic activities for *niche-mainstreaming*: (1) sharing lessons learned (for example in Transition Program), (2) setting up new teams at new locations (bottom-up), (3) addressing different system elements (to strengthen impact) and (4) expansion into other domains (and other countries). We argue that these general strategies and key strategic activities can also be applied elsewhere but should be adapted to the specific context in which they are applied.

Furthermore, based on this case study and other recent case studies that have applied the conceptual framework of deepening, broadening and scaling-up (Broerse & Grin, 2017) we conclude that this framework could be used in practice-oriented research to identify strategic activities for transition experiments. The framework can aid both researchers and practitioners who are involved in transition programs, experiments or innovations projects that are aimed at surpassing the experimental phase. For entrepreneurs or project leaders of innovation projects it could be used as a heuristic tool to identify how the actors in their experiment(s) can strategically act to move from niche to mainstream. First experiences with applying this heuristic tool with practitioners (participants in circa 10 Masterclasses of the Transition Academy in the Netherlands) show that the framework inspired them to generate a high variety of new ideas on possible strategic activities to influence the regime. For policy makers and program managers who support transition experiments that have already started to develop (without initial support), the framework can be used to support their further development in terms of deepening, broadening and scaling-up. Based on the experiences in the Transition Program in Long-term Care, such support could include conducting supportive analyses and creating conditions to remove regime barriers, extending the links with regime players and connecting transition experiments to strategic activities in a 'transition arena' (Van den Bosch & Neuteboom, 2017).

Looking at the scaling up of Buurtzorg from a transition management perspective also raises new research questions. Buurtzorg has long since outgrown the level of a transition experiment and can be regarded as a frontrunner in a transformative movement in healthcare. Follow up research could identify other frontrunners in this movement, or in other transformative movements, and could compare their different strategies for niche-mainstreaming. Similar to our table 4.1, such comparative analysis could focus on key strategies, related strategic activities, actors, results and reflect on their level of success.

Specific recommendations for follow-up research on Buurtzorg include studying the development of Buurtzorg in other, more complex, healthcare domains and studying the translation of the Buurtzorg concept to other countries that are facing similar challenges in healthcare. Furthermore, follow-up research on the ongoing changes in the structure, culture and practices of Dutch healthcare, and also transnational research of healthcare systems in other countries, can provide more insight into if and how a future transition in healthcare can be realized.

5

Positive Health: from niche-discourse to government jargon

Published as: Johansen, F., Loorbach, D., & Stoopendaal, A. (2023). Positieve Gezondheid: Verandering van taal in de gezondheidszorg. *Beleid en Maatschappij*, *50*(1), 4.

CHAPTER 5 POSITIVE HEALTH: FROM NICHE-DISCOURSE TO GOVERNMENT JARGON

Published in Dutch in Beleid en Maatschappij as: **Positieve Gezondheid: verandering van taal in de gezondheidszorg.**

An English summary is included in the Appendix.

5.1 Inleiding

In de discussies over de Nederlandse gezondheidszorg is al enige tijd een verschuiving in het discours (gebruikte taal en manier van denken over gezondheidszorg) gaande die zich steeds scherper aftekent. Het gaat hier om de verschuiving van een focus op ziekte en de oorzaak hiervan opheffen, naar een focus op gezondheid en welzijn en dat behouden en verbeteren (onder andere Taskforce JZJP, 2018; RVZ, 2010). Bij een focus op ziekte wordt vooral gekeken naar wat iemand ziek maakt en hoe dat te 'repareren' is (pathogenese); bij een focus op gezondheid wordt gezocht naar wat iemand gezond maakt en houdt (salutogenese), en hoe we beter kunnen leren omgaan met de gebreken die bij het leven horen (Nelissen & Degryse, 2015; Vaandrager & Koelen, 2011).

In de huidige ordening van de Nederlandse gezondheidszorg is het opsporen en behandelen van ziekte het uitgangspunt voor structuur en financiering, bijvoorbeeld te herkennen in medische specialismen voor verschillende ziektebeelden, medicatie als belangrijke behandelmethode en financiering op basis van diagnose en behandeling (Broerse & Grin, 2017; Commissie Werken in de Zorg, 2019; Rotmans, 2012; Schuitmaker, 2010; Van Raak, 2016; Walg, 2014). Inrichting van gezondheidszorg vanuit een focus op wat ons gezond maakt en houdt daarentegen, betekent mogelijk meer aandacht voor leefstijl en preventie, de invloed van leefomgeving en sociaal-economische status, sociale relaties en de mate waarin iemand zich onderdeel voelt van de maatschappij (RVZ, 2010; Walg, 2014, 2019; De Gruijter, Nederland & Stavenuiter, 2014).

In 2010 gaf de Raad voor de Volksgezondheid en Zorg (RVZ) de aftrap voor deze perspectiefwisseling met het rapport *Zorg voor je gezondheid!*. Dit rapport stelde 'gezondheid en gedrag' voor als nieuwe ordening in plaats van 'ziekte en zorg'. Deze perspectiefwisseling werd door de RVZ voorgesteld als mogelijk antwoord op het toenemend aantal chronische aandoeningen in relatie tot de verwachte beperking van personele en financiële middelen. Een daadwerkelijke verschuiving in de ordening en financiering in de gezondheidszorg op basis van 'gezondheid en gedrag' is echter nog niet gerealiseerd en dit nieuwe perspectief was in de jaren na 2010 slechts beperkt zichtbaar in de manier

van denken over, werken in en organiseren van de gezondheidszorg. Daar lijkt langzaamaan verandering in te komen.

De toenemende aandacht voor het nieuwe perspectief 'gezondheid en gedrag' loopt samen op met het gebruik van het concept Positieve Gezondheid[4] (zie kader hierna).Positieve Gezondheid is in tien jaar tijd een veelgebruikt begrip geworden in het beleidsmatige taalgebruik in de Nederlandse gezondheidszorg en terug te vinden in overheidsbeleid zoals de *Landelijke Nota Gezondheidsbeleid 2020-2024* (VWS, 2020), en ook in visiedocumenten en beleidsstukken van invloedrijke actoren in de gezondheidszorg zoals koepelorganisaties van beroepsgroepen in de zorg (onder andere Commissie Werken in de Zorg, 2019; Federatie Medisch Specialisten, 2017; NFU, 2020; Stuurgroep Kwaliteitskader Wijkverpleging, 2018). Dit is een opmerkelijk snel diffusieproces van een nieuw concept tot een regelmatig gebruikte en algemeen bekende referentie in het overheidsbeleid.

Positieve Gezondheid
Positieve Gezondheid is voortgekomen uit de introductie van een nieuw gezondheidsconcept (Huber e.a., 2011) waarbij gezondheid wordt gezien als het vermogen van mensen om met de fysieke, emotionele en sociale uitdagingen in het leven om te gaan. Én om zo veel mogelijk eigen regie te voeren. Positieve Gezondheid is geïntroduceerd als een uitwerking van deze bredere kijk op gezondheid (Huber e.a., 2013), vertaald in zes dimensies: lichaamsfuncties, mentaal welbevinden, zingeving, kwaliteit van leven, meedoen en dagelijks functioneren. Positieve Gezondheid is zowel een gezondheidsvisie die weergeeft hoe het denken over gezondheid en ziekte aan het veranderen is, als een methode voor mensen om gezondheid in kaart te brengen (aan de hand van een spinnenwebdiagram met zes dimensies), en vormt daarmee een basis voor 'een ander gesprek', vanuit zingeving, over gezondheid en welzijn.

Kader 5.1 Positieve Gezondheid

Om dit snelle diffusieproces van het concept Positieve Gezondheid in de gezondheidszorg te duiden wordt in dit onderzoek gebruik gemaakt van een transitieperspectief. Transitieonderzoek kijkt naar de patronen en mechanismen van structurele veranderingen in maatschappelijke systemen (zoals sectoren, gebieden of complexe organisaties). Transities ontstaan vanuit de 'padafhankelijkheid' van dominante manieren van denken, werken en organiseren in een maatschappelijk deelsysteem (Broerse & Bunders, 2010; Loorbach, Frantzeskaki & Avelino, 2017). Dit wordt ook wel aangeduid als het 'regime' en verwijst naar de manier waarop partijen gewend zijn geraakt om een bepaalde maatschappelijke functie met elkaar vorm te geven, hetgeen zich vertaalt in regels, afspraken, technologische keuzes, kennis en opleidingen, organisatiestructuren.

4 Positieve Gezondheid wordt bewust met hoofdletters geschreven. De term is niet nieuw en komt in de literatuur met verschillende betekenissen voor. Het gebruik van hoofdletters onderscheidt de (Nederlandse) versie met zes levensdomeinen.

Zulke regimes ontstaan geleidelijk, vaak als reactie op historische problemen, maar ontwikkelen tegelijk inertie omdat ze zo geïnstitutionaliseerd en geoptimaliseerd worden. Als tegelijkertijd de samenleving en maatschappelijke behoeften veranderen, kunnen partijen binnen zo'n regime in toenemende mate onder druk komen en kunnen er persistente problemen ontstaan die niet meer vanuit het regime zelf opgelost kunnen worden (Loorbach e.a., 2017).

Transitieonderzoek in de (Nederlandse) gezondheidszorg (onder andere verzameld in Broerse & Bunders, 2010; Broerse & Grin, 2017) ontrafelt enkele van deze complexe en persistente problemen en maakt zichtbaar hoe deze voortkomen uit de dominante kenmerken van de manier van denken, werken en organiseren in de gezondheidszorg (deels ontstaan uit het succes van de gespecialiseerde curatieve zorg (Van Raak, 2016)). Berkers (in Broerse & Grin, 2017) illustreert hoe de stelselwijzigingen van de afgelopen decennia (bijvoorbeeld basisziektekostenverzekering, marktwerking, decentralisatie) vooralsnog geen toekomstbestendig antwoord bieden op hardnekkige problemen op het gebied van financiële houdbaarheid (betaalbaarheid), afnemende personele capaciteit en afnemende solidariteit in het licht van een vergrijzende samenleving en een toenemende zorgvraag. Vanuit transitieonderzoek zijn dit aanwijzingen dat een regime 'onvolhoudbaar' is en steeds meer onder druk zal komen te staan, om uiteindelijk uit evenwicht te raken en naar een nieuw evenwicht op weg te gaan. Dat gaat gepaard met toenemende crises en problemen (en politiek-bestuurlijk ingrijpen uiteindelijk), maar ook met een steeds sterkere zoektocht naar alternatieven (de 'niches') (Loorbach, 2014; Loorbach e.a., 2017).

Deze zoektocht naar een toekomstbestendige inrichting van de gezondheidszorg is zichtbaar in de titels van rapporten die de afgelopen paar jaar zijn uitgebracht: *De juiste zorg op de juiste plek* (Taskforce JZJP, 2018), *Naar een toekomstbestendig zorgstelsel* (BMH, 2020), *Samenwerken aan passende zorg: de toekomst is nú* (Nederlandse Zorgautoriteit & Zorginstituut, 2020), *Discussienota Zorg voor de Toekomst* (VWS, 2021), *Kiezen voor houdbare zorg* (WRR, 2021). Deze rapporten en titels maken duidelijk dat het Nederlandse zorgsysteem onder druk staat en zoekt naar alternatieven. De verschuiving in het discours (van ziekte naar gezondheid) illustreert een andere manier van denken en mogelijk dus ook een andere manier van werken en organiseren, die inmiddels eveneens op het niveau van het regime zelf zichtbaar wordt.

Het concept Positieve Gezondheid verwijst naar een algemeen idee dat gezondheid belangrijker wordt dan ziekte en zorg en dat het inzetten op gezondheid een manier is om maatschappelijk welzijn te vergroten en de maatschappelijke kosten (voor zorg) te verlagen, de richting zoals ook al is geschetst in onder andere het eerdergenoemde

rapport van de RVZ (2010). Het alternatief dat Positieve Gezondheid biedt, kan in transitieterminologie geduid worden als een transformatieve innovatie (Loorbach e.a., 2020): een andere manier van denken, werken en organiseren die het regime uitdaagt, verandert of vervangt. Inmiddels lijkt hier sprake van, gegeven de opname van het concept en de betrokkenheid van allerlei typische regimepartijen als het ministerie van Volksgezondheid, Welzijn en Sport (VWS), adviesraden en de wetenschap.

In dit onderzoek proberen we de ontwikkeling en snelle verspreiding van Positieve Gezondheid als alternatief perspectief voor de toekomst van de gezondheidszorg te traceren en inzicht te krijgen in welke strategieën aan dit diffusieproces hebben bijgedragen. De hoofdvraag voor dit onderzoek is als volgt geformuleerd: *Hoe kunnen we de discursieve verschuiving binnen de Nederlandse gezondheidszorg (aan de hand van het voorbeeld van Positieve Gezondheid) begrijpen vanuit transitieperspectief?* In de volgende paragraaf gaan we allereerst dieper in op de theoretische perspectieven van discours en transitie alvorens onze methode en belangrijkste databronnen toe te lichten. Aan de hand hiervan beschrijven we vervolgens het diffusieproces van Positieve Gezondheid en analyseren we hoe dit tot stand kwam en welke strategieën zijn toegepast. Met een transitiebril wordt ten slotte gereflecteerd op de opname van Positieve Gezondheid in overheidsbeleid en de implicaties voor het toekomstig verloop van de transitie in de zorg.

5.2 Theoretische perspectieven

5.2.1 Discours

In de inleiding wordt een verschuiving gesignaleerd in de wijze waarop over de rol van zorg wordt gedacht en gesproken: van ziekte naar gezondheid. Deze mogelijke paradigmashift kan verstrekkende gevolgen hebben voor het hele zorgsysteem, maar is tot nu toe vooral terug te zien in de taal die gebruikt wordt. Binnen de sociale wetenschappen wordt taal gezien als een sociale handeling en taal vormt daarmee een eigen werkelijkheid (Van den Berg, 2004). Taal kan in dit kader dan ook geïnterpreteerd worden in de ruimste zin van het woord en omvat alle uitingsvormen van betekenis. Taal en taalgedrag kunnen onderzocht worden met een discoursanalyse. Discoursanalyse is onderzoek naar de manier waarop meningen en werkelijkheden discursief – dat wil zeggen in taal – geconstrueerd worden (Van den Berg, 2004, p.30). Discours kan dan gezien worden als een specifieke manier van praten over en het begrijpen van de wereld (of een aspect van de wereld) (Jørgensen & Phillips, 2002). Door het beïnvloeden van een bepaalde opvatting van de werkelijkheid kan daarmee ook gedrag worden beïnvloed. Taal is daarmee niet alleen beschrijvend, maar heeft door de beïnvloeding van gedrag ook een performatieve werking (Austin, 1962): het werkt door in de realiteit via het

handelen. Hier wordt een discoursanalyse gebruikt om te onderzoeken in hoeverre het dominante discours in de Nederlandse gezondheidszorg aan verandering onderhevig is, met als specifieke focus het denken en praten over ziekte en gezondheid.

Discoursanalyse kent een groot aantal benaderingen en abstractieniveaus, waarbij taalgebruik sec wordt bestudeerd dan wel in meer of mindere mate wordt gekoppeld aan sociale praktijken. Dit onderzoek is in de uitvoering geïnspireerd door de kritische discoursanalyse van Fairclough (2005) en de *argumentative discourse analysis* van Hajer (2006). De focus ligt hier op het traceren van de ontwikkeling in de manier van denken en praten over ziekte en gezondheid. Het nader belichten van het gebruik van de begrippen 'ziekte' en 'gezondheid' is relevant, omdat de begripsinvulling ook het gezondheidsbeleid bepaalt en daarmee een potentiële performatieve werking heeft in hoe gezondheidszorg wordt uitgevoerd.

5.2.2 Transitie

Een transitie is gedefinieerd als een schoksgewijze structurele verandering in de dominante manieren van denken, werken en organiseren (regime) in een maatschappelijk domein (Grin, Rotmans & Schot, 2010). De verandering is radicaal in de zin dat deze fundamenteel is (niet noodzakelijk groots of snel) en zich voltrekt op het gebied van zowel cultuur als structuur en praktijken (Frantzeskaki & De Haan, 2009; Rotmans & Loorbach, 2009) of, in andere woorden: een fundamentele verandering van denken, organiseren en doen binnen een maatschappelijk deelsysteem (zoals de gezondheidszorg). Onderzoek naar historische transities heeft het patroon zichtbaar gemaakt, waardoor dominante cultuur, structuur en werkwijzen (regime), als gevolg van maatschappelijke veranderingen en een onvermogen om zich hieraan aan te passen, gaandeweg onder toenemende druk tot verandering komen te staan (Loorbach e.a., 2017). Transities zijn dan het proces waarin door druk van buiten, interne spanningen en opkomende alternatieven een regime uit evenwicht raakt, waarna de ruimte ontstaat om tot nieuwe en meer fundamentele oplossingen te komen dan met optimalisatie en verbetering het geval zou zijn geweest (Rotmans & Loorbach, 2009).

Persistente problemen zijn hardnekkige problemen die ge(re)produceerd worden door bestaande structuren en actoren in een systeem (Loorbach, 2007). Deze (re)productie wordt beïnvloed door belangen, afhankelijkheden, gebrek aan doorzettingsmacht (of noodzaak tot samenwerken) en het ontbreken van een gezamenlijk perspectief. Deze problemen zijn daarmee complex en systemisch van aard en niet oplosbaar via optimalisatie en efficiëntie omdat ze voortkomen uit de kenmerken van het systeem (Broerse & Bunders, 2010; Broerse & Grin, 2017; Schuitmaker, 2010). Deze systeemkenmerken zijn historisch ontstaan als reactie op problemen van die tijd en hebben geleid tot allerlei

routines, vanzelfsprekendheden, structuren en afhankelijkheden van waaruit het lastig is iets compleet anders te gaan doen. Schuitmaker (2010) heeft enkele kenmerken van het gezondheidszorgsysteem geïdentificeerd die bijdragen aan (re)productie van persistente problemen. Kenmerken als standaardisatie, gebruik van (evidence-based) protocollen en richtlijnen en specialisatie dragen bij aan het in stand houden van een systeem dat is gestoeld op het perspectief van 'ziekte en zorg'.

De begrippen 'niche' en 'regime' in transitiestudies kennen hun oorsprong in het *Multi-Level Perspective* (MLP) (Geels, 2002; Rip & Kemp, 1998; Schot, 1998). Dit MLP schetst hoe ontwikkelingen op macroniveau (bijvoorbeeld demografische ontwikkelingen, politieke verschuivingen, digitalisering, individualisering, globalisering, klimaatverandering) een veranderende context bieden waardoor de dominante manier van denken, werken en organiseren (het regime) minder goed in staat blijkt om hardnekkige problemen op te vangen. Wanneer het bestaande regime onder druk komt te staan, ontstaat ruimte voor alternatieven (niches) die zich afzetten tegen de dominante manier van denken, werken en organiseren (Broerse & Grin, 2017; Loorbach e.a., 2017). Deze niches kunnen verschillende vormen hebben, zoals nieuwe organisatievormen, nieuwe technologieën of sociale innovaties.

In de gezondheidszorg is het regime sterk gericht op technologische innovatie, diagnose en behandeling, en nauwe publiek-private samenwerking (Rotmans, 2012, 2014; Walg, 2014). De financieringsstructuur, protocollen, beroepenstructuur, medicamenteuze en technologische behandeloplossingen zijn gebaseerd op dit regime. Dit regime is opgebouwd in de naoorlogse decennia en kwam in de plaats van een veel decentraler regime waarin wijkverpleging en de huisarts als algemeen medicus een veel belangrijker rol speelden (Van Raak, 2016). Met bevolkingsgroei, welvaartsziekten en technologische vooruitgang ontstond de beweging naar het huidige regime, de laatste decennia onder druk van kostenstijgingen steeds verder geliberaliseerd (Rotmans, 2012; Walg, 2014). Maar dit regime blijkt steeds minder een toereikend antwoord op de maatschappelijke verandering van vergrijzing, met toenemende gezondheidsverschillen en met meer chronische, meervoudige aandoeningen. Oplossingen zijn mogelijk op andere domeinen te vinden zijn, zoals bijvoorbeeld leefstijl, leefomgeving, maatschappelijke participatie of armoedebestrijding (BMH, 2020; Nederlandse Zorgautoriteit & Zorginstituut, 2020; RVS, 2020; RVZ, 2010; VWS, 2020, 2021; WRR, 2021).

Deze maatschappelijke ontwikkelingen leiden tot persistente problemen in het systeem van gezondheidszorg, en voeren de druk op om alternatieven te onderzoeken. Hierdoor ontstaan nieuwe niches zoals Positieve Gezondheid. Positieve Gezondheid biedt een alternatieve taal met een focus op gedrag, gezondheid en veerkracht, en daarmee een

alternatieve invulling van de manier van denken, werken en organiseren in de gezondheidszorg.

In de transitietheorie wordt een dergelijke alternatieve manier van denken, werken en organiseren die het regime uitdaagt aangeduid als 'transformatieve innovatie' (Avelino e.a., 2019). Anders dan technologische innovatie gaat het hier primair om sociale innovatie die zich op een andere manier ontwikkelt. In deze context wordt dan ook gesproken over de 'diffusie van transformatieve sociale innovatie': het proces en de methoden waardoor nieuwe manieren van denken, werken en organiseren zich verspreiden en gaandeweg geïnstitutionaliseerd raken. Transitieonderzoekers hebben diverse typologieën ontwikkeld die de ontwikkeling van innovatie in de context van transformatieve verandering weergeven. Loorbach e.a. (2020) benoemen vijf ontwikkelmechanismen die de kern van verschillende typologieën samenvatten: groei, herhaling, samenwerking, kansen benutten en borgen.

Met het transitieperspectief belichten we zowel de maatschappelijke factoren en omstandigheden als het proces van diffusie (in de zin van verspreiding) van het nieuwe discours en de strategieën die bijdragen aan infiltratie[5] van nieuwe taal op regimeniveau (bijvoorbeeld in de vorm van beleid). Deze analyse werpt daarnaast een blik op bestaande systeembarrières en de weerstanden en blokkades die vanuit padafhankelijkheid ontstaan. In recente jaren is binnen transitieonderzoek meer aandacht gekomen voor de rol van bestaande (regime)actoren en instituties (Turnheim & Sovacool, 2020) die actief bijdragen aan systeemverandering en de ontwikkeling van een nieuwe manier van denken, werken en organiseren. Transformatieve innovatie wordt hierbij gesteund door bestaande actoren en instituties en niet tegengewerkt (Berggren, Magnusson & Sushandoyo, 2015) zoals het oorspronkelijke MLP-model aangeeft. In de discussieparagraaf bezien we de ontwikkeling van Positieve Gezondheid met deze transitiebril.

5.3 Methode

Dit onderzoek richt zich op het traceren van de adoptie van Positieve Gezondheid op regimeniveau in de *Landelijke Nota Gezondheidsbeleid 2020-2024*. We volgen het spoor van de ontwikkeling en verspreiding van (de taal van) Positieve Gezondheid (de niche). Discoursanalyse past goed bij transitieanalyse omdat hiermee probleemdefinities en voorgestelde oplossingsrichtingen voor maatschappelijke problemen onderzocht kunnen worden, maar ook omdat het de mogelijkheid biedt om de wording van een alternatieve manier van denken ten opzichte van een dominante te reconstrueren en volgen. Juist daar waar het niet gaat om technologische maar om sociale of transformatieve

5 Infiltratie wordt hier gebruikt in de (neutrale) betekenis van langzame doordringing (Van Dale).

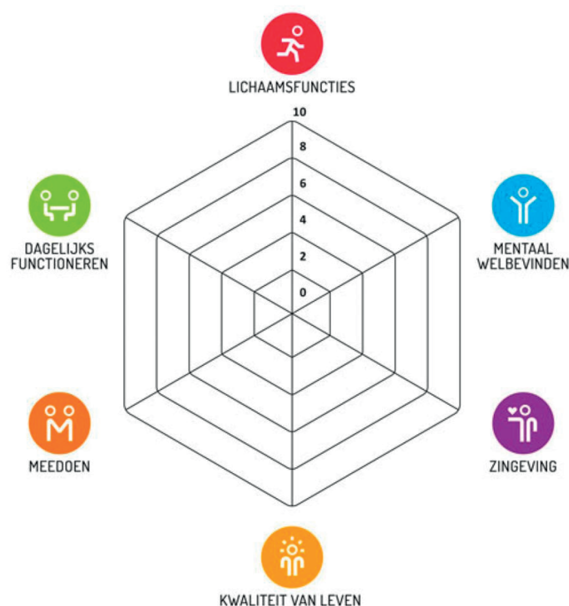
innovatie, lijkt discoursanalyse dus de meest geschikte methode. Het onderzoek is ten eerste gebaseerd op discoursanalyse van verzamelde documenten. Naast documenten vanuit het institute for Positive Health (iPH), zoals beleidsplannen en jaarverslagen, is een set gerelateerde documenten geïdentificeerd, zoals landelijke adviesnota's en (wetenschappelijke) publicaties over Positieve Gezondheid. Voor de publicaties over Positieve Gezondheid is gebruikgemaakt van de materialen die iPH via de eigen website beschikbaar stelt en is gezocht in zowel wetenschappelijke als populaire zoekmachines met de opdracht "Positieve Gezondheid". Deze zoekterm is ook gebruikt bij de website van het ministerie van VWS. In een volgende stap zijn via de sneeuwbalmethode diverse andere relevante bronnen gevonden en aan het onderzoek toegevoegd. Het gaat hier met name om kerndocumenten vanuit de verschillende zorgdomeinen.

Aanvullend op de documentenanalyse is een contextanalyse uitgevoerd waarbij ook websites, nieuwsberichten en beeldmateriaal waarin Positive Health het onderwerp was, zijn bestudeerd. Hierbij is gedetailleerd gekeken naar de discussie rondom Positieve Gezondheid in de vorm van kritiekartikelen en reacties hierop vanuit Machteld Huber (als grondlegger van het concept) en iPH. De analyses zijn aangevuld met twee interviews met vertegenwoordigers van iPH, waarin de bevindingen uit de documenten- en contextanalyse zijn getoetst. Met behulp van een tijdlijn zijn de oorsprong en ontwikkeling van Positieve Gezondheid in Nederland in kaart gebracht. De analyse van het discours in de documenten heeft plaatsgevonden in twee ronden. In eerste instantie inductief aan de hand van een viertal vragen die zijn afgeleid van de onderzoeksvragen: welke problemen en oplossingen worden gepresenteerd, welke argumenten en tegenargumenten zijn te identificeren, welke actoren zijn betrokken of krijgen een rol toebedeeld, en welke zorgdomeinen beslaat dit? In tweede instantie is deductief gezocht naar de toegepaste (discursieve) strategieën (Johansen & Van den Bosch, 2017; Loorbach, 2007) om positie te verwerven voor Positieve Gezondheid en het gedachtegoed te verspreiden. De voorliggende analyse is tot stand gekomen in een iteratief proces waarbij algemeen begrip en hoofdlijnen zijn afgewisseld met verdiepende tekstuele analyse.

5.4 Ontwikkeling van en groeiende aandacht voor Positieve Gezondheid

Positieve Gezondheid is geïntroduceerd door Machteld Huber als een nieuwe brede benadering van gezondheid. In haar onderzoek bleek de gangbare definitie van gezondheid (geformuleerd door de World Health Organization (WHO) in 1948) onvoldoende bruikbaar, aangezien deze uitgaat van een *toestand* van *compleet* fysiek, mentaal en sociaal welbevinden. In de huidige tijd, waarin mensen steeds langer leven en er een hoge prevalentie van chronische ziekten is, is de groep mensen die volgens deze definitie (compleet) gezond is, erg klein. Huber kreeg de mogelijkheid om in 2009 met

de Gezondheidsraad en ZonMw een internationale conferentie te organiseren om een nieuwe definitie van gezondheid te verkennen. Met een groep internationale wetenschappers is het voorstel gedaan voor een nieuwe, meer dynamische omschrijving van gezondheid: gezondheid als het vermogen zich aan te passen en eigen regie te voeren in het licht van de sociale, fysieke en emotionele uitdagingen van het leven (Huber e.a., 2011). ZonMw gaf vervolgens opdracht aan Huber om dit concept verder uit te werken en een aanzet te geven tot operationalisering. Het concept Positieve Gezondheid met de zes domeinen en het spinnenwebdiagram is hier het resultaat van (zie kader en figuur 5.1).



Figuur 5.1 Positieve Gezondheid en spinnenwebdiagram (bron:www.iph.nl)

Een interview met Machteld Huber in het NRC, na haar promotie in 2014, introduceerde Positieve Gezondheid bij het grote publiek en de interesse nam daarna explosief toe. Met een eerste proeftuin in de Noordelijke Maasvallei (Boers & Huber, 2015) werden in een netwerk van zorgprofessionals, welzijnsorganisaties, verzekeraars en gemeenten praktijkervaringen opgedaan met het ontwikkelen van een gemeenschappelijk referentiekader en van handelingsperspectieven voortkomend uit het spinnenwebdiagram. De interesse voor Positieve Gezondheid was dusdanig dat in 2015 een apart instituut werd

opgericht: Stichting Institute for Positive Health (iPH)[6]. Vanuit iPH is de verspreiding van kennis over het concept Positieve Gezondheid verder vormgegeven via lezingen, begeleiding van meer proeftuinen en het voeren van dialogen met stakeholders zoals het ministerie van VWS en zorgverzekeraars.

Met de toenemende bekendheid van Positieve Gezondheid nam ook de kritiek toe. Vooral in 2016 en 2017 worden enkele kritische publicaties uitgebracht (Kingma, 2017; Poiesz, Caris & Lapré, 2016; Van der Stel, 2016; Van Staa, Cardol en Van Dam, 2017; Vosman, 2017). De kritiek richt zich op de breedheid van het concept en hoe met de zes dimensies alles tot gezondheid wordt gerekend. Hierdoor zijn het vakgebied en de uitoefening van het beroep van zorgverlener onbegrensd en wordt medicalisering juist in de hand gewerkt in plaats van teruggedrongen. Een ander punt van kritiek dat wordt opgevoerd, is dat Positieve Gezondheid de focus legt op gedrag in plaats van gezondheid, dat dit verwarrend is en objectieve (biopsychosociale) aandoeningen buiten beschouwing laat. Patiënten voelen zich hierdoor mogelijk niet serieus genomen. Een derde punt van kritiek betreft het uitgangspunt van eigen regie. Critici geven aan dat niet iedereen in staat is om zelf de regie te voeren en zelfredzaam te zijn, bijvoorbeeld als gevolg van levensfase, wilsonbekwaamheid of kwetsbaarheid, en zijn deze mensen dan ongezond? In het verlengde hiervan wordt ook opgemerkt dat aanpassingsvermogen, als kernbegrip binnen Positieve Gezondheid, niet altijd positief of gezond is; bijvoorbeeld in situaties van huiselijk geweld is aanpassing niet het meest aan te bevelen gedrag. Daarnaast is er kritiek ten aanzien van de kwaliteit van het uitgevoerde onderzoek en de wetenschappelijke onderbouwing van Positieve Gezondheid en wordt de vraag gesteld in hoeverre Positieve Gezondheid iets nieuws brengt voor al langer bestaande en breed en op zelfredzaamheid georiënteerde beroepsgroepen zoals huisartsen en ergotherapeuten (Van Boven & Versteegde, 2019; Scheijmans & Stoopendaal, 2018). Een groot aantal van deze kritiekpunten is benoemd in het artikel van Poiesz e.a. (2016) in het *Tijdschrift voor gezondheidswetenschappen*. In ditzelfde tijdschrift is door Machteld Huber een reactie geformuleerd waarin de gemaakte keuzes worden beargumenteerd (Huber, 2016).

Vanaf 2017 begint Positieve Gezondheid als begrip te verschijnen in landelijke rapportages en branchegerelateerde kerndocumenten, bijvoorbeeld *Visiedocument Medisch Specialist 2025* (Federatie Medisch Specialisten, 2017), *Kwaliteitskader Wijkverpleging* (Stuurgroep Kwaliteitskader Wijkverpleging, 2018), *Rapportage commissie Werken in de Zorg* (Commissie Werken in de Zorg, 2019) en *Raamplan Artsopleiding 2020* (NFU, 2020). Het rapport van de Taskforce JZJP (2018) vormt een belangrijke opmaat naar de inbedding van Positieve Gezondheid in het beleid van het ministerie van VWS.

6 Vroege interesse vanuit internationale hoek gaf aanleiding tot het kiezen van een Engelse naam.

Dit rapport is gemaakt in opdracht van VWS en geeft redenen waarom de organisatie van zorg anders moet (en kan) vanuit de verschuiving ziekte en zorg naar gezondheid en gedrag. Positieve Gezondheid wordt genoemd als onderdeel en voorbeeld van de beweging. De inhoud van dit rapport is vervolgens gebruikt voor de hoofdlijnakkoorden tussen VWS en de verschillende zorgdomeinen, waardoor ook in enkele van deze akkoorden Positieve Gezondheid is benoemd. De doorbraak van Positieve Gezondheid in overheidsbeleid komt met de publicatie van de *Landelijke Nota Gezondheidsbeleid 2020-2024* (VWS, 2020), waarin Positieve Gezondheid als belangrijke pijler in de visie is gepresenteerd. Recentere rapporten, zoals een advies van het Zorginstituut en de Nederlandse Zorgautoriteit (2020) en een discussienota van VWS (2020), beide over de toekomst van de zorg, benoemen ook het gedachtegoed van Positieve Gezondheid als bouwsteen voor de toekomst van de zorg en het overheidsbeleid. Het concept Positieve Gezondheid is opgenomen in vele beleidsdocumenten en wordt bekender onder een groter publiek, het verspreidt zich daarmee ook verder.

5.5 Diffusieproces

Transitieonderzoekers hebben diverse typologieën ontwikkeld die de ontwikkeling van innovatie in de context van transformatieve verandering weergeven (Loorbach e.a., 2020). In de kern gaat het bij alle typologieën om verschillende mechanismen (in verschillende bewoordingen) die groei, ontwikkeling, versterking en borging stimuleren. Loorbach e.a. (2020) benoemen vijf ontwikkelmechanismen in dit kader: *groei, herhaling, samenwerking, kansen benutten* en *borgen*. De ontwikkeling en diffusie van Positieve Gezondheid kunnen we bezien in het licht van deze ontwikkelmechanismen van transformatieve innovatie.

Groei, in dit kader, is kwantitatief van aard. In dit onderzoek is geen kwantitatieve analyse uitgevoerd van de toegenomen naamsbekendheid, het aantal afgenomen trainingen of aantal daadwerkelijke gebruikers. Echter, op het oog alleen al kan wel gesproken worden van groei als gekeken wordt naar de toenemende vraag naar trainingen, het toenemende aantal samenwerkingspartners, het toenemende aantal publicaties (inclusief beeldmateriaal) over Positieve Gezondheid of waarin hieraan gerefereerd wordt. Groei in termen van duurzame (structurele) financiering is nog wel in ontwikkeling.

Herhaling refereert aan de vertaling van het gedachtegoed en de praktijken van Positieve Gezondheid in een andere context. Op dit terrein kunnen we diverse ontwikkelingen identificeren, bijvoorbeeld aanpassing van de gesprekstool ‘Mijn Positieve Gezondheid’ voor specifieke doelgroepen en verbreding naar andere domeinen zoals werk. Daarnaast vertaalt iPH ook Positieve Gezondheid naar toepassing op meerdere niveaus: individu, organisatie, wijk/gemeente, provincie en landelijk.

Samenwerking gaat over het bij elkaar brengen van middelen, competenties en capaciteiten, bijvoorbeeld met andere innovators. Stichting iPH zoekt expliciet de samenwerking met anderen op het gebied van bijvoorbeeld training, onderzoek en implementatietrajecten. Uitgangspunt hierbij is synergie en gemeenschappelijkheid zoeken, co-creatie en samenwerken met intrinsiek gemotiveerde mensen of partnerorganisaties, die vervolgens de rol van ambassadeur vervullen. Vanuit iPH wordt gewerkt met een 'coalition of the willing' en er is vanaf het begin veel geïnvesteerd in het vinden en stimuleren van deze intrinsiek gemotiveerde ambassadeurs binnen gevestigde zorginstellingen en praktijken en bij organisaties op regimeniveau (bijvoorbeeld bij VWS, zorgverzekeraars, brancheverenigingen). Deze contacten hebben in ieder geval brede steun opgeleverd voor iPH en veel ruimte geboden voor het uitdragen van Positieve Gezondheid, en hier wordt door instituten als ZonMw en Vilans[7] ook uitdrukkelijk in bijgedragen.

Het *benutten van kansen* is wellicht de meest onzichtbare factor in de voorspoedige diffusie van Positieve Gezondheid. Toevallige ontmoetingen die deuren openen, het treffen van invloedrijke ambassadeurs, mensen op relevante posities kunnen inspireren; het benutten van de kansen die ontmoetingen met zich meebrengen, en het blijven opzoeken van deze ontmoetingen, heeft een belangrijke bijdrage geleverd aan de bekendwording en verspreiding van Positieve Gezondheid.

Het laatste ontwikkelmechanisme is *borging* of *inbedding*, waarbij sprake is van daadwerkelijke institutionalisering als een innovatie onderdeel is geworden van een maatschappelijke structuur, bijvoorbeeld via regelgeving of financiering. Zowel in uitingen van iPH (zoals missie, visie, beleidsplannen, doelstellingen, jaarverslagen en publicaties) in de jaren 2015-2021 als in de diverse nota's en beleidsdocumenten van het ministerie van VWS en adviesrapporten aan de overheid in dezelfde periode, is een sterk vergelijkbare omschrijving te vinden van context en probleemformulering die de noodzaak schetsen om het anders te doen en hoe Positieve Gezondheid hier een bijdrage aan kan leveren (zie tabel 5.1). De prominente positionering van Positieve Gezondheid in de *Landelijke Nota Gezondheidsbeleid 2020-2024* (hierna aangeduid als LNG) van VWS impliceert borging door institutionalisering en verworven legitimiteit van het concept.

7 ZonMw is de Nederlandse organisatie voor gezondheidsonderzoek en zorginnovatie. ZonMw financiert gezondheidsonderzoek én stimuleert het gebruik van de ontwikkelde kennis – om daarmee de zorg en gezondheid te verbeteren. Vilans is de landelijke kennisorganisatie voor de langdurige zorg. ZonMw en Vilans werken beide in opdracht van het ministerie van VWS.

	iPH	VWS en aanverwante instituten LNG
Geschetste context	– Vergrijzing en toename chronisch zieken, toegenomen. levensverwachting – Betaalbaarheid van de zorg staat onder druk.	– Huidig zorgsysteem is financieel onhoudbaar door almaar toenemende kostenstijging. – Toename aantal ouderen met chronische aandoeningen en multimorbiditeit, sociale problemen zoals eenzaamheid. – Technologische ontwikkelingen.
Probleemformulering	– Begrip gezondheid WHO te statisch en ambitieus. – Burgers/patiënten onvoldoende zelfredzaam m.b.t. hun gezondheid. – Onvoldoende samenwerking/samenhang tussen zorg en sociale domein/schotten. – Patiënt centraal krijgt onvoldoende invulling in de praktijk. – Focus op aandoening/klachten/problemen en medicalisatie.	– Medicalisering en hospitalisering door nadruk op aandoeningen en behandeling. – Toename medische mogelijkheden. – Er wordt door bovenstaande twee punten een steeds groter beroep gedaan op beschikbare zorg en middelen. – Gebrek aan samenhang en coördinatie. – Deel van de mensen niet in staat om hun leven op de rit te krijgen en regie te houden op de ondersteuning en zorg die ze ontvangen. – Verspilling van geld en mankracht door onnodige zorg (opgeëist door de burger) of verkeerde keuzen voor de inzet van zorg (duur als het niet nodig is, op locatie als het ook thuis/digitaal kan, te weinig preventie/leefstijl/gezondere omgeving). LNG – Gezamenlijke en domeinoverstijgende visie en aanpak van gezondheidsvraagstukken is nodig. – Gezond zijn en gezond voelen worden beïnvloed door achterliggende problematiek zoals (fysieke of sociale) leefomgeving, opleiding of inkomen/schulden. – Druk op het dagelijks leven bij jeugd en jongvolwassenen. – Vitaliteit van ouderen moet zo veel mogelijk in stand gehouden worden.

Tabel 5.1 Overlappend discours gebruikt door niche en regime actoren in de jaren 2015-2021

	iPH	VWS en aanverwante instituten LNG
Bijdrage van Positieve Gezondheid	– Doet een appèl op de samenleving om met elkaar anders te kijken, te denken en te organiseren. – Focus op zelfredzaamheid, veerkracht, eigen regie versterken. – Van moeten naar willen. – Brug slaan tussen zorg en sociale domein door gemeenschappelijke taal. – Mens daadwerkelijk centraal. – Intrinsieke motivatie bij patiënten en professionals aanboren. – Meer betekenisvol invulling geven aan beleid en inrichting van zorg en welzijn. – Oplossingen zoeken in preventie of andere domeinen dan het medische.	Positieve Gezondheid *als onderdeel van* het doelmatiger organiseren van zorg: – Aanbod meer toesnijden op (daadwerkelijke) vraag. – Investeren in preventie, leefstijl, vroegsignalering en brede beoordeling van wat echt nodig is. – Professionals hebben gevoel waarde toe te voegen. – Zelfredzaamheid mensen en hun omgeving vergroten. – Zorg meer in samenhang, welbevinden echt centraal en zorg integraal rondom mensen en zo dichtbij mogelijk georganiseerd. – Persoonsgerichte zorg die aansluit bij wat mensen nodig hebben om met een ziekte of aandoening zo goed mogelijk hun leven in te kunnen richten. – Vroegtijdige aanpak van sociale problematiek. LNG – Het gaat bij gezondheidsvraagstukken niet alleen om de lichamelijke kanten van gezondheid, maar ook om het vermogen je aan te passen, je welbevinden, eigen regie, veerkracht, participatie en zingeving. Gezondheid is dus meer dan 'niet ziek zijn'. – Positieve Gezondheid als domeinoverstijgend bindmiddel door brede kijk op gezondheid, stimuleert samenwerking.

Tabel 5.1 (Vervolg)

In de ontwikkeling en verspreiding van Positieve Gezondheid kunnen verschillende acties onderscheiden worden die dit diffusieproces ondersteund hebben (zie tabel 5.2). Deze acties/strategieën zijn niet alleen door iPH ingezet en voor een deel niet strategisch ontwikkeld, maar onbewust ontstaan. De optelsom van deze variatie aan activiteiten heeft echter wel bijgedragen aan de gerealiseerde verspreiding van Positieve Gezondheid en kan achteraf worden gezien als een transitiestrategie om dit discours tot transitie te laten bijdragen. Op basis van het kader van transitiemanagement maken wij ook hier onderscheid tussen drie niveaus van beïnvloeding: discursief/cultuur (strategisch), netwerken/structuur (tactisch) en routines/ werkwijzen (operationeel) (Loorbach, 2007).

Strategisch: discursief en cultuur	Presentatie van Positieve Gezondheid als (bijdrage aan) de oplossing voor problemen binnen het zorgsysteem, bijvoorbeeld 'de sleutel in de omslag van de zorg'. Positief woordgebruik: uiteraard *Positieve* Gezondheid, maar ook bijvoorbeeld inspiratie, groei, co-creatie, eigen regie. Aansluiten bij beweging van ziekte naar gezondheid. Vergelijking met andere aanverwante concepten en waar deze elkaar kunnen versterken. Publicaties, inclusief reactie op kritiek en willen aangaan van dialoog. Persoonlijk verhaal van Machteld Huber (en het daarmee hebben van een boegbeeld) versterkt de boodschap.
Tactisch: netwerken en structuur	Coalition of the willing (focus op mensen met intrinsieke motivatie om dit concept te gebruiken). Betrokkenheid van experts (o.a. internationale conferentie). Subsidiëring door en samenwerkingsovereenkomsten met regimespelers (VWS, zorgverzekeraars, Vilans). Kennis en ontwikkeling onderbrengen in een instituut. Wetenschappelijk onderzoek (gepubliceerd). Persaandacht door het winnen van prijzen of goed scoren in rankings. Krachtige digitale aanwezigheid. Lobbywerk.
Operationeel: routines en werkwijzen	Transparantie, bijvoorbeeld ervaringen en praktijkhulpmiddelen delen via de website. Testimonials door praktijkgebruikers (o.a. via YouTube). Geaccrediteerde opleiding (huisartsen, medisch specialisten, verpleegkundigen, fysiotherapeuten). Uitbrengen handboek Positieve Gezondheid (voor huisartsen). Verbreding naar andere domeinen, bijvoorbeeld werk (vitaliteit).

Tabel 5.2 Acties die verspreiding van Positieve Gezondheid ondersteund hebben

Naast de opmars van Positieve Gezondheid is tevens een aantal aanverwante bewegingen te ontdekken. Het concept van Positieve Gezondheid refereert aan de positieve psychologie (Seligman, 2008; Walburg, 2010). De positieve psychologie richt zich op het bevorderen van mentale veerkracht van mensen in tegenstelling tot de probleemgeoriënteerde focus van de klassieke psychologie. Ook moet de inaugurele rede

De weg van nazorg naar voorzorg: buiten de gebaande paden (Ruwaard, 2012) genoemd worden. Een beweging die sterk overlapt met Positieve Gezondheid is de 'positieve gezondheidszorg met het model voor oplossingsgericht werken' (Bannink & Jansen, 2017), waarbij de uitgangspunten hetzelfde zijn, maar het gebruikte praktijkmodel een andere insteek kent. Er blijkt veel overlap te zitten in de door deze partijen gebruikte probleemformulering. Stichting iPH werkt waar mogelijk samen met vertegenwoordigers van deze andere stromingen die gelijkenis hebben met Positieve Gezondheid en als het ware concurrerende discoursen vormen. Hierbij wordt ook het perspectief van de gemene deler gehanteerd en gezocht naar hoe verschillende concepten en ideeën elkaar kunnen versterken.

5.6 Discussie

Over het concept Positieve Gezondheid wordt wel eens gezegd dat het voor elk wat wils biedt (meestal als kritiek), echter mogelijk zit hier ook juist de kracht en verbindende factor. Wanneer het concept tegelijk voldoende helder gekaderd is en weinig interpretatieverschil kent, combineert het concept flexibiliteit én biedt het een gezamenlijke identiteit. Bij de uitingen van kritiek die in een eerdere paragraaf zijn beschreven, is regelmatig het argument naar voren gebracht dat Positieve Gezondheid niets nieuws brengt: de huisarts heeft van nature een brede blik, de ergotherapeut kijkt altijd al naar mogelijkheden in het dagelijks leven, de samenhang tussen domeinen kennen we al sinds de preventiegeneeskunde. Dus niets nieuws onder de zon? Wellicht niet, echter een enkele beroepsgroep of een enkel zorgdomein heeft in het verleden niet de doorzettingsmacht gehad (en mogelijk ook niet geambieerd) om het eigen gedachtegoed gemeengoed te laten zijn binnen het gehele zorgsysteem. Het hoe en waarom hiervan valt buiten de scope van dit onderzoek, maar een mogelijke verklaring is dat specifieke beroepsgroepen of zorgdomeinen hun identiteit juist te zeer aan het eigen beroep of domein ontlenen (en binnen die structuur opereren) om domeinoverstijgend hun gedachtegoed te verspreiden. Naast de kritiek van 'niets nieuws onder de zon' zijn er ook professionals, onderzoekers en beleidsmakers die juist op zoek gaan en bevestigen dat Positieve Gezondheid versterkend kan werken met het eigen domein. Scheijmans en Stoopendaal (2018) vergelijken Positieve Gezondheid met ergotherapie en constateren dat beide de rol van intermediair tussen de sectoren zorg en welzijn kunnen vervullen. Hier wordt ook weer de gemeenschappelijke taal uitgelicht als instrument om de samenwerking tussen professionals en domeinen te verbeteren.

In de vorige paragraaf is het diffusieproces geanalyseerd aan de hand van vijf ontwikkelmechanismen van transformatieve innovatie (Loorbach e.a., 2020). Het gebruik van deze ontwikkelmechanismen is een nuttige lens gebleken om de toegepaste diffusiestrategieën te duiden. Al is het ontwikkelmechanisme *groei* wellicht meer een

resultaat van toegepaste strategieën als herhaling, samenwerking en kansen benutten. Naast de onderzochte ontwikkelmechanismen genoemd door Loorbach e.a. (2020) valt op basis van deze analyse nog een strategie te ontdekken: verstevigen van het concept/gedachtegoed. Uit de analyse komt naar voren dat veel acties gericht zijn op het verstevigen van de basis van het gedachtegoed. Specifieke acties in dit kader zijn evaluatieonderzoek en onderzoek naar meetbaarheid en operationalisatie (Van Vliet e.a., 2021) van het concept Positieve Gezondheid. Daarnaast wordt gewerkt aan versteviging van het concept door het aangaan van de publieke dialoog met criticasters. Een laatste actie die deze strategie ondersteunt is het onderzoeken van aanverwante concepten en deze zien als versterkend en niet concurrerend. Deze strategie van 'versteviging van het concept en gedachtegoed' doet daarmee denken aan de (discursieve) strategieën van verdiepen en verbreden zoals beschreven door Johansen en Van den Bosch (2017). In het kader van Positieve Gezondheid wordt weinig expliciet gesproken over kostenbeheersing in de zorg, echter de omschrijving van beoogde resultaten (bijvoorbeeld minder verwijzingen naar de tweede lijn, oplossingen buiten het medische domein) kan wel in dat licht bezien worden. Deze uitingen van Positieve Gezondheid zijn in die zin ondersteunend aan het overheidsdiscours en er is sprake van overlappende probleemdefinities met betrekking tot onhoudbaarheid van het zorgstelsel, ontwikkeling van zelfredzaamheid van burgers en aanpak van medicalisering. Deze aansluiting, in combinatie met de bredere beweging in het denken van ziekte naar gezondheid, kan op zichzelf al voldoende zijn geweest voor het ministerie van VWS om Positieve Gezondheid vaker te gebruiken in beleid. Echter is het ook goed te realiseren dat VWS (en zijn aanverwante instituten en programma's) vanaf de eerste ontwikkeling van Positieve Gezondheid betrokken is geweest bij iPH. Er werd financiële steun verleend en vanuit VWS is ook input geleverd bij de ontwikkeling van Positieve Gezondheid. Dit geldt voor meerdere stakeholders, zoals ook verzekeraars en diverse beroepsgroepen in de gezondheidszorg.

Met de groeiende toepassing van Positieve Gezondheid in de praktijk wordt ook de invloed van bestaande structuren en belangen zichtbaar (padafhankelijkheid; Loorbach e.a., 2017). Zo kunnen belemmerende financieringsmechanismen de effectieve vormgeving van Positieve Gezondheid frustreren. Dit kwam naar voren in een pilot met een huisartsenpraktijk waarbij de voorgeschreven tijd voor een gesprek van tien minuten naar een kwartier werd verlengd én een ander, op Positieve Gezondheid gebaseerd, gesprek werd gevoerd. Dit leidde tot 25 procent reductie in doorverwijzingen en een afname in het aantal medicatievoorschriften (Jung e.a., 2018). Maar de pilot werd door de opdrachtgevende/betalende zorgverzekeraar niet uitgebreid, ondanks de aanzienlijke daling van het aantal doorverwijzingen naar het regionale ziekenhuis (dat financieel in zwaar weer verkeerde). Het (financiële) belang van het ziekenhuis, zeker relevant om de

regionale zorginfrastructuur voor inwoners te waarborgen, was reden om een barrière voor uitbreiding van het succesvolle project op te werpen. Dit terwijl de resultaten van het project wel in lijn waren met het doel van zowel de verzekeraar (zinnige zorg) als het ministerie van VWS (de juiste zorg op de juiste plek/passende zorg).

Deze casus, waar duidelijk aan gerefereerd wordt in het adviesrapport *Samenwerken aan passende zorg; de toekomst is nú* van Zorginstituut Nederland en de Nederlandse Zorgautoriteit (2020) maakt zichtbaar dat meer nagedacht moet worden over de mogelijke impact van denken, werken en organiseren vanuit Positieve Gezondheid voor het bestaande zorgsysteem en de financiële structuren: een omslag zal diep ingrijpen op de verdeling van middelen. Daarmee is het uitfaseren van belemmerende elementen in de beweging van ziekte naar gezondheid die VWS wil maken, en iPH met Positieve Gezondheid, een cruciale maar voorlopig nog nauwelijks uitgewerkte uitdaging. De diffusiestrategieën die naar voren komen in deze analyse onderschrijven het belang van taal en daarmee de beïnvloeding van dominante cultuur en praktijken (Frantzeskaki & De Haan, 2009), maar markeren ook direct de impact van (achterblijvende) structuurveranderingen zoals financiering of echelons. De rapportages (van VWS en andere regimespelers) die Positieve Gezondheid omarmen gebruiken vaak woorden als 'integraal' en 'domeinoverstijgend', waarmee direct ook een belangrijke uitdaging wordt neergelegd ten aanzien van hoe we begrippen als gezondheid en gezondheidszorg interpreteren en vertalen in een werkbaar systeem. De onderzoeksagenda voor duurzame transities (Köhler e.a., 2019) richt zich uitdrukkelijk ook op de rol van bestaande organisaties en regimespelers (Turnheim & Sovacool, 2020) en de versterkende rol (Berggren e.a., 2015) die zij kunnen spelen in het realiseren van blijvende fundamentele verandering, vergelijkbaar met de strategie van iPH om al in een vroeg stadium nauw samen te werken met VWS en zorgverzekeraars.

5.7 Conclusie

In dit artikel is geschetst hoe het zorgstelsel onder druk staat, waardoor er ruimte komt voor alternatieven. Ogenschijnlijk wordt nu wezenlijk gezocht naar andere waarden om het stelsel van gezondheidszorg opnieuw in te richten. Hierbij wordt door de overheid gebruikgemaakt van begrippen als 'passende zorg', 'de juiste zorg op de juiste plek' en 'integrale zorg', maar vaak ook wordt Positieve Gezondheid genoemd. In dit artikel is getracht te begrijpen hoe en waarom het gedachtegoed van Positieve Gezondheid een prominente plek heeft weten in te nemen in het veranderende beleidsdiscours in de Nederlandse gezondheidszorg.

Positieve Gezondheid geeft invulling aan de voorgestelde paradigmashift van 'ziekte' naar 'gezondheid', geïntroduceerd bij beleidsmakers via de Raad voor de Volksgezond-

heid en Zorg (RVZ) in 2010. De conceptontwikkeling werd gesteund door de Gezondheidsraad en ZonMw. Hiermee was (beleidsmatig) een zachte landing mogelijk voor Positieve Gezondheid. Een tweede verklaring voor de warme ontvangst van Positieve Gezondheid is de vroegtijdige en voortdurende betrokkenheid van systeemspelers zoals het ministerie van VWS en de verzekeraars bij de ontwikkeling van het concept. Vanaf de vroege ontwikkeling van Positieve Gezondheid zijn partijen uitgenodigd om input te leveren en derhalve is er bij systeemspelers ook sprake van herkenning van het concept. Stichting iPH plukt hier de vruchten van een proactieve netwerkstrategie. Een laatste verklaring voor de opkomst van Positieve Gezondheid is gelegen in de taal zelf. Het discours rondom de paradigmashift van ziekte naar gezondheid kent begrippen als veerkracht, eigen regie, preventie, zelfredzaamheid en leefstijl(geneeskunde) en sluit aan bij het bredere overheidsdiscours over het uitfaseren van de verzorgingsstaat. De focus op gezondheid (in plaats van ziekte) past goed bij de preventie- en leefstijlgedachte en de mogelijkheid om daarmee kosten te besparen omdat mensen gezonder oud worden en minder een beroep doen op het zorgsysteem.

Vanuit transitieperspectief kun je de vraag stellen of met de diffusie van het concept Positieve Gezondheid de transitie van zorg naar gezondheid onomkeerbaar is geworden of dat het hier vooral gaat om de mainstreaming van een idee en concept, maar dat deze vooral is opgenomen in het bestaande regime zonder al te veel structurele veranderingen. Deze vraag laat zich alleen definitief beantwoorden door historici in de toekomst: het is te vroeg om te constateren of de omslag in denken ook tot diepe verandering in structuur en werken van de zorg leidt. Hoewel onmiskenbaar is dat het denken in brede zin fundamenteel aan het verschuiven is, is ook zichtbaar geworden dat onderliggende systeembarrières en belangen nog zeer stabiel zijn. De vraag is dus in hoeverre partijen ook in staat zijn om gaandeweg het andere denken te internaliseren en gepaard te laten gaan met stapsgewijze veranderingen in de regels, procedures, routines, afspraken, samenwerkingsverbanden, investeringen en opleidingen. De transitiethese is dat als ze hier niet in slagen, het nu nog dominante regime intact zal blijven, maar door de persistente problemen onvermijdelijk met toekomstige crises te maken gaat krijgen. Om dan wellicht alsnog in transitie te raken.

6

Transition Pains: recognizing effects of organizational realignment to a changing context

CHAPTER 6 TRANSITION PAINS: RECOGNIZING EFFECTS OF ORGANIZATIONAL REALIGNMENT TO A CHANGING CONTEXT

6.1 Introduction

The generous amount of literature on change management illustrates that managing change in practice requires more than a step-by-step plan or "how to" guidelines. The less tangible 'practice' part leaves room for enrichment of the change management discourse with new or revisited concepts and ideas to support management practitioners looking to enhance performance. In this paper we explore the practice of change from the perspective of organizational members for whom change is sometimes confusing or even feels paradoxical. Going through a change process could even be called painful.

The specific context for exploring change experiences of organizational members is the context of disruptive external change (i.e., transition). The context of transition is relevant as the disruptive character of transformative societal change (Grin et al., 2010) is especially challenging for organizations to adapt to. The disruptive character of external change implies that readjustment of organizational strategy, policies and work organization is necessary in order to survive these transformative changes (Rotmans & Loorbach, 2010) as opposed to more continuous change (Weick & Quinn, 1999). This process of readjusting or realigning strategy and policies with societal changes is likely to come with adjustments in daily work organization, thereby affecting organizational members and their behavior.

Our findings are based on a longitudinal study of a change process in an organization that operates in both the healthcare domain and social domain, both domains that have a transition context (Broerse & Bunders, 2010; Broerse & Grin, 2017; Johansen & Van den Bosch, 2015; Johansen et al., 2018; Van Raak, 2016). We identified experienced tension, stress, grief and anger as stemming from confusion. This confusion was created by inconsistencies in the process of realignment of strategy, policies and work organization to a changing context. We understand these experienced inconsistencies among cognitions such as any knowledge, opinion or belief as cognitive dissonance (Festinger, 1957). As we will elaborate on in this paper, we identify the transition context as feeding ground for dissonance (interpreted as experienced inconsistency between cognitions) as organizations are challenged to realign vision, strategy and policy with external societal changes. A gap occurs when strategy has been adapted to changes in the environment but not translated into daily practices. In this paper we examine how the gaps in the process of realignment affect people in organizations.

We follow the line of thought from scholars who challenge us to look at so called resistance to change from a context perspective (Burnes, 2015; Klarner et al., 2011; Piderit, 2000; Vince & Broussine, 1996): the context of change (e.g., level of participation, possibility of choice, availability of information, level of support) generates responses that help to interpret events.

This research was conducted from a transition perspective. Transitions are defined as a specific type of social change: a process of radical, non-linear change in a societal subsystem (Grin et al., 2010) following a build-up of tensions that stem from persistent problems in the subsystem. The field of sustainability transitions research (Loorbach et al., 2017) represents the social and academic interest in transformations in societal systems. Applying this transition perspective means we primarily look at organizations as responding to disruptive changes in the environment. From this transition perspective, organizational change is the result of the build-up and discharge of tension in the regime. Specifically, we look at how these tensions, and the organizational change process that follows, are experienced by organizational members. Our main research questions were formulated as:

- What happens within organizations, and specifically concerning organizational members, trying to realign with a disruptive changing context?
- How can the tensions within an organization be understood from a transition perspective and what does the transition perspective have to offer in dealing with these tensions?

In section 2 the transition perspective is introduced and we elaborate on the main concept of dissonance as source for transition pains. Section 3 introduces our case and methods. Our case is illustrated in section 4 by a reconstruction and analysis of developments in the light of a changing environment. In section 5 we conceptualize our findings as transition pains and in section 6 present examples of dissonance and further explore the relation to transition pains. We conclude this paper with implications for theory and practice (section 7) and discussion and conclusion in section 8.

6.2 Theoretical perspective

In this section we develop the theoretical perspective for analyzing our case study as an organization in the context of a transition. We give an introduction to the transition perspective and discuss the concept of dissonance as a key factor in understanding behavior of organizational members.

6.2.1 Introduction to the transition perspective

The disruptive, non-linear character of transitions is a result of persistent problems associated with the dominant way in which a societal sub-system is organized (regime). Societal regimes (fossil energy, intensive agriculture, car-based mobility or specialized healthcare) consist of technologies and institutions as well as shared cultures, structures and practices. Such societal regimes develop path-dependently and thereby gradually reduce diversity and adaptive capacity. As the context changes (broader landscape trends such as demographic or technological changes, sustainability concerns), increasing pressures upon these regimes might trigger internal crises and start off a process of shock-wise and often disruptive reconfiguration (Grin et al., 2010). Organizations embedded within such a regime context (incumbents) often have co-evolved with this context and aligned with the dominant culture (e.g., values), structures (e.g., regulations) and practices of these regimes.

When a process of transition emerges, organizations are pushed to start rethinking their own organizational logics and model more fundamentally (Loorbach & Wijsman, 2013; Loorbach et al., 2014). While there is much work focusing on change agents, policy and governance strategies for experimentation and emergences (e.g., Avelino & Rotmans, 2009; Avelino & Wittmayer, 2016; De Haan & Rotmans, 2011), only recently authors have started to explore strategic options for incumbents facing transitions (Bosman et al., 2014; Bosman, 2022; Hengelaar, 2017; Mühlemeier, 2019).

For incumbents, a destabilizing regime implies that the dominant logic of the context in which they operate becomes unstable leading to uncertainties and challenging the status quo. We hypothesize that realignment of an incumbent organization in a transforming environment requires a transition at the organizational level. This research studies what happens within organizations trying to realign themselves to a changing context while simultaneously dealing with internal dynamics. Our study shows that this process of realignment is likely to cause confusion among organizational members as they experience inconsistencies between the organization's response to the external environment and internal policies and work organization.

6.2.2 Dissonance

When realigning organizational strategies in answer to regime developments, there is a risk of creating a gap between strategy, policy and the practice of day-to-day work. This gap can be experienced by organizational members as an inconsistency between what is said and what is done. In this paper we interpret these experienced inconsistencies as dissonance and hypothesize that dissonance can occur at different levels, wherever

there is a gap or inconsistency between what is said and what is done. In our study, we have found dissonance to be a key factor in understanding responses to realignment.

At the individual level our point of reference is cognitive dissonance as introduced by Festinger (1957) as the existence of non-fitting relations or discrepancy among cognitions (any knowledge, opinion or belief). Dissonance exists as an everyday condition (e.g., when deliberating the pros and cons to a decision) but has a stronger presence when new events or new information is inconsistent with existing knowledge or beliefs. This discrepancy generally leads to a feeling of discomfort and an individual will try to reduce the dissonance (e.g., by changing their behavior, their environment or their beliefs) or avoid situations and information which will likely increase the dissonance.

At the operational level this gap has been described by Clay-Williams et al. (2015) as the gap between work-as-imagined, described in guidelines and procedures, and work-as-done, the actual practice. In this conceptualization, instructions for work are not always compatible with other procedures used in the workplace. This can result in different or even incompatible assumptions of how work is accomplished because of the contradiction between the internal logic or consistency of a guideline and the applicability of that logic to actual workplace activities. From another perspective, Kump (2019) builds on the work of Nadler (1993) and Nag et al. (2007) who have illustrated how radical change causes incongruences. These incongruences lead to power struggles (following Lewin (1947) who introduced how radical change disturbs the equilibrium of power in a social system) but also how incongruences emerge between practices, knowledge and identity of organizational members. Kump (2019) has developed a model of interrelations between individual and collective practice, knowledge and identity within organizations that helps explain tensions and a sense of being "out of sync". This research enriches Kump's conceptual study (2019) with empirical illustration.

At the tactical level Meyer & Rowan (1977) have introduced the concept of decoupling as the gap between the formal and actual world in organizations in which a policy is introduced but not actually implemented and effective. De Bree & Stoopendaal (2018) have researched the reverse process of recoupling (to close the gap) in Dutch healthcare. In their research they found opportunities for recoupling based on effective use of (cyclical) management systems through reflection on inconsistencies between goal, system, practice and outcome.

At the strategic level strategic dissonance has been introduced by Burgelman & Grove (1996) as the lack of alignment between strategic intent and strategic action. The strategic characteristic of dissonance is related to the transformation in an industry that can

fuel a divergence. The divergences between strategy and action are viewed as natural outcomes of the internal and external dynamic forces that influence organizations. Burgelman & Grove suggest that these divergences create an opportunity to learn. Managing strategic dissonance is done for instance through accepting the existence of dissonance, allowing dissent and unanticipated invention. Culture is presented as the key for managing strategic dissonance: strong bottom-up and top-down forces in a confrontational/ collegial culture that encourages debate and the capability to make clear decisions (Burgelman & Grove, 1996). We propose that the concept of strategic dissonance brings together the transition perspective (forcing strategic (re)action from incumbents) with the concept of cognitive dissonance in the experiences of organizational members who feel discomfort or are confused by discrepancies between presented organizational strategy and the daily action that is required of them.

Besides literature that has a focus on the 'gap' between strategy, policy and practice we recognize similarities in literature that highlights organizational contradictions and the role of sense-making (Clegg et al., 2002; Hargrave & Van de Ven, 2017; Smith & Lewis, 2011; Sparr, 2018). Clegg et al. (2002) support the view that contradiction in organizations can result from the demands that the external environment imposes on organizations. The authors point out that actions that try to resolve these contradictions may have an opposite effect due to complexity and imperfection of language. Hargrave & Van de Ven (2017) highlight that when people cannot reconcile contradictory elements, they react to them with confusion, ignorance, anxiety and defensiveness. In this, the literature on dissonance and paradox shares the element of experienced contradiction. In this paper, we investigate this experience of contradiction and describe the experiences we have found in our case study.

6.3 Case and Methods

6.3.1 CASE

In this research an exploratory case study was conducted. This case explores organizational dynamics from the perspective of transition studies. This transition perspective places organizational change in the broader context of societal change. Societal change creates pressure for regime change and in turn organizational change. This external pressure may conflict with internal organizational dynamics causing tension within an organization. These dynamics are explored in this case study. For reasons of simplification the case study organization is anonymized and referred to as CASE.

CASE is a Dutch healthcare organization offering supported living services. The organization is part of the established regional healthcare regime. As such, CASE is an incum-

bent organization that experiences these internal organizational dynamics related to regime change. CASE operates on the border of two regimes: mental healthcare and social support. Box 6.1 gives a short introduction on CASE. In the past years CASE has experienced a large number of changes in the social and mental healthcare domains, for the most a result of decentralization leading to a new finance structure with new financiers and new regulations. Additionally, landscape developments concerning a more challenging client population and a problematic labor market are of significant influence. These changes necessitated an organizational transition to cope with this new environment. A radical change was initiated in 2013 when there was a transformation in organizational and management structure: a new director and managers came in with a new paradigm towards client support and everyday practices. The process of adaptation to this transformation is still ongoing. The changes initiated in 2013 and 2014 have had variable effects. The new vision and strategy and the general direction are not clear to all organizational members as they indicate to experience a lack of clarity and direction. This is especially apparent when the presented organizational vision and strategy does not always match everyday reality on the work floor. This empirical example of an organization where dissonance is regularly experienced makes CASE an interesting case to study.

Introducing CASE
This case study was conducted at CASE, a foundation that supports people with psychiatric disabilities to develop skills towards maintaining a house(hold), social relations, a job and community involvement. CASE offers their clients supported living & housing and provides support to people in and around their own home. CASE operates on multiple domains: the social domain, mental healthcare and housing. Additionally, CASE operates within several different finance regimes, depending on the nature of the clients' needs (short-term, long-term, forensic background, type of supported living).
CASE operates since 1970. In 2011 CASE consisted of 6 housing locations with 170 clients, 198 home clients and 171 employees (in 7 teams). At the end of 2019 CASE numbered 10 housing locations with 204 clients, 426 home clients and 214 employees (in 16 teams).

Box 6.1 Introducing CASE.

6.3.2 Methods

In this case study several research methods are combined. Overall, an extended case study was conducted. The timeline runs from 2011 to 2019. The years 2011-2015 were researched retrospectively. The research was conducted on site from 2016 to 2019. A historical analysis based on internal and external documents as well as interviews resulted in the reconstruction of a focused timeline for the research period 2011 to 2019. In the years 2017-2019 17 interviews were conducted with key figures e.g., management (7 interviews) and with employees of CASE since at least 2011 (10 interviews). All interviews lasted 1-1,5 hours and were transcribed verbatim. Additionally, from 2016

to 2019 the primary researcher conducted on site research in the role of company secretary. As company secretary the researcher was able to attend strategy meetings for both management and employees as well as access a large number of documents to develop the timeline and historical analysis, e.g., minutes from different types of meetings, internal and external reports, strategic plans and periodic (financial) reports. In the role of company secretary, the primary researcher had a unique position to experience the organizational dynamics and add this perspective to the research. Permission to access documents and perform observations in the role of company secretary was granted by successive directors during the research period. In the years 2017-2018 other focused scientific research was conducted at CASE resulting in a learning history of self-organization (Kreijenbroek, 2019). The research outcomes of this learning history were used in this case study to corroborate results.

The analysis has an abductive character as both inductive and deductive rounds of analysis were performed in a recursive and iterative process (Timmermans & Tavory, 2012). The gathering of data started with several orientational interviews and the document analysis (round 1). Using inductive coding this analysis resulted in a historical timeline and the identification of three distinctive time periods. We labeled these periods 'critical', 'transformative' and 'adaptive'. These labels seem to best describe the general experience of organizational members, however, Lewin's original typology of phases of (radical) change are recognizable: unfreezing, moving and refreezing (Lewin, 1947). Additionally, this phase of analysis resulted in identifying dissonance (or incongruence) as a useful (theoretical) concept to explore the internal organizational dynamics. This resulted in a refinement of the interview guide for the second round of interviews as well as a codebook for the analysis of these interviews and the collected observations (round 2). This deductive phase of analysis resulted in an empirically based description of the experiences of dissonance which we conceptualized as transition pain. Pain is used as a metaphor.

During the research, a process of continuous reflection was conducted to validate the outcomes and uphold the objectivity of the primary researcher. We have actively sought to reduce this bias by reflecting upon it, critical questioning by co-authors and validation of our findings with organizational members and the researcher that developed the learning history. The results of the interviews may have been influenced because respondents often knew the researcher as company secretary. However, the experiences shared throughout all interviews showed such a clear pattern that we do not believe that this has significantly influenced the results.

6.4 Periods of change

6.4.1 Reconstruction

Our research focus begins in 2011 as this year is identified as the starting point for radical change. In 2011 the first signs of 'trouble' at CASE became visible: financially and through discussions on organizational structure. In 2012 problems increased as the negative financial impact of new regulations and finance structure (expected in 2015) became clear. The regime changes that were announced presented CASE with a changing external environment: new financial constructions to be arranged with multiple external partners (local municipalities) requiring CASE to be present as a player in the field and negotiate contracts rather than just focus on the own internal organization. Simultaneously, there was acknowledgement that the internal organization was not functioning properly and an independent investigation was commissioned. During this period tension was building within the organization as a growing number of people realized that the organizational culture, structure and practices, as well as its position in the field, were not sustainable. This period of 2011-2012 is termed 'critical'.

In reaction to both the changes in the environment and the internal problems, a large-scale reorganization was initiated in 2013 with a pivotal adjustment in organizational structure: the cancellation of the management layer of team leaders, introduction of self-organizing teams, downsizing the support team and the appointment of three regional managers. Concurrently, there was a change in director who was charged with positioning CASE as a leading player in the field and rebuilding a healthy financial position. The new director introduced a different paradigm towards client support. Following the vision behind the regime changes, this new paradigm focused more on assistance for clients to become self-supporting then on caring/ taking over for somebody. This period of radical change in 2013-2014 is termed 'transformative'.

From 2015 onward the mayor change in finance and regulations is implemented and the work processes are finetuned to adapt to the developments in the external environment and support the internal organization. This period of re-orientation in 2015-2019 is termed 'adaptive'.

6.4.2 Critical period

The critical period was characterized by a growing amount of tension. CASE in this period was a very internally oriented organization, primarily concerned with its own internal struggles. A sense of discomfort was first felt by the (mostly staff and management) employees who were aware of coming external developments in the regime, who recognized the need for transformative change and how ill-prepared the organization

was. Respondents describe the discrepancy between the developments in the external environment and the internal focus of the organization in terms of *unprofessional* and *non-committal.*

An important factor in this phase was identified by respondents as a lack of direction and cohesion:

> *What is lacking is commonality, starting points and criteria, which regulate room for regulation, relationships and interaction; but also, agreements about monitoring their follow-up and agreements about learning and development.* (Change report)
> *So, it was a combination between no strategy, no clarity and therefore anarchy in the company where everybody just did as they pleased more or less.* (Round 1 interview with hired change manager)
>
> *A: Doors were locked, everyone in offices, departments didn't communicate with each other and no insight into each other's results.*
> *B: Everyone had their own folder on the computer with their own documents, nothing was shared. So, there was a lack of cooperation. This is very illustrative of the relationships.*
> *A: It was difficult, nobody knew anything, nobody had a complete overview, there was no cohesion.*
> *B: People started filling in the blanks by themselves.*
> (Conversation between new director in 2013 (A) and secretary (B) illustrating the atmosphere)

The dysfunctionality within the organization was eventually recognized and acknowledged when the management is confronted with the financial repercussions of upcoming regime changes. This led to an external inquiry into the organizational culture, structure and practices. The change report at the end of 2012 states a lack of appropriate leadership as the main problem. Important to note is that most employees have not experienced this period as critical. Looking back, employees admit to a certain lack of professionalism, but in general were operating in a stable environment with clear organizational structure. The financial and organizational unsustainability was mostly felt by people working with staff support, the employees' council and 'outsiders' such as interim management or the supervisory board. Among this group there was frustration that no action was taken to address the regime changes.

6.4.3 Transformative period

The report following the external inquiry signaled the start of a transformative period in which the organization aspired to become futureproof as well as handle the problems

in culture and management. As such, the changes introduced at the start of the transformative period were felt as a great shock among many employees. Because the organization was lagging behind to begin with, there were multiple changes in the process of realignment: in leadership, organizational structure, division of responsibilities and a new paradigm towards supporting clients. In this case, the radical actions in the transformative period were necessary to ensure the continuation of the organization. The necessity of the changes initiated was recognized by the organizational members who participated in the research. Respondents showed a good grasp of the developments in the external environment and the consequences for CASE. However, this period was experienced as fast-paced and chaotic:

> *It is always very chaotic and messy. And there is always something going on. And it's never easy-going.* (Round 2 interview with support worker)

At CASE, the introduction of self-organizing teams was a disruptive experience as teams lost both their team leader and were confronted with new managers and a new director. Employees describe dealing with both shock and loss, as they experienced a multitude of changes at a fast pace without feeling support from management:

> *And then we started with the self-organization. At that point I thought: what will we be dealing with? It sounds very nice but at the same time also worrying. A team leader who is suddenly gone, while we're not yet self-organizing. But the team leader is already gone. A bit like: you can't swim, but swim anyway*. (Round 1 interview with staff employee, former support worker)

> *It was a period of 'go figure it out yourself'. At least that was how it felt.* (Round 2 interview with support worker)

Following the new organizational structure, employees were faced with different expectations in the way they did their daily work with clients but without instructions or support on how to realize these changes as the new manager operated at a distance due to a large span of control. The manager was not always on site to provide instructions, ask questions or discuss a new policy. This created stress among employees. Multiple respondents refer to changes that were implemented without regard for the necessary conditions or consequences:

> *Sometimes I get the idea that first something is done, and afterward we think about it. And that can be very frustrating on the work floor. Especially because there are so*

many changes (…) without stopping and thinking about this and what is necessary. (Round 2 interview with support worker)

When I look at the work floor, I think we could have done much better by paying more attention to those people, but that just didn't happen at that time. (…) I think the work floor has stayed behind when you look at our ambitions. Because we didn't engage them enough and also because we left things open-ended. We asked a lot of them, but also gave them every room to take a different approach. (Round 1 interview with manager support staff)

There was a distinct gap between employees/teams and the staff and management developing new organizational and strategic policies. The general feeling that the organization repeatedly acted in the fashion of "doing first, thinking later" lead to incomprehension amongst employees and created stress and sometimes anger. Respondents identify a recurring pattern in these experiences caused by "acting without thinking about requirements or consequences". In the years following this transformative period this theme would surface again repeatedly.

6.4.4 Adaptive period

Following the transformational years two different periods of adaption are identified:

I) *Perspective:* From late 2015 through 2017 there were no large scale changes and new hope and perspective was emerging as to what kind of organization CASE could be. The vision for the future of the organization was able to develop. New initiatives were started and a new branding (*Realizing Possibilities*) was developed.

This was the phase of emerging consciousness, of 'we are capable'. At a certain point there was the development of a kind of pride, reflected in the idea of Realizing Possibilities. (…) At this time, you can see the development of the participation- and education center and people asking or suggesting ideas for organization of activities for clients. So, people developed a certain pride of we can really make a change. (Round 2 interview with regional manager)

II) *Dissonance:* Since 2017, the second adaptive period is recognizable in which dissonance becomes more prominent as every day practices are not felt to be congruent with the new branding:

I realized that it looked better on paper than in practice. So, the ideas were well written down, the vision, the why do we do the things we do. But everyday practice did not seem to fit with that. (…) People were confused. Just no idea, what are we going to do,

> *left or right? (…) It seemed as if a lot of employees in those teams just didn't have any knowledge*. (Round 2 interview with former regional manager)

The experienced dissonance becomes more pronounced as the effects of new policy become noticeable e.g., in the form of new client types and a more business-like approach to work efficiency. Not knowing what is expected of them causes stress among employees.

> *With the self-organizing teams, we were expected to perform additional tasks for which I wasn't qualified, such as writing reports, using and teaching new digital programs. (…) We were expected to work and report differently, but without guidance, direction or training. This was awful. It caused a lot of stress for many people, certainly for me.* (Round 2 interview with support worker)

In some parts of the organization employees experienced multiple changes in management. One respondent illustrates how this added to the experienced stress:

> *At location [X] we had three new managers in three years. And they all have their way of…you know, it's fine…if you're pushed a bit in a certain way. But once you're going in that direction then another manager comes and wants it a different way. That asks a lot of you. (…) Here we go again, what is expected of me this time?* (Round 2 interview with support worker)

During the adaptive period CASE has seen a large turnover in personnel (up to 20% a year). In part, this turnover was due to the experienced demands placed on employees while they did not feel adequately equipped to realize these demands (e.g., supporting new types of clients with more severe problems), thus feeling continuous stress. Also, this was in part due to a felt lack of support from the organizational structure resulting from the self-organizing teams. The voice of these employees became heard through the exit-interviews. Though not part of this research it is probable that this high turnover rate in both personnel and management was not conducive to the change process and painful experiences were not discussed. The adaptive period was still recognizable at the end of this research in early 2020. The Covid-pandemic has brought its own dynamic to CASE and signals a new period outside of the span of this study.

6.4.5 Summary of findings

The three identified periods are summarized in the findings in table 6.1 and are identified by specific characteristics of culture, structure and practices. The use of time periods is a way of distinguishing specific characteristics in both external and internal dynamics.

We do not mean to imply a linear process or a 'before' and 'after', but rather aim to clarify different dynamics and characteristics at certain time periods.

6.5 Conceptualizing Transition Pains

6.5.1 Pain as a metaphor

At the start of this research, we were not specifically looking for pain. However, after the first few orientational interviews, the concept of pain surfaced as a possible metaphor to encompass the myriad of symptoms we encountered as we investigated the experiences of different organizational members. In the previous section the quotes illustrate a frequent use of words like *stress, chaos, shock, frustration, worrying, confused* and strong emotional responses such as *experiencing something as awful or terrible* by respondents. Discussing the results of the interviews we developed the idea of using pain as an overarching metaphor to connect the individual experiences that could be labeled as painful. Researching pain and pain analogies we found that although pain is generally experienced as being unpleasant, it is also very useful as it has a signaling function and is inherently a call to action. In this paper, we focus on this more neutral signaling function of pain. Using the metaphor of pain (also labor pains or growing pains) is not uncommon in organizational literature (e.g., Abrahamson, 2000; Flamholtz & Randle, 2015), however, using pain discourse in relation to organizational practices is worth exploring further as it enriches the current discourse by adding an awareness of pain experience and its functions, thereby making pain more productive or functional (Goossens et al., 2021). In this way, we build on research and reviews (Kiefer, 2002; Klarner et al., 2011; Piderit, 2000) into the role of emotion in organizational change that challenges the negative connotation of emotion as the cause of problems or resistance to change "rather than an expression of the underlying difficulties" (Kiefer, 2002 p. 40). When viewing emotion (and pain) as being functional because of the signaling function, it isn't a problem that needs to be solved anymore.

	Critical period (2011-2012)	Transformative Period (2013-2014)	Adaptive period (2015-2019 and ongoing)
External environment	Long-term care regime	Preparation for change from long-term care regime to decentralized social domain regime with increasing financial risks	Social domain regime with crossovers to mental healthcare regime Participation society, stimulating independent living, community focus Decreasing labor market
Internal organization:			
Culture	Internal orientation Culture characterized as 'sick': too familiar, anarchy, unprofessional	Developing external orientation Culture characterized as ambitious, fast-moving, unsafe, prominent focus on client recovery	Balancing internal and external orientation Culture characterized as business-like, innovative, professional, inconsistent
Structure	Hierarchal layers Large support team	Self-organizing teams Small support team	Several adaptations to support primary teams (e.g., team coach)
Practices	Unqualified support workers Lack of guidance for support and recovery work (lots of drinking coffee, smoking and playing table tennis)	Vision and methodical guidance on client support through mandatory training programs	Discussions on quality of client support Increasing collaboration with other providers

Table 6.1 Summary of findings in terms over external developments and developing internal culture, structure and practices

6.5.2 Developing the language of transition pains

Pain is defined as an unpleasant sensory and emotional experience associated with actual or potential tissue damage, or described in terms of such damage (International Association for the Study of Pain, IASP). IASP adds that pain is always subjective and depends on individual interpretation and life experiences. Although this definition formulates pain as being negative, following Neilson (2016), we argue that pain is also useful in the sense that it serves a double purpose: it signals (potential) damage (warning) and forces meaningful behavior to deal with the pain (Van Cranenburgh, 2009).

This necessity to adapt (behavior to deal with pain) and the way we choose to respond in order to deal with discomfort makes 'pain' a useable analogy to explore what happens within organizations during the transition process. Using this analogy, we discern pain areas, type of pain, pain behavior, pain function and pain interventions. Table 6.2 provides some examples where we combine pain terminology with empirical findings to develop the concept of pain in organizational terms. The pain areas were identified during the empirical analysis and are mostly case specific (although general enough

to recognize in other settings). The type of pain, pain behavior and pain interventions come from (neuroscience) pain literature (Van Cranenburgh, 2009) that describes different manifestations of pain and how people react to pain in different ways, also depending on the intervention. The different pain functions were identified during the empirical analysis. In this way the pain vocabulary was developed in an iterative way by going back and forth between neuroscientific pain literature, our transition perspective in the context of organizational change and the empirical data.

If we take the IASP definition of pain and filter out the purely physical elements, the description of pain would be: an unpleasant emotional experience associated with actual of potential damage (or described in such terms). Excerpts from the interviews illustrate our interpretation of this experience of pain during the period of organizational alignment. Support workers generally spoke about their own experiences, management generally spoke more about what they observed among support workers.

Examples from the interviews that helped to build the pain vocabulary:

- *People were confused and lacked direction and self-confidence.*
- *I don't feel taken seriously.*
- *Our team leader was fired, he wasn't needed anymore and we had to figure everything out for ourselves. Literally. Oh, that was a terrible time.*
- *That was a very unpleasant experience for me.*
- *There was a lot unclear and that caused a lot of stress for many people.*
- *The new director retracted several decisions. That was a major relief for me.*
- *An increasing number of coworkers fall ill, are overworked or suffering from burnout. That was never the case in the past.*
- *The uncertainty caused a lot of tension for people, leading to unrest and tensions in the team as well as a lot of emotions.*
- *Contradictory policies cause a lot of frustration.*
- *There is no attention for how an individual is feeling.*
- *The expectations are high, that can make it difficult at times.*
- *After a certain point you experience a kind of fatigue for change.*

Pain areas	Type of pain	Pain behavior	Pain function	Pain interventions
Clients	Acute/ chronic	Coping	Warning	Suppression
Employees	Feverish	Catastrophizing	Call to action	Distraction
Strategy	Diffuse/ local	Lethargic	Processing	Change of position
Policy	Shock	Anger/ frustration	Movement	Reorganization
Quality	Stress	Acceptance	Recovery	Trying alternatives
Finance	Grief/ loss	Ignoring/ blocking	Realignment	Relaxation
Cohesion	Abrasive	Changing focus		Community support
Innovation				
Development				
Culture				

Table 6.2 Dimensions of pain in organizational terms

Based on our empirical findings, and our exploration of a pain discourse in organizational terms, we developed the following conceptualization of transition pains:
Pain experienced by organizational members related to processes of change in the context of disruptive external change (i.e., transition).

Transition pains can thus be recognized in terms of anxiety, grief, tension or stress. These types of reactions signal an underlying issue to be addressed. In our research we have found that the underlying issue is most often related to organizational members experiencing a sense of dissonance. During the process of realignment, transition pains are a signal that organizational members are experiencing confusion, stress or loss. Based on the empirical findings we developed a further illustration of our conceptualization of transition pains (table 6.3).

In section 2 we have proposed that the concept of strategic dissonance brings together the transition perspective (forcing strategic (re)action from incumbents) with the concept of cognitive dissonance in the experiences of organizational members who feel discomfort or are confused by discrepancies between presented organizational strategy and the daily action that is required of them. We view transition pains as the specific effect of experienced dissonance among organizational members following the organizational dynamics of realignment with a changing external environment. The pain analogy made it possible to identify these dimensions of pain in the research material. In this way, the pain analogy provides language to discuss 'what goes on' within an organization realigning itself to a changing context.

	Critical period (2011-2012)	Transformative Period (2013-2014)	Adaptive period (2015-2019 and ongoing)
Pain areas	Lack of development Anarchy/ non-committal Unprofessional Finances Lack of cohesion	Lack of employee support Development in high speed Operational rather than strategic Chaos	Inconsistency Development in high speed Instability through changes in personnel and leadership Lack of control over processes
Type of pain	Tension Diffuse	Shock/ stress Grief/ loss	Stress (continuous) Often localized
Pain behavior	Anger/ frustration	Acceptance or walking away (ignoring/ blocking) Changing focus	Divergent: coping, but also catastrophizing
Pain function	Warning/ call to action	Processing/ realignment	Movement/ recovery
Pain interventions used	Radical change program, including change in leadership	Innovation, positivity (new branding)	Developing support structure and building communities

Table 6.3 Illustration of transition pains at CASE

6.6 Exploring the relation between dissonance and transition pain

In section 4 we described the experiences of organizational members during a change process (in the context of transition). In section 5 we conceptualized these experiences as transition pain following a sense of dissonance. Respondents have identified a number of situations that cause dissonance. In these situations, organizational members experience a discrepancy between policy and practice. Table 6.4 illustrates some examples of these discrepancies using the distinction by Clay-Williams et al. (2015) between work-as-imagined and work-as-done. In practice, people may experience something very different from the advocated policies. Repeated experiences of such lack of congruence or contradiction can build the pain symptoms such as frustration or uncertainty.

An important source of dissonance seems to be a lack of information needed to attribute meaning to changes or choices made (sensemaking); to bridge the gap as it were. At CASE, the organizational structure of self-organization was chosen and rapidly implemented, but without developing an alternative supporting structure to replace the old one. Job design in relation to the psychological climate (Karanika-Murray et al., 2017) was neglected. The experienced chaos still has its effect on long-term organizational members who feel the ensuing gap was never properly addressed and therefore still causes (the same) problems with every new policy that has followed. Confrontation, avoidance and/ or leaving the organization are regular occurrences as employees experience a lack of support, information and connection to work practices.

Policy (work-as-imagined)	≠	Practice (work-as-done)
Self-organization as the main organizational philosophy.		Employees experience that a great number of decisions are still being made top-down.
Vision and guidelines towards method of client support (including training for all new employees).		Training principles and guidelines are not followed in practice (lack of implementation and monitoring) which does not support the intended practice.
Recruitment based on core values and branding.		New employees don't recognize the presented values when they start work (their expectations are not met).
Clear policy and guidelines.		In practice different meanings are attributed to the same policy by different people.
Self-organization stimulates individual leadership.		Individual leadership is not always accepted because of the importance attributed to equality in self-organization.
All employees need to be reachable and connected to the Internet, therefore mobile phones are provided.		Mobile phones are deemed unnecessary by employees and are not switched on. Costs for phones are not understood by employees in relation to other cutbacks in costs that affect client support.
Client support is focused on rehabilitation and developing self-supportive skills. Company cars will therefore be terminated.		Clients are not self-supportive enough to visit the doctor or social services on their own. Because of efficiency, there is less personnel available and no time to accompany the client on public transportation.

Table 6.4 Examples of experienced dissonance when policy and practice don't match

The experienced dissonance is reflected in pain symptoms such as stress, anxiety and tension. These symptoms can turn into behavior that reflects avoidance or resistance, but is not actually that. It is behavior that signals that people are looking for ways to deal with pain. Pain can be suffered, suppressed, avoided, addressed or even harnessed. For example, in our interviews the respondents regularly expressed cynicism towards organizational policies, especially if they experienced *multiple* occurrences of dissonance. Cynicism can also be interpreted as a reaction of someone who is tired and has little perspective of a better situation. Cynicism is a passive way of dealing with pain (suffering) as is ignoring or avoiding organization information. We also found active ways of dealing with pain such as debating strategy and policy (addressing the pain, searching for meaning) or making suggestions, creating work-arounds to policy or trying to leave the pain behind by moving to another team or leaving the organization. In this way, organizational members try to deal with pain by coping, ignoring, avoiding, battling, or turning their focus and attention to other things. This goes for employees as well as management. New managers also struggled with the incongruences between strategy, policy and practice and were not always able to support employees because of their own sense of dissonance.

6.7 Implications for theory and practice

6.7.1 Theory

The findings and conceptualization of transition pains enrich the vocabulary for studying organizational dynamics that play out in incumbent organizations in transitional environments. We hypothesized that realignment of an incumbent organization in a transforming environment requires a transition at the organizational level. This research has deepened the understanding of what happens to organizational members within organizations trying to realign themselves to a changing context while simultaneously dealing with internal dynamics. The dissonance-lens that has informed our conceptualization of transition pains, provides insights for transition dynamics at the organizational level that builds on the theoretical model of change dynamics in transitions (Loorbach et al., 2017). Specifically, the 'messy and chaotic middle' where the related patterns of build-up and break-down meet can be unraveled a little further with the vocabulary developed in this paper. Introducing concepts such as dissonance, incongruence and paradox, seems to adequately give words to experiences of people experiencing systems or organizations in transition. Although not specifically part of this research, we expect that the concept of transition pains can be applied and further added to when studying frontrunners and/or niches in addition to incumbents.

This study has emphasized that it is very rarely resistance to change, or lack of understanding of the need for change, but more likely a lack of support to deal with change. In this way the vocabulary of dissonance and pain adds to the cause for retiring resistance to change. This lens can inform the development of tools and education for reflexive monitoring (Van Mierlo & Beers, 2020).

6.7.2 Practice

The pain discourse can be used by (change) practitioners to address experiences of organizational members during the change process, without necessarily focusing on eliminating the pain. Viewing pain symptoms as a response e.g., to experienced dissonance, the underlying discrepancy can be addressed. Recognizing these signals provides the opportunity to address these experiences timely.

The pain metaphor helps to better understand the struggle that organizational members can experience and the different ways in which they look to deal with pain. This increases our understanding of responses to organizational change. Our research indicates that dissonance is often not recognized as the source of pain and thus action is not taken to reduce the dissonance. However, in the context of transition and disruptive external changes, and not forgetting normal human behavior of trial and error, dissonance is

always likely to arise at some point. We did find that two elements are helpful for organizational members to reduce the experience of dissonance and lessen the pain. A main point made by respondents was the importance of a sense of purpose, both individual (in this case supporting rehabilitation of clients) and knowing the "why" behind policy. A sense of hope and perspective helped respondents deal with the dissonance. A second point we found was a need for some kind of support e.g., people pulling the wagon to show the way, connecting with policy makers to help understand policy, dialogue with colleagues on the design of the work process and presence of management close by. Burgelman & Grove (1996) describe the importance of a confrontational/ collegial culture that encourages debate and allows dissent and unanticipated invention. In this way, transition pains signal that dialogue is necessary that helps to discuss purpose of or reasons for change and expectations, exchange information and provide the opportunity to voice ideas about work improvement.

Although not explicitly mentioned by respondents, we do propose that it also helps to simply acknowledge the pain and show empathy as manager, change practitioner or colleague. Kanov et al. (2004) describe the use of compassion in response to suffering and how compassion is a capacity that can be developed at the organizational level as a collective response. Through values, practices and routines it is possible to develop the capacity for noticing pain and responding in support. For transition pains to be helpful in any process, they first have to be noticed and recognized as a signal. Following Kanov, practitioners could focus on developing the capacity for recognizing transition pains as signs of experienced dissonance and create room for these experiences, both in dialogue and in support.

6.8 Discussion and conclusion

This case study has explored organizational attempts to align with a transforming context. The research illustrates how dealing with the tensions created by a disruptively changing context in turn creates tensions within organizations as organizational members are confronted with changes resulting from adjustments in strategy, policy or structure while still operating based on a different dominant logic. We have conceptualized the identified tensions as transition pains stemming from experienced dissonance. The pain metaphor has proven useful as it encases a variety of symptoms that stem from these tensions (e.g., anxiety, frustration, stress) and illustrates the way individuals experience change as pain. The pain metaphor allows for differences in individual responses, similar to each individual dealing with pain in his or her own way. Specifically, the pain metaphor allows for feelings of loss that are inherent to change. The pain metaphor has also been helpful in describing the specific characteristics of the tensions in the different

time periods. In this way, the pain discourse can be used to signal phases with different characteristics as well as individual experiences.

The theoretical lens of dissonance has been helpful to reflect on the more intangible and emotional side of what happens in a process of realignment and specifically, how the gaps between policy and practice cause the tensions that organizational members experience. The concept of dissonance made it possible to investigate the pain and confusion felt by organizational members and shows the need for compassion, a support structure (information, meaning, nearness of leadership, feeling equipped to work) and room for debate to help deal with inconsistencies that arise. This case has emphasized that it is very rarely resistance to change, or lack of understanding of the need for change, but more likely a lack of support to deal with change.

Known remedies to lessen organizational pain include discussions on improving information and communication, clarifying responsibilities related to organizational structure and designing or improving procedures. This type of remedies seems to be based on the need or want to lessen the insecurity or uncertainty that is often the base for tension. In a way they try to compensate for a sense of loss. The disruptive changes in society indicate that 'old' or 'known' solutions may not be adequate. From a transition perspective, we understand the tensions that are manifest within an organization trying to realign itself with a changing context as the result of a battle between the old, almost redundant, system and the new, but not fully materialized, way of doing things. This case study supports the idea that there is need for new remedies (such as capacity for compassion) and to anticipate rather than react to transition pains with old remedies of suppression or contention. From the perspective of transition, change and adaption is continuous. Thus, the question is not how to eliminate tensions but how to learn to live and deal with them. In this way, change could be approached as an opportunity to learn and develop healthy adaptive practices within organizations: by anticipating change, involving people at an early stage, building capacity for compassion, accepting the existence of dissonance, allowing dissent and thus creating enough reflexivity to make change less painful.

7

Conclusions and recommendations: towards Healthy Care

CHAPTER 7 CONCLUSIONS AND RECOMMENDATIONS: TOWARDS HEALTHY CARE

7.1 Recap of this thesis research

With this thesis research I set out to explore transition dynamics in the Dutch healthcare sector, with a specific interest in alternatives that develop based on an idea of sustainable healthcare. These alternatives were sometimes hard to find when I started my research in 2014, but now, in 2023, sustainability has become very fashionable in healthcare and an increase in sustainable alternatives can be detected. Simultaneously, broad discussions have emerged around possible futures of Dutch healthcare, leaving one slightly dizzy while studying the similarities and differences between sustainable care (*duurzame zorg)*, tenable care *(houdbare zorg)*, fitting or appropriate care *(passende zorg)*, future-proof care *(toekomstbestendige zorg)*, or even healthy care (*gezonde zorg*) and green care (*groene zorg)*. This maze of different ways to discuss concerns ánd possible solution pathways for the future of healthcare makes for an interesting backdrop to study how the concept of sustainability gains meaning and significance and how to understand these transition dynamics in Dutch healthcare.

7

This explorative study makes a substantial contribution to mapping the developing transition in the Dutch healthcare system over the course of almost a decade. The exploration of persistent problems, the experienced tensions, the dominant paradigm and way of doing things as well as possible solution pathways all contribute to the conceptualization of sustainable healthcare as *Healthy Care*[8]. *Healthy Care* connects the different perspectives on sustainable healthcare (social, environmental and tenable) through the health paradigm. With *Healthy Care* as a guiding perspective, the lessons learned from the case studies may serve as inspiration for practitioners and, for scholars, adds to a better understanding of sustainability transitions from a socio-institutional perspective. Before synthesizing the research findings, the cases are briefly reintroduced.

Chapter 3 highlights the effort of the Dutch Corporate Social Responsibility (CSR) Network for Sustainable Healthcare to create a group of frontrunners under healthcare providers such as hospitals and long-term care organizations. This 'expedition' was an early exploration of how sustainability could be (broadly) interpreted in healthcare and of what a transition could look like. Although the expedition in itself was well received, ultimately, the initiating CSR network lacked the backing of system players at the time and could not develop a sufficiently strong sense of urgency to persuade

8 In Dutch: Gezonde Zorg as conceptualized in the Integral Care Agreement (Integraal Zorg Akkoord, 2022).

enough healthcare providers and other institutions to get involved. From a transition point of view the expedition did not fully touch on persistent problems and unsustainability of the system as introduced in chapters 1 and 2. It did however bring an inspiring and broad view on sustainable healthcare to the participants, developing a common discourse and introducing alternatives such as Positive Health. Overall, the expedition brought together knowledge and inspiration for those who were already predisposed towards the idea of sustainable healthcare, but at the time was not able to create the envisioned movement of frontrunners.

Chapters 4 and 5 show alternative practices in which transformative agency plays an important strategic role in the scaling-up process. These two alternatives to the regime developed in a relatively short period (both in approximately 10 years) and challenge(d) the status quo of the system. Chapter 4 presents the strategies that underpinned the rise of Buurtzorg (Neighborhood Care), building on and expanding the model of Deepening, Broadening and Scaling up (Van den Bosch, 2010). This case study identifies how Buurtzorg became a symbol of a transformative movement, representing a new standard and a new paradigm by choosing a new organizational model and promoting self-organization. Chapter 5 demonstrates how Positive Health has been influential in supporting the development of a new paradigm in healthcare by introducing a new concept for health and with that, new discourse (language, symbols and practices). An important factor in the rise of both Buurtzorg and Positive Health was the fact that they were 'new' organizations (outsiders to the regime) and as such had the freedom to develop as entrepreneurs: outside the regime and not 'burdened' by dominant culture, structures and practices. Other similarities include: a strong leading figure with a personal story, making good use of windows of opportunity and actively building a network that includes influential regime players such as government and insurance companies. These two cases illustrate influential transformative practices that support a transition in Dutch healthcare. Interestingly enough, Buurtzorg and Positive Health are both frequently identified as examples of (contributing to) sustainable healthcare even though they do not primarily present themselves as such.

In chapter 6, the fourth case gives voice to healthcare workers employed by a change-minded incumbent healthcare organization. Within this incumbent organization, the necessity to realign strategy, policy and work organization with a dynamically changing context creates tension and stress in the adaptation process. The struggles and effects on the people in the organization are illustrated using the concept of transition pains to describe the experiences of dissonance that people can have and how they respond to these discrepancies between strategy, policy and work routines. When the voiced strategy is not translated to congruent work policies or when employees experience

discrepancies in the day-to-day choices that are made but not easily explained, this case study shows in how organizational members view the process and label their experiences. This can be identified as pain symptoms. The chapter further conceptualizes transition pains.

These four cases give insight into several change dynamics in the context of a disruptive external environment that is identified in the Dutch healthcare domain. The transition perspective that these four cases bring is helpful in investigating the research questions:

How does sustainability develop meaning and significance in Dutch healthcare?

> *How can meaning-making towards sustainable healthcare be understood in terms of (changing) culture, structure and practices?*
>
> *How can an increase in significance of sustainable healthcare be understood in terms of transformative agency?*

In this final chapter, I first revisit the transition dynamics in the Dutch healthcare system to identify the phases of transition. I then further introduce my conceptualization of sustainable healthcare as *Healthy Care*, building on the research outcomes that focus on sensemaking. The next section synthesizes the research results on transformative agency and the insights for transition governance. This chapter closes with theoretical and practical implications of this research and recommendations for further research.

7.2 The healthcare system in transition?

In several of the empirical chapters the following question is posited: is the healthcare system in transition? The tensions felt within the Dutch healthcare system, described in chapter 1 and in several of the case studies, are indicative of the (felt) *un*sustainability in the system. These signal a transition in the sense that there is a growing shared view that the healthcare system cannot continue to develop in the same direction. Identifying the unsustainability creates space for envisioning alternative futures and designs for health and healthcare systems. The discursive diversity in labeling alternatives indicates a destabilizing context and a future direction not yet clear. The case studies in this research illustrate how alternatives can evolve in practice and in the interaction between policy and practice in niche-regime interaction.

According to policymakers the Dutch healthcare system is in transition. Transition and transformation have become part of the policy discourse. Fundamental change is seen as necessary although the lenses used to identify the problem(s) and a direction for

solutions may differ. Within this context there are several different perspectives on sustainable healthcare, as highlighted in chapter 1. Figure 7.1 illustrates how a different lens may point to different alternative futures. If one sees scarcity in resources or personnel as the main issue and driver for transition (top half of figure 1), a different approach is probably taken to change the dominant culture, structure and practices then if one sees climate change as the main driver for transition (bottom half of figure 7.1). With scarcity as main driver for transition, a paradigm shift towards health leads to alternatives focused on prevention, lifestyle and shifting care away from the hospital. With climate change as main driver for transition, the emphasis is on reducing the footprint of healthcare and the burden of disease. These two examples developed from the case studies and the orientation in chapter 1 show how different landscape developments make for different starting points and a different narrative.

These narratives or storylines are not incompatible, but have a very different point of origin that make an integral approach to sustainable healthcare challenging. Certainly, overlap between these examples/ elaborations in figure 7.1 can be found, e.g., in the concept of a healing environment that addresses both the well-being paradigm and creating 'green' hospitals.

It fits within the broader view of transitions that initially in a context without much external pressures and internal crises, innovation will mainly serve to optimize the status quo or happens at the fringes in niches. Over time however as these dynamics evolve, transitions occur as outcome of patterns of build-up and break-down as visualized in the X-curve. Although certainly not a linear process, identifying phases in transitions is helpful to develop a shared understanding of developments in a societal (sub)domain and options for governance strategies. In Dutch healthcare, the highly increased use of transition terminology in both policy and practice indicates that the primary dynamics of optimization and experimentation have been surpassed and that improvement of the existing way of doing things is generally not accepted as the best way to go. However, a developing discourse because policymakers have adopted the word 'transition', is not a guarantee for actual transition.

Actors within the Dutch healthcare system are seeking for alternatives and patterns of destabilization and acceleration can be recognized in many subdomains as networks and coalitions of change-minded regime-actors, incumbents and niche-players are formed, transition agendas are developed and societal dialogue is developing. The phase of chaos and emergence seems, for the most part, yet to come, as dominant structures, patterns and routines are still in place. Toch et al. (2022) formulate it as standing at crossroads with many possible directions. Where we have reached a tipping point,

but the playing field is still wide open and actors have to choose which way to go, what to keep, what to rearrange and what to let go of. In my opinion, this perfectly illustrates the current sentiment in Dutch healthcare and the different possible (joint) directions illustrated in figure 7.1, as we move into the 'messy middle' of the X-curve.

Scarcity as main driver for transition			
Macro-level (landscape)	Demographic developments: ageing of the population and decreasing work force (scarcity of personnel) Necessitates containing demand for care (costs and accessibility)		
Meso-level (regime)	*Dominant way of thinking, organizing and doing*		
		From:	To:
	Culture	Medical 'repair' paradigm Diagnosing and prescribing treatment	Health paradigm Shared decision-making
	Structure	Fee-per-treatment Compartmentalization Exclusively medical curriculum Hierarchical relations/ top-down	Population-based financing Interdisciplinary approach Broad curriculum covering lifestyle, prevention, the social domain Self-organizing teams
	Practices	Fragmentation of care tasks Referring to care-receivers as patients	Integration of care tasks Referring to care-receivers as civilians
Micro-level (niche)	Alternatives: Positive Health: finding solutions to medical questions in other domains through a different consultation style E-health: treatment and care using telemonitoring, digital solutions such as apps and virtual reality		
Climate change as main driver for transition			
Macro-level (landscape)	Global development: climate-change Necessitates 'greening' of healthcare delivery		
Meso-level (regime)	*Dominant way of thinking, organizing and doing*		
		From:	To:
	Culture	Safety-paradigm (use of disposables to eliminate risk of infection)	Balancing risk and footprint
	Structure	No governance or regulative structure for supporting green healthcare	Sustainable procurement Design and decision making based on the R-ladder
	Practices	No priority given to reducing environmental footprint through food Use of disposable materials during operations Pollution through travel movements	Meatless Monday in hospital restaurant and challenging snack machines Reducing the number of used materials in the OR Telemonitoring and e-health solutions
Micro-level (niche)	Alternatives[1]: Pharmafilter (technological solutions for a cleaner environment, e.g., waste disposal)		

Figure 7.1 Different elaborations of sustainable healthcare building on the Multi-Level Perspective (Geels, 2002; Geels & Schot, 2010) and clovermodel of culture, structure, practices (Frantzeskaki & De Haan, 2009).

9 In this research, alternatives were mainly found and at the practice level, but did not necessarily encompass a different culture and structure. At the time of finishing this thesis, more fundamental alternatives

The phase of chaos and emergence can bring inertia and raise counter forces as interests of (regime) players are at stake and a common direction is unclear. Incumbent culture, structures and practices may be challenged by different actors making use of opportunities that arise in the chaos. These may also include 'unwanted' actors and developments such as the take-over of healthcare provision by private equity companies, resulting in basic healthcare values being compromised (e.g., accessibility).

7.3 Sustainability in healthcare: gaining meaning and significance

In this section, the main perspectives on sustainable healthcare are recapped and related to the empirical research as a preliminary to the main conceptualization of sustainable healthcare in the next section.

7.3.1 Tenability of healthcare as a system

'Sustainability' of the health care system concerns the question whether and how health care can still be provided in an affordable, accessible and qualitative way in the long-term future. As illustrated in the opening chapter, although health is seen as an important value, recent Dutch policy discourse reveals that the rising costs of healthcare created by demand from an unhealthy population cause an unsustainable situation. This policy discourse emphasizes that a decrease in demand for healthcare following changes in lifestyle, early detection, healthy living conditions and environment and finding solutions for medical questions in other domains, can help to sustain the affordability of the Dutch healthcare system without compromising values of quality and accessibility. This requires both a mind shift in the general population towards a more frugal use of healthcare services and transferring budget to other domains that can support health and health demands such as education and living environments. Especially a more frugal use of healthcare services may prove a difficult barrier as long as the link between lifestyle, cost of disease and healthcare delivery and insurance premium remains indirect.

Essential in this perspective is the necessity to decrease demand as main pathway e.g., by restricting care or treatment that is not proven to be effective, by looking for solutions outside the medical and care domains, by investing in prevention, self-help and e-health and by decreasing costs throughout the system. This necessitates choosing which care and treatment is provided through insured care and which is not, always creating a bottle-neck as interests of actors in the system are inherently divergent.

---

are emerging e.g., PharmaSwap to save expensive medication being thrown out, intravenous alternative for extremely polluting anesthetic gasses.

Although the empirical research was not specifically focused towards the tenability of the healthcare system, the cases show that several measures are experimented with to reduce overhead costs in order to pool resources around care delivery. Buurtzorg (chapter 4) is a main example of this as they introduced a radically new organizational model, reducing overhead by working with self-organizing teams and a digital platform, integrating care and building communities of care while enhancing the healthcare profession. Buurtzorg questioned the production-drive in Dutch healthcare and criticized the single-minded economic focus and the dominant financial way of thinking over making and keeping people healthy. CASE (chapter 6) was one of the many healthcare providers that followed the Buurtzorg example and introduced self-organizing teams, primarily as a measure to economize and radically break with an unhealthy organizational culture, although an accompanying vision on client support and professional workmanship was presented.[10]

7.3.2 Social and human-oriented care

Another main perspective on sustainable healthcare is focused on health and well-begin as main paradigm, and sustaining the delivery of healthcare in a humane fashion. This perspective is primarily focused on the people in the system as main actors.

Sustaining health extends to creating a healthy workplace for both healthcare workers and healthy work environments for other working populations as well as providing naturing and healing environments in general, but specifically in healthcare institutions such as hospitals. Supporting the health of individuals, whether patients, clients, visitors or workers improves the vitality and employability of the population. From the perspective of sustainability in delivering healthcare, health of the population is essential in case of staff shortages, very present currently in Dutch healthcare. Simultaneously, in the Dutch healthcare field there is a growing work pressure and general dissatisfaction amongst staff, e.g., hospital personnel on strike for better wages and less work pressure, in particular considering the efforts made by healthcare workers during the Covid-19 pandemic. The dissatisfaction of healthcare workers emphasizes that the policy discourse on sustainable healthcare that includes support of the workforce, at this point mostly consists of words and not yet specific actions. The shortage of labor with the same demand for care increases work pressure for healthcare workers and in turn increasing absence due to sickness. This negative cycle calls for a reorientation on maintaining and improving a healthy and inviting work environment in healthcare. This has been made a main point in the Integral Care Agreement (2022) emphasizing how currently 1 in 6 employees in the Netherlands are working in healthcare. Increasing the

10 CASE has since reversed the model of self-organization and reinstated mid-levelmanagement.

labor force in healthcare is not feasible, it will be a large enough challenge to maintain the current labor force.

This current dissatisfaction among healthcare workers appears recurrent of the dissonance explored in the empirical research at CASE (chapter 6) and the identification of transition pain. This case emphasized the importance of sense-making as well as support, guidance and compassion for organizational members in dealing with transitional periods.

Chapter 5 addressed the rise of Positive Health as example of a discursive shift from the medical-oriented illness and disease paradigm to one where health and well-being are central. This suggested paradigm shift was also seen in the other cases: Buurtzorg, Expedition to Sustainable Healthcare and CASE. Positive Health illustrates a paradigm for sustainable healthcare as focused on health and well-being from the perspective of resilience and adaptation as opposed to repair. Fundamentally transforming healthcare based on a new paradigm that builds on health instead of sickness and on humanity instead of bureaucracy for now remains the domain of niches. Nevertheless, recent (popular) Dutch publications (notably Bijlsma & Van Beek, 2022) acknowledge this new paradigm and (in language at least) tie it together as sustainable healthcare.

7.3.3 Sustainability in healthcare: green care

The attention for reducing the environmental impact of healthcare in the Netherlands has been steadily increasing over the past decade. The Green Deal Sustainable Healthcare is on its third edition and has stimulated the development of strategic goals and environmental policy to reduce carbon footprint in healthcare organizations, supported by a government program. Sustainability in the meaning of attention for environmental impact has certainly seen a rise in importance, priority and popularity in Dutch healthcare, possibly aided by the visible and noticeable effects of the COVID-pandemic related to cleaner air, but also related to more visible waste due to the use of disposable materials. Sustainability in healthcare has been coined as Green Care, specifically by an alliance of (often young) healthcare professionals that combined their individual efforts towards sustainability in healthcare in the Green Care Alliance in March 2021.

Greening healthcare by applying sustainability measures such as energy reduction or waste recycling, can be seen as a narrow interpretation of sustainable healthcare but also as an easy and acceptable starting point. For example, although sustainability was approached from a broad perspective in the Expedition to Sustainable Healthcare (chapter 3) including subjects such as Positive Health, sustainable procurement and governance, many participants chose to focus on the environmental aspects. Possibly,

this was an easier way to start as sustainability measures are also taken by many people at home and recognizable in many aspects of daily life, e.g., increase of vegetarian diets, recycling, reducing use of energy and switching to natural energy sources. As such, sustainability in healthcare (or green care) can be taken up as a separate subject or policy, lacking integration with the main care policies. The evaluation report of the second Green Deal for Sustainable Healthcare (2022) pointed out that more attention could be paid to the interconnections between the demand for healthcare and sustainability measures: the health of people is related to the health of the planet, and decreasing the demand for health is necessary for affordable healthcare.

Planetary health and the effects of climate change on global health were not extensively explored in this study. The RIVM-report (Steenmeijer et al., 2022) calculating the environmental footprint of Dutch healthcare helped to create awareness of how climate change through increased greenhouse gas emissions causes air pollution and increases heat stress and longer hay fever seasons. Climate change influences global health and the nature of the need for care. Planetary health is still very much a developing area in Dutch healthcare.

7.3.4 Making sense of sustainability in healthcare

Transitions are a process of sense-making in society in which persistent problems are acknowledged and new practices, ideas and concepts gain meaning and significance. Chapter 3 provides an illustration of this process during the Expedition to Sustainable Healthcare. The expedition was an explorative journey in the sense that the participants, together with the expedition designers, searched for the meaning and form of the desired change labelled as sustainable healthcare. In this exploration they developed a shared discourse and the envisioning of alternative futures in healthcare. Each perspective on sustainable healthcare (chapter 1 and above) has its main ambassadors and supporters. For example, some studies and reports focus primarily on tenability of the healthcare system in terms of containing demand and cost in relation to a declining workforce (WRR, 2021). Other programs, studies and reports are explicitly ‘green’ in nature by focusing on the contribution of healthcare to climate-change and the need to address this unsustainability in the healthcare system (Green Deal Duurzame Zorg, 2022; RIVM, 2022). Perspectives are also combined, e.g., in the Framework Appropriate Care (ZIN, 2022) three societal challenges are identified and formulated as objectives: human-oriented, tenable and environmentally sustainable healthcare. With the Framework Appropriate Care, the government acknowledges the limits to growth within the Dutch healthcare system, both in containing demand and in reducing the environmental footprint. The health perspective as a paradigm is less prominent here.

The cases show that policymakers, in particular at the regime level at the ministry of Health, Welfare and Sports and at associated institutions, have integrated transition and transformation objectives into the policy discourse and through this developing discourse sustainability has gained significance and meaning. Starting as early as 2007 with the Transition Program for Long-term Care (chapter 4) and developing into a main perspective in 2022 with the Framework Appropriate Care and the Integral Care Agreement. Both sustainability in healthcare and the transition lens have increased considerably in meaning and significance in Dutch healthcare in the past 15-20 years. At the same time, inertia at the policy level goes hand in hand with regime actors protecting their interests and attempts to steer transition in their favor. A lack of clear direction for the future of Dutch healthcare may be the cause.

7.4 Conceptualizing sustainable healthcare as Healthy Care

The perspectives on sustainable healthcare combined, in essence are all about how we can ensure a healthy future for healthcare. Synthesizing the results from the orientation in chapter 1 and the insights from the empirical case studies, I propose that Healthy Care may function as a binding concept that connects the different perspectives. Healthy Care implies a health and care system based on supporting a healthy population and employees in a healthy environment that is affordable and accessible. Healthy Care builds on the health paradigm to bind the different perspectives together. The aim here is not to provide or suggest a specific definition, but to identify characteristics of Healthy

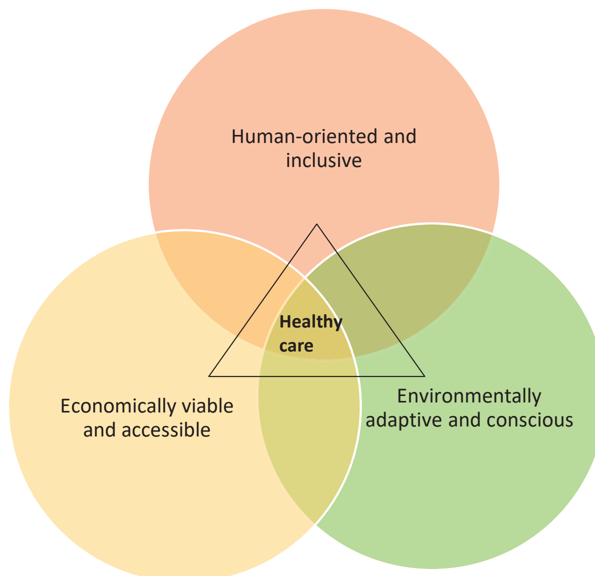


Figure 7.2 Visualization of Healthy Care

Care as interpretation of sustainable healthcare. Connecting with the Framework Appropriate Care and the Integral Care Agreement, and inspired by the Triple Bottom Line (Elkington, 1994), this conceptualization is visualized in figure 7.2.

Based on this study I propose that Healthy Care has the following characteristics:

- Health paradigm as starting point: health and well-being are central as well as an orientation on what makes and keeps us healthy. This includes what causes illness and disease and how to diagnose and treat this, but not necessarily as primary solution.
- Human-oriented and inclusive: compassionate, holistic and integrated care. This characteristic is community-oriented and also calls attention for a healthy and happy workplace for healthcare professionals and -workers;
- Environmentally adaptive and conscious: addresses the burden of disease and thus healthcare delivery that is environmentally focused on reducing environmental footprint and creating healthy and healing environments (nature positive);
- Economically viable and accessible: balancing supply and demand in a way that is financially affordable without compromising other values or domains and realistically dealing with scarcity.

Healthy Care also encompasses the fifth perspective introduced in chapter 1: the impact of climate change on global health. Although outside the scope of this research, the WHO One Health approach can be seen as congruent with this conceptualization of sustainable healthcare as Healthy Care. One Health is an integrated, unifying approach that aims to sustainably balance and optimize the health of people, animals and ecosystems (WHO, 2022).

Healthy Care suggests cultures, structures and practices that are designed to prevent disease and maintain health, healthy and healing environments, does not do harm to the health of people or the health of the planet and creates an inviting community for people to be a part of. In the first paragraph I stated that there is a significant difference between a system designed to improve and maintain health and crossing over into other domains to do so and a system dedicated to delivering care and treatment based on a medical 'repair' paradigm. Clearly a health(y care) system has multiple benefits over the current production- and repair-oriented healthcare system, yet also would imply deep institutional, structural and behavioral changes.

In some ways, this study has unintentionally been an exploration of this transition from a variety of angles: transition intervention, discourse, organizational change, and as a creator of disturbances, discussion and dialogue. The empirical cases in this study

each make contributions to the exploration and adoption of the health and well-being paradigm as an important foundation for a transition in Dutch healthcare. The empirical cases also share the challenge of (societal) embedding: the dominant 'repair' system is still omnipresent. Yet, in this thesis and through the empirical cases, it is also clear that there is strong drive behind a potential transition to Healthy Care. The next section explores this challenge by investigating the role of transformative agency in the empirical cases.

7.5 Transformative agency

Transition Management (Loorbach, 2007, 2014; Loorbach & Rotmans, 2009) is often misinterpreted as a directional model for managing a transition process. In practice, transition processes defy traditional or top-down management. More accurately, transitions are influenced by agency, but not managed as a whole as they develop non-linear and shock wise over a generation or more (Loorbach, 2014). Research into historical transitions and transition processes has offered ways of steering transitions and transition management may be interpreted as governance of transitions. Transition governance, therefore, is focused on identifying emerging alternatives that challenge the status quo, highlighting unsustainable practices, identifying windows of opportunity (Kingdon, 1995) and transition points or tipping points that can create space to accelerate transitions (Loorbach, 2014), supporting change networks to develop into advocacy coalitions and share all the lessons learned. With the case studies in this research, I was able to investigate the (not always deliberate) strategies to develop alternative practices in support of sustainable healthcare. The cases have shown several different elements that can be translated to general governance principles, mostly to give more attention to the 'softer' factors such as behavior, culture, personal change and routines (Loorbach, 2014). In this section I will discuss the main elements of transformative agency and governance that were found in the research: development of alternative practices, new common language, working with a coalition of the willing and doing, building support structures and niche-regime interaction.

7.5.1 Development of alternative practices

As the tension, stress and pressure (Frantzeskaki & De Haan, 2009) builds up in a system there is a natural development of alternatives in niches, as illustrated by Buurtzorg and Positive Health. While these niches developed independently, the impact of these alternative cultures and practices has been supportive of a transformative movement in healthcare by challenging the dominant way of thinking, doing and organizing. From a governance perspective, experimentation should be actively encouraged to allow for development of alternative practices. The 'safe' development of niches has been studied in socio-technical transitions and somewhat experimented with in Dutch long-term

healthcare with transition experiments in the Transition Program for Long-term Care (Van den Bosch, 2010). Room for experimentation and developing alternative practices requires space for developing new culture, structures and practices together and specifically for identifying system barriers and exploring how to turn these into opportunities. The direction of alternative practices is becoming clear: building on health, well-being, humanity, prevention, communities and reduction of medical intervention to realize economic durability, reduce environmental footprint and ensure (fair and equal) healthcare (for all) for future generations.

7.5.2 New common language

In chapter 5 we studied the development of new discourse: new language, new concepts, new practices, all signaling the strengthening of a new paradigm: from sickness (medical model) to health and well-being (biopsychosocial model). We studied the interaction between discourse and policy in the case of Positive Health and showed the iterative process that develops between discourse and policy: policy explicates how the language is changing, changing language reflects the transition, but can also push it forward. The common language provides common ground for practitioners and policy makers to do their own experimenting with new concepts and alternative practices, and at the same time adding to the discourse by sharing their experiences within a certain language frame. In the case of Positive Health, the early and active involvement of regime players, together with overlapping interests between niche and regime, are reflected in the new discourse and the way policy makers make use of this. The importance of common language to support a vision and new cultures, structures and practices was also emphasized as an important take-away from the Expedition for Sustainable healthcare (chapter 3). The evaluation report of the second Green Deal Sustainable Healthcare (2022) emphasized the importance of anchoring sustainability in the DNA of the healthcare regime and supporting this with a common language on all levels. At the same time, as introduced at the beginning of this chapter, a variety of concepts has been introduced that all relate in some fashion to sustainable healthcare. Bosman (2022) identified how discursive diversity leads to uncertainty for incumbents. The different perspectives and narratives introduced in this study may well cause a similar uncertainty for Dutch healthcare actors.

7.5.3 Working with a coalition of the willing and doing

The cases in chapters 3, 4 and 5 all emphasize the importance of working with a 'coalition of the willing' and searching out intrinsically motivated people to support an alternative way of doing things. These people become advocates and support a wider spreading of an alternative practice thus a coalition of the willing *and doing*. Based on this study, I argue that to develop a coalition of the willing and doing an inspiring figurehead,

with a personal story and the ability to tell this story, is extremely helpful. Governance activities can focus on identifying possible change agents that can serve as figureheads and support their storytelling if they are not yet (able or) doing this themselves. The examples of the rapid development of Buurtzorg and Positive Health highlight the important role of their respective charismatic leaders with storytelling abilities. Both leaders appear to function as boundary spanners or connectors between multiple social worlds, crossing boundaries and domains to invite other frontrunners to join the coalition and build communities of practice. However, relying solely on individual leaders will not be sufficient as a transition develops. Realizing change in culture, structure and practices requires efforts of many, not just of a few. A transition in Dutch healthcare will require a shift from personal leadership to collective leadership that engages with the regime (see also paragraph 7.5.5). This can also be described as shifting the attention from frontrunners to 'frontrunning' as a verb (Jhagroe & Van Steenbergen, 2014); an action that can be performed by any individual and in a coalition as a whole as a form of resisting dominant practices, experimenting with alternatives and engaging with the regime and the dominant discourse. This frontrunning can and needs to be done in all phases of transition and comes more to the forefront as the dominant regime starts to destabilize. Shifting the focus from frontrunners to frontrunning also enables a shift to dealing with transition pain (e.g., loss) and to actors who engage in frontrunning by supporting others in a transition.

7.5.4 Building support structures

In chapter 6 we demonstrated how transition pains come about and discussed the importance of a support structure for employees who are faced with organizational change. Specifically, following a change in context and therefore changing organizational strategy, policy and practices that do not match or make sense anymore as there are different dominant logics at work. From chapter 3 we can derive several elements for support structures: leadership, focused responsibility, developing a shared vision, transition pathways and evaluation/ learning. An important element of building a support structure is providing a common language that supports the narrative for change. Additionally, chapter 6 offers insights into necessary elements for a support structure consisting of information, sensemaking activities, nearness of leadership, frontrunners within an organization to help others, time to adapt and feeling equipped to work. This case also emphasizes the need for compassion and room for debate to help deal with inconsistencies that arise as well as participation in designing the support structure. This case has illustrated that it is very rarely resistance to change, or lack of understanding of the need for change, but more likely a lack of support to deal with change.

7.5.5 Niche-regime interaction

The study of transition pains illustrates the difference between the 'new kids on the block' (Buurtzorg and Positive Health), who have gathered a following of 'believers' and the challenges that incumbents face in making change manageable, even when they are willing to develop new culture, structure and practices. Actors that work on transforming culture, structures and practices have different hurdles to overcome, depending on the niche or regime context in which they operate. Outsiders to the regime and often newly formed organizations led by entrepreneurs are not burdened by existing culture, structure and practices. This enables strategies that make use of a certain countervailing power, a contrasting voice and discourse, and can fuel emerging alternative practices. Next to outsiders to the regime, who can help light the fire of transition by creating a sense of urgency through a different language, view and practice, an important role can be played by intrapreneurs able to stimulate niche-regime interaction. Intrapreneurs depart from the customary way of thinking, doing and organizing in existing organizations and can serve as boundary spanners with both niche- and regime players e.g., by building niche-regime networks. Connecting niches, incumbents and regime-actors is essential in supporting transition through the phase of chaos and emergence and forward to the phase of institutionalization of the emerging regime and break-down of practices that no longer serve this emerging regime. As an example, the design of the Expedition to Sustainable Healthcare (chapter 3) did not pay enough attention to the problem analysis of the unsustainability of the current system (the persistent problems) and was not able to realize many niche-regime connections to support the scaling up of experiments and breaking down of old pathways.

7.5.6 Taking transition in healthcare to the next phase

As the 'greening' of healthcare is taking a leap in The Netherlands, the question is how to build on this momentum and take this enthusiasm for 'classic' sustainability a step further in thinking, doing and organizing things differently in healthcare. Not only looking at possibilities for reducing the environmental impact of healthcare, but also how to reduce overconsumption in healthcare and reducing ones '(health)care footprint' e.g., by creating a type of (personal) circular economy of staying healthy to live longer without disease. All based on a new paradigm of health, prevention and well-being instead of sickness and curation.

Although the healthcare system is very complex in design and structure through its compartmentalization, a differentiation from other societal systems is often observed. This can be recognized both within the healthcare domain and in relation to other domains and governmental departments and ministries, e.g., urban planning & living environment, housing, economy and climate. This '*not my domain*' approach may prove an

important barrier when looking for sustainable solution pathways. However, the emerging healthcare regime shows much more openness to other domains, professions and a new generation of healthcare workers has been educated to apply border-crossing skills inside and outside the healthcare and social domains, building support communities around health and well-being. A first step has been taken as the ministers from several departments have signed the latest Green Deal Sustainable Healthcare (3.0, 2022) and thus acknowledge a common responsibility.

As illustrated by the X-curve, the development of new ways of thinking, doing and organizing needs to be accompanied by actions that phase-out or even demolish old cultures, structures and practices to make room for a new narrative and regime. This requires courage to do things differently. As signaled in the manifest of the Dutch CSR network (2014) and more recently in the report of the Taskforce De Juiste Zorg op de Juiste Plek (2018). From a governance perspective it can be helpful to create different spaces for experimentation with new culture, structures and practices, especially financial structures and support the translation and scaling up of lessons learned to mainstream level. This does need a long-term perspective which is a challenge as the Dutch political system at national level works primarily on a short-term basis. Additionally, this requires one or more regime players to be willing to decide on and voice unpopular policy that goes against the old regime, support other regime players and incumbent healthcare actors to develop new practices. The coming years will likely see further destabilization of the old regime, bringing chaos and disruption as well as uncertainty. As the contours of the emerging regime remain blurred at this point, setting up support systems for professionals, incumbent organizations and new-comers alike, to help navigate the storm will be vital. It is possible that the coming decade will see a reshaping of the healthcare domain and specifically the borders with other domains, including education and professions, financial structures, organizational models and healthcare interventions.

7.6 Implications & recommendations for theory, governance & policy and practice

In this section, I offer implications, recommendations and a research agenda that follow from this thesis study.

7.6.1 Implications for theory

In this research I have taken up the call for studying socio-economic/ socio-institutional transitions in addition to the available rich literature on socio-technical transitions and have thereby illustrated how these types of transitions (or these societal subsystems) are of equal importance and complexity (maybe even more so) and why this is a growing field of research. With this research I have added to the knowledge of the dynamics of

transition in (Dutch/ Western) healthcare, empirically illustrated several persistent problems and collected possible pathways and strategies, e.g., through studying frontrunner development, new organizational models and new discourse. This study has added empirical enrichment to the theory of transition management by exploring theoretical concepts (such as transition experiments, framework deepening, broadening, scaling up) in different practices and from different perspectives, specifically looking at the idea of fundamentally changing culture, structure and practices. A main theme in this thesis is the niche to mainstream development and alignment of alternatives with the regime. Specifically, I have looked at what strategies are applied and how this has (or has not) been supportive of the further development of alternatives in healthcare. By using this lens, concepts such as 'coalition of the willing', 'niche-entrepreneurs' and boundary work have come to the foreground. This study has strongly emphasized agency and the (different) actor-perspective(s) in transitions and brought the people in transitions more in the spotlight. Specifically, this study highlights the experience of both outsiders and incumbents, as well as third party organizations such as the Dutch CSR network for healthcare.

Through the research on transition pains we have also attended to the question of the distinction between how change management and transition studies look at context/ external environment for organizations as (non) disruptive. Dealing with the tensions created by a disruptively changing context in turn creates tensions within organizations as organizational members are confronted with changes resulting from adjustments in strategy, policy or structure while still operating based on a different dominant logic. This study has introduced the concept of transition pains to provide language for how incumbents, and specifically their organizational members, can experience this realignment of strategy, policy and practice and how experiences of dissonance influence perception and readiness for change. With this perspective I hope to have supported the growing group of authors who call for a retirement of 'resistance to change' (e.g., Burnes, 2015; Klarner et al., 2011; Piderit, 2000). Both the organizational level in transitions as well as further elaboration on the concept of transition pains are recommended areas for further research.

The cases in this study all look at the interaction between niche and regime from different perspectives. Specifically, this study has offered insights into discursive dynamics in niche-regime interactions. The cases show examples of using different narratives both countering the regime and of aligning with the narrative of the regime. Buurtzorg chose to use a narrative that problematizes the regime (although also in close contact with regime players at the time) and was very visible as a counter voice early in the transition, helping to create a sense of urgency for radical change. In the case of Positive Health,

we see alignment of the narrative with regime developments seeking to strengthen the relationship with the regime in a later phase of transition.

Specifically for healthcare, this research has explored the different meanings of sustainability in healthcare, brought together different viewpoints and attempted to map the field somewhat. Not with the aim of providing a definition, sustainability will always mean different things in different contexts and from different perspectives, but to support debate and a sense of direction. To build capacity to develop sustainable alternatives rather than working towards a specific result. With this, I have provided a better understanding of the difference between optimization and transformation in healthcare. With this thesis I hope to close the gap after earlier research by Van den Bosch (2010), Schuitmaker (2012), Essink (2013), Cramer (2014) and Van Raak (2016) into persistent problems, transition experiments and practicing transition policies in health systems and pave the way for others studying transitions in both the healthcare domain and social domain.

Although the aim was not to develop or provide a concrete definition of sustainable healthcare, in the course of this study the work of Joan Tronto on an Ethic of Care (1993) was brought to my attention. I am very taken with how her positioning and definition of care seem to fit perfectly with my conceptualization of sustainable healthcare – through a transition lens - as Healthy Care. Tronto posits that "The world will look different if we move care from its current peripheral location to a place near the center of human life. (…) We will need to rethink our conceptions of human nature to shift from the dilemma of autonomy or dependency to a more sophisticated sense of human interdependence." (p.101). She presents the following definition of caring: "*a species activity that includes everything that we do to maintain, continue, and repair our 'world' so that we can live in it as well as possible.* That world includes our bodies, ourselves, and our environment, all of which we seek to interweave in a complex, life-sustaining web." (p.103, referencing Fisher & Tronto, 1990). It would be interesting to make a further study of Tronto's arguments for an ethic of care and a caring democracy (Tronto, 2013) and its possible applications in the Dutch healthcare transition.

As the research concerning fundamental changes in the way of thinking about, organizing and practicing healthcare is scarce and optimization is still the name of the game, the field is wide open for follow-up research. It has been a decade since Schuitmaker's thesis on persistent problems in healthcare (2013) and it would be interesting to evaluate his analysis of persistent problems and possibly redefine them with the knowledge we have now, and using the new discourse that has become available to us through developing

alternatives and transition studies. And in this way, supporting further development of the transition discourse.

This research has focused on the destabilization of the regime and the development and acceleration of alternatives. In many earlier transition studies, the attention has gone to the (original) s-curve, studying niche-development from every possible angle. As a possible transition develops (and to support this development) the 'right hand' side of the X-curve becomes interesting, as well as the descending curve that represents the current regime. On the right side of the X-curve, I see opportunities for research concerning the role of incumbents in transition and follow-up research on what transition does to or for people in incumbent organizations and the role of sensemaking, investigating incumbents (both healthcare providers and regime players like insurance companies) who successfully implement alternatives (which we have seen is easier for newcomers) and the development of government steering policies. Additionally, the necessity for break-down or phase-out of current culture, structure and practices to make room for alternatives has been identified, but (in healthcare) hardly experimented with.

7.6.2 Implications for governance and policy

This thesis study aims to contribute to knowledge of governance to support the transition in Dutch healthcare. To this aim, we have analyzed several different transition interventions. The value of the Expedition to Sustainable Healthcare (chapter 3) as a transition instrument lies in the sharing of ideas about different futures in healthcare and stimulating a changing discourse. For similar interventions it is important to focus more on addressing the persistent problems and exploring the pathways that can lead to radical changes in the healthcare system. This case shows that 'classic' (environmental) sustainability is sufficiently institutionalized to be adopted in a rapid fashion in healthcare. Changing ways of thinking and doing in healthcare to break the pattern in persistent problems requires many more transition experiments such as this expedition and based more in niche-regime interaction. The transition in healthcare can be supported by a systematic development of expeditions where every expedition learns from the other ones to support the development of new pathways in the healthcare system as a whole. Further research into transition pathways could support healthcare organizations in translating visions of alternative futures in healthcare from a broad societal perspective to day-to-day culture, structure and practices that inspire and motivate healthcare professionals.

Based on the case study of Buurtzorg and other recent case studies that have applied the conceptual framework of deepening, broadening and scaling-up (Broerse & Grin, 2017) we illustrated that this framework could be used in practice-oriented research

to identify strategic activities for transition experiments. The framework can aid both researchers and practitioners who are involved in transition programs, experiments or innovation-projects that are aimed at surpassing the experimental phase. For entrepreneurs or project leaders of innovation projects it could be used as a heuristic tool to identify how the actors in their experiment(s) can strategically act to move from niche to mainstream. First experiences with applying this heuristic tool with practitioners (participants in circa 10 Masterclasses of the Transition Academy in the Netherlands) show that the framework inspired them to generate a high variety of new ideas on possible strategic activities to influence the regime. For policy makers and program managers who support transition experiments that have already started to develop (without initial support), the framework can be used to support their further development in terms of deepening, broadening and scaling-up. Based on the experiences in the Transition Program in Long-term Care, such support could include conducting supportive analyses and creating conditions to remove regime barriers, extending the links with regime players and connecting transition experiments to strategic activities in a 'transition arena' (Van den Bosch & Neuteboom, 2017).

Chapter 4 introduced an actor-perspective, characterizing Buurtzorg as a 'revolutionary entrepreneur' (Janssen & Moors, 2013) that applies strategies aimed at inducing system change directly. Our findings confirm the importance of this type of entrepreneurial orientation towards system change and positioning oneself as an 'outsider' to the existing healthcare regime to address persistent problems express an alternative vision on transforming the healthcare system. The strategic position of as an 'outsider' to the regime may create more room, or even freedom, to develop and scale up a radically new healthcare approach. According to Cramer (2014) the incumbent healthcare organizations in the Transition Program faced more restrictions when attempting to scale up their radically new practices. Our case study therefore suggests the importance of selecting transition experiments that are initiated by entrepreneurs instead of incumbent organizations. The case study of Buurtzorg has also led to an adjustment of the original conceptual framework of 'deepening, broadening and scaling up' transition experiments, emphasizing the non-linear character of the three strategies and the integrated use of different types of strategies at the same time. Based on this, we have identified key strategic activities for *niche-mainstreaming* that can be useful in a variety of domains.

In the synthesis on transformative agency (in section 7.5), I have touched on how figureheads from niche-actors and other actors engaged in frontrunning can function as boundary people. In chapter 5 we have hinted that Positive Health seems to function as boundary object (Star & Griesemer, 1989) and how this supports the seemingly easy adoption of Positive Health into regular policy. This idea developed during the research

and was not further elaborated on, however, further research into the possible role of boundary work (Gieryn 1983; Guston, 1999; Jasanoff, 1987, 1990) in governing transitions seems interesting. Especially as this seems to support a transition pathway with "little" disruption. Additionally, in further research boundary work can be linked to research on transformative agency.

For national policy development and positioning of regime players, it is important to realize that transitions take quite some time and effort to develop a shared problem definition, a sense of going in the same direction and especially identifying and breaking down or phasing out system barriers. To make the transition to Healthy Care will require more than a quick identification of promising new practices and expecting a rapid diffusion. Next to translating a new paradigm into new language, symbols and values, this requires a large investment in changing structures in healthcare such as financial arrangements and incentives that support prevention and healthy living, decreasing administrative control-procedures, developing digital health technologies, creating new curricula that incorporate Healthy Care and repositioning regime actors with an appropriate mandate to give direction to the emergence and institutionalization of a new way of thinking, doing and organizing as well as encourage societal and political dialogue on limiting the demand for care and what this means for all parties involved, from ministries to providers, suppliers and care receivers.

7.6.3 Implications for practice

Practice (through studying empirical cases) informs theory, but studying practice equally provides lessons for practice. The CSP framework in particular offers a practical 'translation' to develop a grip on the elements of transition dynamics that instigate or support alternatives in practice. The developing paradigm from sickness to health has powerful potential in my opinion. This research gives practitioners insight into what future healthcare may look like and bring back enthusiasm that may have been lost along the way. And possibly, also tempt young people towards a career in healthcare.

A main practical implication of this research is the use of strategies for niche-development and mainstreaming, using the framework for deepening, broadening and scaling-up. This framework, with the example of the Buurtzorg case study, is easy to use in different situations to evaluate your own different type of strategies. The case of Positive Health also looks at strategies, but from the perspective of different levels of engagement. Combined they offer a rich pallet of possible strategies. Additionally, this research has offered a discourse and advocated debate and compassion in organizations who are experiencing (or want to prevent) problems due to disruptive changes in the healthcare system.

This research has provided a range of ideas for incorporating Healthy Care into the own organization or practice, but also encouraging practitioners not to stop after integrating lifestyle into care interventions or 'greening' a hospital. Environmental sustainability in healthcare since 2013 is developing at high speed. At the time of writing this final chapter, not a day goes by without some type of news item that relates to the 'greening' of healthcare. On the other hand, this raises the question how susceptible healthcare is to 'greenwashing' that has developed in other domains e.g., business or the fashion industry. Our research from chapter 3 showed that healthcare providers, when asked, often see themselves as being inherently socially responsible. With the growing attention for sustainability in healthcare it is safe to assume that at some point regulation and control will increase, thus possibly encouraging 'greenwashing'. Future research can look into the form and frequency greenwashing takes in healthcare and barriers for actually implementing sustainability practices. This line of thought is equally applicable to the risk of 'transition washing'.

This research has emphasized the need for courage in the health(care) transition. Courage in niche-entrepreneurs to experiment with alternatives, incumbent directors as well as healthcare professionals, policy makers, but maybe most of all politicians, especially when it comes to making unpopular and controversial decisions. On the other hand, taking up a frontrunner position in bringing Healthy Care to the next phase of transition offers the opportunity to help shape healthy and healing environments, experiment with new forms of health and care, design new pathways and collaborations as well as new healthcare professions, attend to ecological challenges, phase out unhealthy policies and incentives, address system barriers and inspire a societal and political dialogue on Healthy Care practices.

7.7 Limitations of the study

By definition, societal transitions have long time-horizons. Transitions can only be determined by hindsight; thus, this thesis explores and reports on movements that may signal transition, but the current regime may also prove to be resilient and direct changes that are more consistent with optimization than transformation. Even though this research period spans almost a decade, the focus is on a transition in-the-making. A transition that may not even come to pass. The long time-horizon of transitions, together with the decade I've worked on this thesis, means part of the research may be slightly dated and day-to-day reality may be experienced quite differently now.

Being a transition researcher, often means researching something that has not yet (fully) emerged. This leads to transition research needing to be a sense-making, and sense-giving, process in its own right. With the choice of cases and perspectives, the research

findings and illustrations of transition movement(s) are constrained to these examples. The four cases together do not cover the entire field of Dutch healthcare. Nor do they do justice to all (transition) dynamics in the field as they mainly highlight alternatives interacting with the regime. These choices mean less attention is paid to barriers such as path dependency and lock-in.

Although transition studies are anchored in transdisciplinary approaches, this research may not fully do justice to insights from other fields (both academic and from practice). To keep focus, it was necessary to make certain choices to border the research, especially when engaging with theoretical fields of research that were largely unknown to me. Helpful insights can probably also be found when digging deeper into for instance complexity science, resilience thinking, organizational psychology, institutional theory and sustainability science.

The most challenging part of this research was giving words to the concept of transition pain and its relationship to dissonance. This may be related to the research being done at my own place of work at the time. Initially, CASE was similar to the other cases in seemingly being a frontrunner among incumbents. However, while doing the research, it was the pain felt by colleagues that was more present than the actual changes made. This changed the direction of the research. Additionally, the original plan was to perform more action-oriented research by introducing interventions in the organization (for which I had a good position to do so). However, I found this extremely difficult to instigate as day-to-day problems vied for attention (and later covid), management changed and organisational principles shifted.

In my day-to-day work mode, I unfortunately tend towards a linear way of thinking (let's make a plan, make a schematic) when thinking up solutions (and a hidden norm that there always has to be a solution). At the same time, my work experience has taught me that things usually don't go to plan and that it doesn't hurt if something is uncertain or uncomfortable as it can generate creative solutions or encourage debate, both we can learn from. In this research, this workstyle-dilemma is recognizable in my tendency towards 'managing' and accelerating transition ("how to") and looking for tangible pathways to realize this. Generally, working for regime actors and incumbent organizations, I have to be content with a slow, creeping revolution while conceptually working from the idea of a 'grand' transition.

7.8 Final remarks

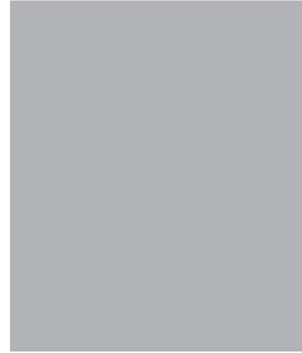
With this thesis study, I have had a front row seat to experience the acceleration of a transition in Dutch healthcare in the past 10 years. Learning and developing the idea

of Healthy Care, and the relevance of a (personal) transition in the way we perceive our health as well as our care system, has pointed me in the direction of health transitions, healthy cities (specifically Rotterdam) and healthy societies as a focus area for my own personal future work focus. An important realization here has been that health is mainly 'produced' or 'realized' outside of the healthcare system. Health is generated through education on healthy living, through healthy living environments that invite walking, cycling and exercise outside, through reducing health differences, through healthy work environments, and through reducing climate change and subsequent climate- and war-migration.

Following this line of thought, Healthy Care lacks a business case for most actors in the current system as health is free of (visible) cost when realized outside of the healthcare domain. While production of (medical) care and treatment 'cost' money and thus still provide a financial incentive to offer and optimize. Treating more people with less resources is the main goal for many sectors in healthcare. Really changing clinical and care practices and deep-rooted habits may prove the main challenge, although successful examples can be found here and there.

For me personally, a new paradigm based on health and healthy healing environments is extremely motivating. At the same time, this personal motivation and enthusiasm may have coloured my outlook in doing this research as well as in the tone of my findings and recommendations. Transition thinking has strongly influenced my path by showing me that, ultimately, it is not really about (environmental) sustainability (as a stand-alone goal) but about developing a new perspective on healthcare, based on sustainable values, and translating this into new supporting language, symbols, structures, financing and everyday practices to secure healthcare provision in the foreseeable future.

In the course of this research, I have been called both a pessimist and an optimist. And I probably have been both, depending on the context and my perspective at different times. This research has challenged me to step out of my day-to-day context, to zoom in and zoom out, build relations and create distance, all giving a little more meaning to health, healing and caring. Some people are spurred on by predictions of thunder and doom to change their behaviors, others are inspired by visions of a possible future to develop new behaviors. While acknowledging the message of the pessimist, at the end of the day I prefer the role of the - deliberate - optimist.



References

REFERENCES

- Abrahamson, E. (2000). Change without pain. *Harvard business review*, *78*(4), 75-79.
- Andringa, J. & Weterings, R. (2008). *Competentieprofiel van transitieprofessionals.* Competentiecahier nr. 2. June 2008. Utrecht: Competence Centre Transitions (CCT).
- Atwoli, L., Baqui, A. H., Benfield, T., Bosurgi, R., Godlee, F., Hancocks, S., ... & Vazquez, D. (2021). Call for emergency action to limit global temperature increases, restore biodiversity, and protect health. *BMJ* 2021;374:n1734.
- Austin, J.L. (1962). *How to do things with words: Lecture I. How to do things with words*. Oxford: Oxford University Press, 1-11.
- Avelino, F. (2009). Empowerment and the challenge of applying transition management to ongoing projects. *Policy Science 42*, 369–390 (2009).
- Avelino, F., Dumitru, A., Cipolla, C., Kunze, I., & Wittmayer, J. (2020). Translocal empowerment in transformative social innovation networks. *European Planning Studies*, *28*(5), 955-977.
- Avelino, F., & Rotmans, J. (2009). Power in transition: an interdisciplinary framework to study power in relation to structural change. *European journal of social theory*, *12*(4), 543-569.
- Avelino, F., & Wittmayer, J. M. (2016). Shifting power relations in sustainability transitions: a multi-actor perspective. *Journal of Environmental Policy & Planning*, *18*(5), 628-649.
- Avelino, F., Wittmayer, J.M., Pel, B., Weaver, P., Dumitru, A., Haxeltine, A., … O'Riordan, T. (2019). Transformative social innovation and (dis) empowerment. *Technological Forecasting and Social Change*, 145: 195-206.
- Bannink, F.P., & Jansen, P. (2017). *Positieve gezondheidszorg: Oplossingsgericht werken in de huisartsenpraktijk*. Amsterdam: Pearson.
- Barsties, L. S., Steenbergen, F. S. V., & Loorbach, D. (2021). Social Obstetrics as Niche-Development in Addressing Health Inequities. *Sustainability*, *13*(22), 12814.
- Beanland, A., (2022). *WBCSD Healthy Planet, Healthy People - Understanding the relationship between human health and nature*, World Business Council for Sustainable Development. Switzerland. Retrieved from: https://policycommons.net/artifacts/3351819/wbcsd-healthy-planet-healthy-people/4150711/
- Beers, P. J., Van Mierlo, B., & Hoes, A. C. (2016). Toward an integrative perspective on social learning in system innovation initiatives. *Ecology and Society*, *21*(1).
- Berggren, C., Magnusson, T., & Sushandoyo, D. (2015). Transition pathways revisited: established firms as multi-level actors in the heavy vehicle industry. *Research policy*, 44 (5): 1017-1028.
- Berkers, E. (2017). Contested health system, 1970 to the present. In: J.E. Broerse & J. Grin (eds.), *Toward sustainable transitions in healthcare systems*, New York: Routledge, 23-45.
- Bijlsma, J. & Van Beek, C. (2022). *Heel de zorg. Routes naar duurzamer, gezonder en beter.* Magma Publicaties.
- BMH (2020). *Brede Maatschappelijke Heroverweging: Naar een toekomstbestendig zorgstelsel*. Den Haag: Rijksoverheid. Retrieved from: https://open.overheid.nl/repository/ronl-f5a6a54c-f4ae-40b9-9344- 21d0a6fe86ac/1/pdf/bmh-2-naar-een-toekomstbestendig-zorgstelsel.pdf.
- Boers, I. & Huber, M., (2015). *Hoe krijgt het concept 'Positieve gezondheid' regionaal handen en voeten? Procesbeschrijving van het traject dat wordt afgelegd door het Netwerk Positieve gezondheid in de Noordelijke Maasvallei*. Driebergen: Louis Bolk Instituut.
- Bosman, R. (2022). *Into Transition Space: destabilisation and incumbent agency in an accelerating energy transition.* Doctoral dissertation, Erasmus University Rotterdam.

- Bosman, R., Loorbach, D., Frantzeskaki, N., & Pistorius, T. (2014). Discursive regime dynamics in the Dutch energy transition. *Environmental Innovation and Societal Transitions*, *13*, 45-59.
- Braithwaite, J. (2018). Changing how we think about healthcare improvement. *The BMJ, 361*:k2014.
- Braithwaite, J., Churruca, K., Long, J. C., Ellis, L. A., & Herkes, J. (2018). When complexity science meets implementation science: a theoretical and empirical analysis of systems change. *BMC medicine*, *16*, 1-14.
- Broerse, J.E.W. & Bunders, J.F. (Eds.) (2010). *Transitions in Health Systems: Dealing with Persistent Problems.* Amsterdam: VU University Press.
- Broerse, J.E.W. & Grin, J. (Eds.) (2017). *Toward Sustainable Transitions in Healthcare Systems.* New York: Routledge.
- Brown H.S. & Vergragt, P.J. (2008). Bounded socio-technical experiments as agents of systemic change: the case of a zero-energy residential building. *Technological Forecasting and Social Change, 75*: 107–130.
- Brown, H.S., Vergragt, P.J., Green, K. & Berchicci, L. (2003). Learning for sustainability transition through bounded socio-technical experiments in personal mobility. *Technology Analysis and Strategic Management, 15*: 291–315.
- Bureau Bartels (2019). *Evaluatie Green Deal Duurzame Zorg*. Retrieved from: https://open.overheid.nl/documenten/ronl-103fee63df128367a757ab380a227e22721274ac/pdf
- Burgelman, R. A., & Grove, A. S. (1996). Strategic dissonance. *California management review*, *38*(2), 8-28.
- Burnes, B. (2015). Understanding resistance to change–building on Coch and French. *Journal of change management*, *15*(2), 92-116.
- Buurtzorg (2008). *Mission, summary and idea: Business Plan*. Internal document Buurtzorg Nederland.
- Buurtzorg (2015). *Annual financial report*. Internal document Buurtzorg Nederland.
- Centraal Bureau Statistiek (CBS) (2014). *Gezondheid en zorg in cijfers 2014.* Den Haag: Centraal Bureau voor de Statistiek.
- Centraal Bureau Statistiek (CBS) (2016a). *CBS StatLine – Gezondheid, leefstijl, zorggebruik en –aanbod, doodsoorzaken; kerncijfers.* Referenced online: http://statline.cbs.nl/statweb/publication/?vw=t&dm=slnl&pa=81628ned
- Centraal Bureau Statistiek (CBS) (2016b). *Gezondheid, relaties en werk belangrijker voor geluk dan geld*. Referenced online: https://www.cbs.nl/nl-nl/nieuws/2016/11/gezondheid-relaties-en-werk-belangrijker-voor-geluk-dan-geld
- Centraal Bureau Statistiek (CBS) (2019). *Prognose periode-levensverwachting; geslacht en leeftijd.* Referenced online: https://www.cbs.nl/nl-nl/cijfers/detail/84347NED?q=gemiddelde%20levensverwachting%20in%202018
- Centraal Bureau Statistiek (CBS) (2021). *Uitgaven zorg en welzijn.* Referenced online: https://www.cbs.nl/nl-nl/nieuws/2021/26/zorguitgaven-inclusief-steunmaatregelen-stegen-in-2020-met-8-3-procent
- Charlesworth, K., Jamieson, M., Davey, R., & Butler, C. D. (2015). Transformational change in healthcare: an examination of four case studies. *Australian Health Review*, *40*(2), 163-167.
- Chreim, S., Williams, B. E., & Coller, K. E. (2012). Radical change in healthcare organization: Mapping transition between templates, enabling factors, and implementation processes. *Journal of Health Organization and Management*, Vol. 26 No. 2, pp. 215-236.

- Clay-Williams, R., Hounsgaard, J., & Hollnagel, E. (2015). Where the rubber meets the road: using FRAM to align work-as-imagined with work-as-done when implementing clinical guidelines. *Implementation Science*, *10*(1), 125.
- Clegg, S. R., da Cunha, J. V., & e Cunha, M. P. (2002). Management paradoxes: A relational view. *Human relations*, *55*(5), 483-503.
- Coalition agreement (2010). *Vrijheid en Verantwoordelijkheid. Regeerakoord VVD – CDA. 30-09-2010*. Retrieved from: https://www.rijksoverheid.nl/documenten/rapporten/2010/09/30/regeerakkoord-vvd-cda
- Commissie Werken in de Zorg (2019). *Rapportage commissie Werken in de Zorg; 'behoud en innovatie als dé opgave'*. Retrieved from: www.eerstekamer.nl/overig/20191220/rapportage_commissie_werken_in_de/meta.
- Connor, A., & O'Donoghue, D. (2012). Sustainability: the seventh dimension of quality in health care. *Hemodialysis International, 16*(1), 2-5.
- Costello, A., Abbas, M., Allen, A., Ball, S., Bell, S., Bellamy, R., … & Lee, M. (2009). Managing the health effects of climate change. *The Lancet*, Vol. 373 No. 9676, pp.1693-1733.
- Cramer, H.J. (2014). *The barriers to empowering niche-innovations in long-term care*. Doctoral dissertation. Enschede: Twente University.
- Dallinga, A., Van den Bosch, S. & Pijnappel-Clark, M. (2011). *Wegwijzer Wijk- en Buurtgericht Werken 2011. De inzichten uit het Transitie Programma Langdurende Zorg. Verbreed naar tien nieuwe praktijken*. Utrecht, Viatore.
- De Blok, J & Pool, A. (2010). *Buurtzorg: menselijkheid boven bureaucratie*. Den Haag: Boom Lemma.
- De Bree, M., & Stoopendaal, A. (2018). De-and recoupling and public regulation. *Organization Studies*, *41*(5), 599-620.
- De Gruijter, M., Nederland T. & Stavenuiter M.M.J (2014). *Meedenkers aan het woord. Focusgroepen over 'Zorg voor Gezondheid in 2030'.* Utrecht: Verwey-Jonker Instituut.
- De Haan, H. (2010). *Towards transition theory*. Doctoral dissertation. Rotterdam: Erasmus University Rotterdam.
- De Haan, F.J. & Rotmans, J. (2011). Patterns in Transitions: Understanding Complex Chains of Change. *Technological Forecasting and Social Change* 78, 90–102.
- Deuten, J.J., Rip, A. & Jelsma, J. (1997). Societal Embedding and Product Creation Management. *Technology Analysis & Strategic Management* 9(2), 131-148.
- Dickinson, H. & Pierre, J. (2016). Between substance and governance: Healthcare governance and the limits to reform. *Journal of Health Organization and Management*, Vol. 30 No. 1, pp. 109-116.
- Dunning, C. (1991). *Kiezen en delen, rapport van de commissie Keuzen in de Zorg*. Den Haag: Staatsuitgeverij.
- Elkington, J. (1994). Towards the sustainable corporation: Win-win-win business strategies for sustainable development. *California management review*, Vol 36 No 2, pp. 90-100.
- Elzen, B., van Mierlo, B., & Leeuwis, C. (2012). Anchoring of innovations: Assessing Dutch efforts to harvest energy from glasshouses. *Environmental innovation and societal transitions*, *5*, 1-18.
- Ernst & Young (2009). *Maatschappelijke Business Case Buurtzorg Nederland*. Transitieprogramma in de Langdurige Zorg.
- Essink, D.R. (2012) *Sustainable health systems: the role of change agents in health system innovation*. Doctoral dissertation. Amsterdam: Vrije Universiteit.
- Essink, D., Spanjers, R., Broerse, J.E.W. & De Cock Buning, Tj. (2010). Sustainable development: a guiding vision in health system innovation?. In: Broerse, J.E.W. & Bunders, J.F. (Eds.), *Transitions in Health Systems: Dealing with Persistent Problems*. VU University Press, Amsterdam.

- Exton, R. (2008). The entrepreneur: a new breed of health service leader? *Journal of health organization and management*, *22*(3), 208-222.
- Fairclough, N. (2005). Critical discourse analysis in transdisciplinary research. In: R. Wodak & P. Chilton (red.), *A new agenda in (critical) discourse analysis*. Amsterdam/Philadelphia: John Benjamins Publishing Company, 53-70.
- Farla, J., Markard, J., Raven, R., & Coenen, L. (2012). Sustainability transitions in the making: A closer look at actors, strategies and resources. *Technological forecasting and social change*, *79*(6), 991-998.
- Federatie Medisch Specialisten (2017). *Visiedocument Medisch Specialist 2025*. Utrecht: Federatie Medisch Specialisten. Retrieved from: https://demedischspecialist.nl/sites/default/files/Visiedocument%20Medisch%20Specialist%202025-DEF.pdf.
- Festinger. L. (1957). *A theory of cognitive dissonance* (Vol. 2). Stanford university press.
- Fineberg, H.V. (2012). A successful and sustainable health system—how to get there from here. *New England Journal of Medicine*, Vol.366 No.11, pp.1020-1027.
- Fisher, B. & Tronto, J. (1990). Toward a Feminist Theory of Caring. In: E. Abel & M. Nelson (eds), *Circles of Care. Work and Identity in Women's Lives.* Albany: State University of New York Press, 35-62.
- Flamholtz, E. G., & Randle, Y. (2015). *Growing pains: Building sustainably successful organizations*. John Wiley & Sons.
- Frantzeskaki, N., & Haan, H. de (2009). Transitions: Two steps from theory to policy. *Futures*, 41 (9): 593-606.
- Geels, F.W. (2002). Technological transitions as evolutionary reconfiguration processes: a multi-level perspective and a case-study. *Research policy*, 31 (8-9): 1257-1274.
- Geels, F.W., & Deuten, J.J. (2006). Local and global dynamics in technological development: a socio-cognitive perspective on knowledge flows and lessons from reinforced concrete. *Science and Public Policy*, *33*(4), 265-275.
- Geels, F.W., & Raven, R. (2006). Non-linearity and expectations in niche-development trajectories: ups and downs in Dutch biogas development (1973–2003). *Technology Analysis & Strategic Management*, *18*(3-4), 375-392.
- Geels, F.W., & Schot, J. (2010). The dynamics of transitions: a socio-technical perspective. *Transitions to sustainable development: New directions in the study of long term transformative change*, 11-104.
- Gfk - Growth for knowledge (2017). Good Life Factors. Global Gfk Survey. Available online: https://www.gfk.com/blog/2017/11/living-good-life-really-mean-hear-consumers#:~:text=Top%20factors%20internationally,a%20job%20that%20is%20interesting.
- Giddens, A. (1984). *Elements of the theory of structuration*. Routledge.
- Gieryn, T. F. (1983). Boundary-work and the demarcation of science from non-science: Strains and interests in professional ideologies of scientists. *American sociological review*, 781-795.
- Goossens, T., Reitsma, R., Terlouw, P. & Van Twist, M. (2021). Pijn bij veranderingen. *Management & Organisatie 75(1)*, 56-73.
- Green Deal: Duurzame zorg voor een gezonde toekomst (2019). Retrieved from: https://www.greendeals.nl/sites/default/files/2019-05/Deal%20tekst%20GreenDeal%20226%20Duurzame%20zorg%20voor%20gezonde%20toekomst_0.pdf
- Green Deal: Nederland op weg naar duurzame zorg (2015). Retrieved from: https://www.greendeals.nl/sites/default/files/downloads/GD190-samenvatting-Nederland-op-Weg-naar-Duurzame-Zorg.pdf

- Green Deal: Nederland op weg naar duurzame zorg (2018). Eindpublicatie. Retrieved from: https://www.greendeals.nl/green-deals/nederland-op-weg-naar-duurzame-zorg.
- Green Deal: Samenwerken aan duurzame zorg (2022). Retrieved from: https://www.greendeals.nl/sites/default/files/2023-01/C-238%20Green%20Deal%20Samen%20werken%20aan%20duurzame%20zorg.pdf
- Greenhalgh, T., Howick, J., & Maskrey, N. (2014). Evidence based medicine: a movement in crisis? *Bmj*, *348*.
- Grin, J. (2006). Why the optimization of care is so difficult in current health care systems: lessons from policy analyses for optimization of health care in the Netherlands. Paper. Amsterdam: University of Amsterdam.
- Grin, J., Rotmans, J. & Schot, J. (2010). *Transitions to sustainable development. New directions in the study of long term transformative change.* London: Routledge.
- Gruijter, M. de, Nederland, T., & Stavenuiter, M.M.J. (2014). *Meedenkers aan het woord. Focusgroepen over 'Zorg voor Gezondheid in 2030'*. Utrecht: Verwey-Jonker Instituut.
- Gupta Strategists (2019). *Een stuur voor de transitie naar duurzame gezondheidszorg*. Retrieved from: https://gupta-strategists.nl/studies/een-stuur-voor-de-transitie-naar-duurzame-gezondheidszorg
- Guston, D. H. (1999). Stabilizing the boundary between US politics and science: The role of the Office of Technology Transfer as a boundary organization. *Social studies of science*, *29*(1), 87-111.
- Hajer, M.A. (2006). Doing discourse analysis: coalitions, practices, meaning. In: M. van den Brink & T. Metze (red.), *Words matter in policy and planning: discourse theory and method in the social sciences*, Utrecht: Koninklijk Nederlands Aardrijkskundig Genootschap, 65-74.
- Hancock, T. (1999). Health care reform and reform for health: creating a health system for communities in the 21st century. *Futures 31,* 417-436.
- Hargrave, T. J., & Van de Ven, A. H. (2017). Integrating dialectical and paradox perspectives on managing contradictions in organizations. *Organization Studies*, *38*(3-4), 319-339.
- Haxeltine, A., Whitmarsh, L., Bergman, N., Rotmans, J., Schilperoord, M., & Kohler, J. (2008). A Conceptual Framework for transition modelling. *International journal of innovation and sustainable development*, *3*(1-2), 93-114.
- Haxeltine, A., Pel, B., Wittmayer, J., Dumitru, A., Kemp, R., & Avelino, F. (2017). Building a middle-range theory of Transformative Social Innovation; theoretical pitfalls and methodological responses. *European Public & Social Innovation Review*, *2*(1), 59-77.
- HCWH & Arup (2019). *Healthcare's climate footprint: How the health sector contributes to the global climate crisis and opportunities for action*. HCWH and Arup. Retrieved from: https://noharm- global.org/sites/default/files/documents- files/5961/HealthCaresClimateFootprint_092319.pdf.
- Hebinck, A., Diercks, G., von Wirth, T., Beers, P. J., Barsties, L., Buchel, S., ... & Loorbach, D. (2022). An actionable understanding of societal transitions: the X-curve framework. *Sustainability Science*, *17*(3), 1009-1021.
- Helderman, J. K. (2007). *Bringing the market back in? Institutional complementarity and hierarchy in Dutch housing and health care*. Doctoral dissertation. Rotterdam: Erasmus University Rotterdam.
- Hengelaar, G. A. (2017). *The Proactive Incumbent: Holy grail or hidden gem? Investigating whether the Dutch electricity sector can overcome the incumbent's curse and lead the sustainability transition*. Doctoral dissertation. Rotterdam: Erasmus Research Institute of Management.
- Hermans, F., Roep, D., & Klerkx, L. (2016). Scale dynamics of grassroots innovations through parallel pathways of transformative change. *Ecological Economics*, *130*, 285-295.

- Hisschemöller, M. & R. Hoppe (1996). Coping with Intractable Controversies: The Case for Problem Structuring in Policy Design and Analysis. *Knowledge and Policy, the International Journal of Knowledge Transfer and Utilization*, 8(4): 40-61.
- Horton, R., Beaglehole, R., Bonita, R., Raeburn, J., McKee, M., & Wall, S. (2014). From public to planetary health: a manifesto. *The Lancet*, *383*(9920), 847.
- Horton, R., & Lo, S. (2015). Planetary health: a new science for exceptional action. *The Lancet*, *386*(10007), 1921-1922.
- Huber, M.A.S. (2014). *Towards a new, dynamic concept of Health*. Doctoral dissertation. Maastricht: Maastricht University.
- Huber, M. (2016). Antwoord op 'Gezondheid: een definitie?' van Poiesz, Caris en Lapré. *Tijdschrift voor gezondheidswetenschappen*, 94 (8): 292-296.
- Huber, M., Knottnerus, J.A., Green, L., Horst, H. van der, Jadad, A.R., Kromhout, D., … Smid, H. (2011). How should we define health? *BMJ*, 343:d4163: 235-237.
- Huber, M., Vliet, M. van, Giezenberg, M., & Knottnerus, A. (2013). *Towards a Conceptual Framework relating to 'Health as the ability to adapt and to self manage'*. Driebergen: Louis Bolk Instituut.
- Huy, Q. N. (2002). Emotional balancing of organizational continuity and radical change: The contribution of middle managers. *Administrative science quarterly*, *47*(1), 31-69.
- IASP. Referenced online: https://www.iasp-pain.org/resources/terminology/#pain
- IPCC (2022): *Climate Change 2022: Impacts, Adaptation, and Vulnerability*. Contribution of Working Group II to the Sixth Assessment Report of the Intergovernmental Panel on Climate Change. Cambridge, UK and New York, NY: Cambridge University Press. Retrieved from: https://www.ipcc.ch/report/ar6/wg2/
- IZA (2022). *Integraal Zorgakkoord: Samen werken aan gezonde zorg*. Internet: Rijksoverheid. Retrieved from: https://www.rijksoverheid.nl/docu menten/rapporten/2022/09/16/integ raal-zorgakkoord-samen-werkenaan-gezonde-zorg
- Janssen, M. (2016). *Situated Novelty. A study on healthcare innovation and its governance*. Doctoral dissertation. Rotterdam: Erasmus University Rotterdam.
- Janssen, M., & Moors, E.H. (2013). Caring for healthcare entrepreneurs - Towards successful entrepreneurial strategies for sustainable innovations in Dutch healthcare. *Technological Forecasting and Social Change*, *80*(7), 1360-1374.
- Jasanoff, S. S. (1987). Contested boundaries in policy-relevant science. *Social studies of science*, *17*(2), 195-230.
- Jasanoff, S. (1990). American exceptionalism and the political acknowledgment of risk. *Daedalus*, 61-81
- Jhagroe, S., & van Steenbergen, F. (2014). Van koplopers naar koplopen: een pleidooi voor inclusief leiderschap. *management*, *42*(4), 341-368.
- Johansen, F., Loorbach, D., & Stoopendaal, A. (2018). Exploring a transition in Dutch healthcare. *Journal of health organization and management*, *32*(7), 875.
- Johansen, F., & Bosch, S. van den (2017). The scaling-up of Neighbourhood Care: From experiment towards a transformative movement in healthcare. *Futures*, 89: 60-73.
- Jørgensen, M.W., & Phillips, L.J. (2002). *Discourse analysis as theory and method*. Londen: Sage.
- Jung, H.P., Jung, T., Liebrand, S., Huber, M., Stupar-Rutenfrans, S., & Wensing, M. (2018). Meer tijd voor patiënten, minder verwijzingen. *Huisarts en wetenschap*, 61 (3): 39-41.
- Kanov, J. M., Maitlis, S., Worline, M. C., Dutton, J. E., Frost, P. J., & Lilius, J. M. (2004). Compassion in organizational life. *American Behavioral Scientist*, *47*(6), 808-827.

- Karanika-Murray, M., Michaelides, G., & Wood, S. J. (2017). Job demands, job control, psychological climate, and job satisfaction: A cognitive dissonance perspective. *Journal of Organizational Effectiveness: People and Performance, 4*(3), 238-255.
- Kemp, R., Loorbach, D., & Rotmans, J. (2007). Transition management as a model for managing processes of co-evolution towards sustainable development. *The International Journal of Sustainable Development & World Ecology*, *14*(1), 78-91.
- Kemp, R., Schot, J., & Hoogma, R. (1998). Regime shifts to sustainability through processes of niche formation: the approach of strategic niche management. *Technology analysis & strategic management*, *10*(2), 175-198.
- Kiefer, T. (2002). Understanding the emotional experience of organizational change: Evidence from a merger. *Advances in Developing Human Resources*, *4*(1), 39-61.
- Kingdon, J. (1995). *Agenda, Alternatives, and Public Policies*. New York: Harper Collins Publishers.
- Kingma, E. (2017). Kritische Vragen bij Positieve Gezondheid. *Tijdschrift voor Gezondheidszorg en Ethiek*, 3: 81-83.
- Kivisaari, S., Lovio, R. & Väyrynen, E. (2004). Managing experiments for transition: Examples of societal embedding in energy and health care sectors. In: B. Elzen, F.W. Geels, & K. Green, (Eds.), *System Innovation and the Transition to Sustainability: Theory, Evidence and Policy*. pp. 223-250. Cheltenham: Edward Elgar.
- Klarner, P., By, R. T., & Diefenbach, T. (2011). Employee emotions during organizational change, Towards a new research agenda. *Scandinavian Journal of Management*, *27*(3), 332-340.
- Klimaatakkoord (2019). Den Haag.
- Knegt, Y. (2011). *Nu zorg(en) voor morgen. Schetsen van een routekaart naar Maatschappelijk Verantwoord Ondernemen in de Zorgsector*. Working paper. Woerden: Nationaal Instituut voor Gezondheidsbevordering en Ziektepreventie (NIGZ).
- Köhler, J., Geels, F.W., Kern, F., Markard, J., Onsongo, E., Wieczorek, A., … Wells, P. (2019). An agenda for sustainability transitions research: State of the art and future directions. *Environmental innovation and societal transitions*, 31: 1-32.
- Kooiker, S.E. (2011). *Nederlanders aan het woord over gezondheid en gezond leven: Achtergrondrapport bij de Volksgezondheid Toekomst Verkenning 2010. Van gezond naar beter*. Rijksinstituut voor Volksgezondheid en Milieu RIVM.
- KPMG (2015). *De toegevoegde waarde van Buurtzorg t.o.v. andere aanbieders van thuiszorg. Een kwantitatieve analyse van thuiszorg in Nederland anno 2013*. Tweede Kamer der Staten-Generaal. kst-31765-114.
- Kreijenbroek, S. (2019) *Zelfsturing binnen de hiërachie. De invloed van dominante logica*. Unpublished manuscript.
- Kump, B. (2019). Beyond power struggles: A multilevel perspective on incongruences at the interface of practice, knowledge, and identity in radical organizational change. *The Journal of Applied Behavioral Science*, *55*(1), 5-26.
- Lagergren, M. (1985). Public health services in the advanced welfare state. Observations from the Swedish futures study Care in Society. *Futures 17*(4), 348.359.
- Laloux, F. (2015). *Reinventing organizations*. Lannoo Meulenhoff-Belgium.
- Larson, J. S. (1999). The conceptualization of health. *Medical care research and review*, *56*(2), 123-136.
- Lawhon, M., & Murphy, J. T. (2011). Socio-technical regimes and sustainability transitions Insights from political ecology. *Progress in Human Geography*, *36*(3), 354-378.

- Levinthal, D.A. (1998). The slow pace of rapid technological change: gradualism and punctuation in technological change. *Industrial and corporate change*, *7*(2), 217-247.
- Lewin, K. (1947). Frontiers in group dynamics: Concept, method and reality in social science; social equilibria and social change. *Human relations*, *1*(1), 5-41.
- Lodder, M., Roorda, C., Loorbach, D. & Spork, C. (2017). *Staat van transitie:patronen van opbouw en afspraak in vijf domeinen.* Rotterdam: DRIFT.
- Loorbach, D. (2007). *Transition management: new mode of governance for sustainable development*. Doctoral dissertation Erasmus University Rotterdam). Utrecht: International Books.
- Loorbach, D. (2010), "Transition management for sustainable development: a prescriptive, complexity-based governance framework", *Governance*, Vol. 23 No.1, pp. 161-183.
- Loorbach, D. (2014). *To Transition! Governance panarcy in the New Transformation.* Inaugural lecture. Erasmus University Rotterdam.
- Loorbach, D., Frantzeskaki, N., & Avelino, F. (2017). Sustainability transitions research: transforming science and practice for societal change. *Annual Review of Environment and Resources*, 42: 599-626.
- Loorbach, D., & Rotmans, J. (2006). *Managing transitions for sustainable development* (pp. 187-206). Springer Netherlands.
- Loorbach, D. & Rotmans, J. (2010). The practice of transition management: Examples and lessons from four distinct cases. *Futures 42* (3), 237-246.
- Loorbach, D., Rotmans, J., & Lijnis Huffenreuter, R. (2014). *Ondernemen in transitie. Bedrijfstransities als innovatief model voor duurzaam ondernemen.* Stichting Maatschappij en Onderneming.
- Loorbach, D., & Wijsman, K. (2013). Business transition management: exploring a new role for business in sustainability transitions. *Journal of cleaner production*, *45*, 20-28.
- Loorbach, D., Wittmayer, J., Avelino, F., Wirth, T. von, & Frantzeskaki, N. (2020). Transformative innovation and translocal diffusion. *Environmental Innovation and Societal Transitions*, 35: 251-260.
- Mackenbach, J.P., Stronks, K., & Anema, J.R. (2016). *Volksgezondheid en gezondheidszorg*. Bohn Stafleu Van Loghum.
- Markard, J., Raven, R. & Truffer, B. (2012). Sustainability transitions: An emerging field of research and its prospects. *Research Policy 41*(6), 955–967.
- McDuffie E, Martin R, Yin H, Brauer M. (2021). Research Report 210. Boston, MA: Health Effects Institute. Retrieved from: https://www.healthdata.org/policy-report/global-burden-disease-major-air-pollution-sources-gbd-maps-global-approach
- Meyer, J. W., & Rowan, B. (1977). Institutionalized organizations: Formal structure as myth and ceremony. *American journal of sociology*, *83*(2), 340-363.
- Monissen, D. & Ackerman, G. (2011) Duurzame gezondheidszorg en politiek – een paradox? In: Van Gerven, M., Huisman, J. & Nijnens, H. (red.) (2011) *Duurzame gezondheidszorg, Visies en praktijkervaringen.* Zeist: Christofoor.
- Moore, M.L. & Westley, F. (2011). Surmountable chasms: networks and social innovation for resilient systems. *Ecology and Society 16*(1), 5.
- Mühlemeier, S. (2019). Dinosaurs in transition? A conceptual exploration of local incumbents in the Swiss and German energy transition. *Environmental Innovation and Societal Transitions*, *31*, 126-143.
- Nadler, D. A. (1993). Concepts for the management of organizational change. *Managing change*, *2*, 85-98.

- Nag, R., Corley, K. G., & Gioia, D. A. (2007). The intersection of organizational identity, knowledge, and practice: Attempting strategic change via knowledge grafting. *Academy of Management journal*, *50*(4), 821-847.
- Nandram, S.S. (2015). *Organizational innovation by integrating simplification, Learning from Buurtzorg Nederland.* Springer International Publishing.
- Nederlandse Zorgautoriteit & Zorginstituut (NZa/ZI). (2020). *Samenwerken aan passende zorg: de toekomst is nú*. Utrecht: NZa. Retrieved from: www.zorginstituutnederland.nl/publicaties/adviezen/2020/11/27/advies-samenwerken-aan-passende-zorg-de-toekomst-is-nu.
- Neilson, S. (2016). Pain as metaphor: metaphor and medicine. *Medical humanities*, *42*(1), 3-10.
- Nelissen, J., & Degryse, J. (2015). Salutogenese. *Huisarts Nu*, 44 (1): 26-31.
- Neuteboom, J., Van Raak, R., and Rotmans, J. (Eds.) (2009), *Mensenzorg – een transitiebeweging.* Rotterdam: DRIFT.
- NFU (2020). *Raamplan Artsopleiding 2020*. Utrecht: NFU Nederlandse Federatie van Universitair Medische Centra. Retrieved from: www.nfu.nl/sites/default/files/2020-08/20.1577_ Raamplan_ Artsenopleiding_-_maart_2020.pdf.
- NIVEL (2009). *Buurtzorg: nieuw en toch vertrouwd. Een onderzoek naar de ervaringen van cliënten, mantelzorgers, medewerkers en huisartsen.* Utrecht: NIVEL.
- Nooteboom, B. (1999). Innovation, Learning and industrial organisation. *Cambridge Journal of Economics, 23(2), 127-150.*
- NRC (2022). *Artikelenreeks Zorg wordt schaars.*
- NZA (2007). *Monitorspecial De rol van ZBC's in de ziekenhuiszorg*. Utrecht: Nederlandse Zorgautoriteit.
- OECD (2018). *Health at a glance: Europe 2018. State of Health in the EU Cycle*, Paris: Organisation for Economic Co-operation and Development.
- OECD/ European Union (2022). Health at a Glance: Europe 2022, Paris: OECD Publishing. Retrieved from: https://www.oecd-ilibrary.org/social-issues-migration-health/health-at-a-glance-europe-2022_507433b0-en
- OESO (2019). Long-term care (health) expenditure. Referenced online: https://ec.europa.eu/eurostat/databrowser/view/TPS00214/default/table?lang=en
- Oldenhof, L.E. (2015). *The Multiple Middle: Managing in Healthcare.* Doctoral dissertation. Rotterdam: Erasmus University Rotterdam.
- Oliver, T. H., Boyd, E., Balcombe, K., Benton, T. G., Bullock, J. M., Donovan, D., ... & Zaum, D. (2018). Overcoming undesirable resilience in the global food system. *Global Sustainability*, *1*, e9.
- Pesch, U. (2015). Tracing discursive space: Agency and change in sustainability transitions. *Technological Forecasting and Social Change*, *90*, 379-388.
- Pel, B., Haxeltine, A., Avelino, F., Dumitru, A., Kemp, R., Bauler, T., Kunze, I., Dorland, J., Wittmayer, J., & Jørgensen, M. S. (2020). Towards a theory of transformative social innovation: A relational framework and 12 propositions. *Research Policy*, *49*(8).
- Piderit, S. K. (2000). Rethinking resistance and recognizing ambivalence: A multidimensional view of attitudes toward an organizational change. *Academy of management review*, *25*(4), 783-794.
- Pichler, P. P., Jaccard, I. S., Weisz, U., & Weisz, H. (2019). International comparison of health care carbon footprints. *Environmental research letters*, *14*(6), 064004.
- Plsek, P.E. & Greenhalgh, T. (2001). The challenge of complexity in healthcare. *British Medical Journal, 323*(7313),625.
- Poiesz, T., Caris, J., & Lapré, F. (2016). Gezondheid: een definitie? *Tijdschrift voor gezondheidswetenschappen*, 94 (7): 252-255.

- Pool. A. & Mast, J. (2011). *Eerst buurten, dan zorgen, Professioneel verplegen en verzorgen bij Buurtzorg.* Den Haag: Boom Lemma.
- Raven, R., Van den Bosch, S. & Weterings, R. (2010). Transitions and strategic niche management: towards a competence kit for practitioners. *International Journal of Technology Management 51*(1), 57-74.
- Rip, A. (1995). Introduction of new technology: Making use of recent insights from sociology and economics of technology. *Technology Analysis and Strategic Management,* Vol 7(4), 417-431.
- Rip, A. & Kemp, R. (1998). Technological change. In: S. Rayner & E.L. Malone (Eds.), *Human Choice and Climate Change – An International Assessment*, Vol 2, pp. 327-299. Columbus, OH: Batelle Press.
- Rittel, H. W., & Webber, M. M. (1973). Dilemmas in a general theory of planning. *Policy sciences*, *4*(2), 155-169.
- RIVM (2018). *Volksgezondheid Toekomst Verkenning 2018, Een gezond vooruitzicht*. *Synthese.* Bilthoven: Rijksinstituut voor Volksgezondheid en Milieu.
- RIVM (2020) *Corona-inclusieve Volksgezondheid Toekomst Verkenning, Verder kijken dan corona, over de toekomst van onze gezondheid*. Bilthoven: Rijksinstituut voor Volksgezondheid en Milieu.
- Robson, C. (2011). *Real World Research*. Third edition. Chichester: John Wiley and Sons.
- Rogers, E.M. (1995). *Diffusion of Innovations.* New York: The Free Press.
- Romanello, M., McGushin, A., Di Napoli, C., Drummond, P., Hughes, N., Jamart, L., ... & Hamilton, I. (2021). The 2021 report of the Lancet Countdown on health and climate change: code red for a healthy future. *The Lancet*, *398*(10311), 1619-1662.
- Rotmans, J. (2012). *In het oog van de orkaan. Nederland in transitie*. Boxtel: Æeneas.
- Rotmans, J. (2014). *Verandering van tijdperk: Nederland kantelt*. Boxtel: Æeneas.
- Rotmans, J., Kemp, R. & Van Asselt, M. (2001). More evolution than revolution: Transition management in public policy. *Foresight 3*(1): 17.
- Rotmans, J. & Loorbach, D. (2008). Transition management: reflexive steering of societal complexity through searching, learning and experimenting. In: Van den Bergh, J.C.J.M., Bruinsma F.R. (Eds.), *Managing the Transition to Renewable Energy. Theory and Practice from Local, Regional and Macro Perspectives,* Cheltenham, Edward Elgar.
- Rotmans, J., & Loorbach, D. (2009). Complexity and transition management. *Journal of industrial ecology*, 13 (2): 184-196.
- Rotmans, J. & Loorbach, D. (2010). Towards a better understanding of transitions and their governance: a systemic and reflexive approach. In: Grin, J., Rotmans, J. and Schot, J. (Eds.). *Transitions to sustainable development. New directions in the study of long term transformative change.* London: Routledge.
- Ruwaard, D. (2012). *De weg van nazorg naar voorzorg: buiten de gebaande paden*. Inaugural lecture. Maastricht: Maastricht University.
- RVZ (2010). *Zorg voor je gezondheid! Gedrag en gezondheid, 'de nieuwe ordening'*. Den Haag: Raad voor de Volksgezondheid en Zorg.
- RVZ (2014). *Met de kennis van later. Naar een toekomstgericht zorgbeleid.* Den Haag: Raad voor de Volksgezondheid en Zorg.
- Scheijmans, C., & Stoopendaal, A. (2018). Ergotherapie en Positieve Gezondheid: vinden, versterken en samenwerken. *Ergotherapie Magazine*, 2: 20-23.
- Schot, J.W. (1998). The usefulness of evolutionary models for explaining Innovation. The case of the Netherlands in the nineteenth century. *History and Technology 14*(3), 173–200.
- Schot, J., & Geels, F.W. (2007). Niches in evolutionary theories of technical change. *Journal of Evolutionary Economics*, *17*(5), 605-622.

- Schroeder, K., Thompson, T., Frith, K., & Pencheon, D. (2013), *Sustainable healthcare*, John Wiley & Sons Ltd., Chichester.
- Schuitmaker, T.J. (2010). Persistent problems in the Dutch healthcare system: an instrument for analysing system deficits. In: J.E. Broerse & J.G.F. Bunders (red.), *Transitions in Health Systems: dealing with persistent problems*, Amsterdam: VU University Press, 21-47.
- Schuitmaker, T.J. (2013). *Persistent problems in the Dutch health care system: learning from novel practices for a transition in health care with the UPP framework*. Doctoral dissertation. Amsterdam: University of Amsterdam.
- Seligman, M.E. (2008). Positive health. *Applied psychology*, 57: 3-18.
- Sengers, F., Berkhout, F., Wieczorek, A. & Raven, R.P.J.M. (2016). Experimenting in the city: unpacking notions of experimentation for sustainability. In: Evans, J., Karvonen, A., Raven, R.P.J.M. (Eds.). *The Experimental City.* Routledge. p. 15-31
- SER (2020). *Zorg voor de toekomst, Over de toekomstbestendigheid van de zorg.* Den Haag: Sociaal-Economische Raad.
- Serra, M., Ospina-Palacio, D., Espinal, S., Rodriguez, D., & Jadad, A. R. (2018). *Trusted networks: the key to achieving world-class health results with a reduced budget*. Bogota: Beati.
- Shove, E. (2012). Energy transitions in practice: the case of global indoor climate change. In: Verbong, G., & Loorbach, D. (Eds.). *Governing the energy transition: reality, illusion or necessity?* Routledge.
- Shove, E., & Walker, G. (2010). Governing transitions in the sustainability of everyday life. *Research policy*, *39*(4), 471-476.
- Slaghuis, S. (2016). *Riding the waves of quality improvement.* Doctaral dissertation. Rotterdam: Erasmus University Rotterdam.
- Smith, A. (2007). Translating sustainabilities between green niches and socio-technical regimes. *Technology Analysis & Strategic Management* 19(4), 427-450.
- Smith, A., & Raven, R. (2012). What is protective space? Reconsidering niches in transitions to sustainability. *Research policy*, *41*(6), 1025-1036.
- Smith, W.K., & Lewis, M.W. (2011). Toward a theory of paradox: A dynamic equilibrium model of organizing. *Academy of management Review*, *36*(2), 381-403.
- Sondeijker, S. (2009). *Imagining Sustainability: Methodological building blocks for transition scenarios*. Doctoral dissertation. Rotterdam: Erasmus University Rotterdam.
- Spaargaren, G. (2011). Theories of practices: Agency, technology, and culture: Exploring the relevance of practice theories for the governance of sustainable consumption practices in the new world-order. *Global Environmental Change*, *21*(3), 813-822.
- Sparr, J.L. (2018). Paradoxes in Organizational Change: The Crucial Role of Leaders' Sensegiving, *Journal of Change Management, 18*:2, 162-180. DOI:10.1080/14697017.2018.1446696
- Star, S. L., & Griesemer, J. R. (1989). Institutional ecology,translations' and boundary objects: Amateurs and professionals in Berkeley's Museum of Vertebrate Zoology, 1907-39. *Social studies of science*, *19*(3), 387-420.
- Steenmeijer, M., Pieters, L., Warmerhoven, N., Huiberts, E., Stoelinga, M., Zijp, M., ... & Waaijers-van der Loop, S. (2022). *Het effect van de Nederlandse zorg op het milieu. Methode voor milieuvoetafdruk en voorbeelden voor een goede zorgomgeving. RIVM-rapport; 2022-0127*. Bilthoven: Rijksinstituut voor Volksgezondheid en Milieu.
- Stuurgroep Kwaliteitskader Wijkverpleging (2018). *Kwaliteitskader wijkverpleging*. www.kwaliteitwijkverpleging.nl/wp-content/uploads/2021/03/kwaliteitskader-wijkverpleging.pdf.

- Sturmberg, J. P. (Ed.). (2016). *The value of systems and complexity sciences for healthcare* (No. 8801). Springer International Publishing.
- Sturmberg, J. P., & Martin, C. M. (Eds.). (2013). *Handbook of systems and complexity in health* (pp. 1-17). New York: Springer.
- Super, S.; A Klerkx, L.W.; Hermens, N.; A Koelen, M. (2020). A multilevel transition perspective on embedding intersectoral action in local health policies. *Health Promot. Int.*, 36, 1050–1061.
- Taskforce JZJP (2018). *De juiste zorg op de juiste plek. Wie durft?* www.dejuistezorgopdejuisteplek.nl/over-ons/.
- Tjepkema, S. (2003). *The learning infrastructure of self-managing work teams.* Doctoral dissertation. Enschede: Twente University Press.
- Timmermans, S., & Tavory, I. (2012). Theory construction in qualitative research: From grounded theory to abductive analysis. *Sociological theory*, *30*(3), 167-186.
- Toch, H., Maes, A. & Van de Poel, D. (2022) *Zo kan zorg anders. De ontelbare kansen van de gezondheidstransitie.* Kalmthout: Pelckmans.
- Toebes, B. (2001). The right to health as a human right in international law. *Refugee Survey Quarterly*, *20*(3).
- Tronto, J.C. (1993). *Moral boundaries: A political argument for an ethic of care*. Psychology Press.
- Tronto, J. (2013). *Caring democracy: Markets, equality and justice.* New York and London:New York University Press,
- Tuohy, C. H. (2012). Reform and the politics of hybridization in mature health care states. *Journal of health politics, policy and law*, *37*(4), 611-632.
- Turnheim, B., & Sovacool, B.K. (2020). Forever stuck in old ways? Pluralising incumbencies in sustainability transitions. *Environmental Innovation and Societal Transitions*, 35: 180-184.
- United Nations (2022). *The Sustainable Development Goals Report 2022.* United Nations. Retrieved from: https://unstats.un.org/sdgs/report/2022/
- United Nations World Commission on Environment and Development (WCED) (1987). *Our common future.* Oxford University Press.
- Vaandrager, L., & Koelen, M. (2011). Van pathogenese naar salutogenese. *Tijdschrift voor gezondheidswetenschappen*, 89 (7): 350-351.
- Van Beest, R. (2014). *Inventarisatie Zorgcoöperaties 2014. Burgerinitiatieven in wonen-zorg-welzijn in Nederland & omstreken.* Aedes-Actiz Kenniscentrum Wonen-Zorg.
- Van Beuningen, J., & Moonen, L. (2013). Gezondheid en leefstijl gerelateerd aan geluk. *Tijdschrift voor gezondheidswetenschappen, 91*, 261-262.
- Van Boven, K., & Versteegde, T. (2019). Positieve Gezondheid een onsamenhangend concept. *Bijblijven*, 35 (8): 55-58.
- Van Cranenburgh, B. (2009). *Pijn vanuit een neurowetenschappelijk perspectief.* Elsevier gezondheidszorg, Maarssen.
- Van Dalen, A. (2010). *Uit de schaduw van het zorgsysteem, Hoe Buurtzorg Nederland zorg organiseert*. Den Haag: Boom Lemma.
- Van Dalen, A. (2012). *Zorgvernieuwing, over anders besturen en organiseren*. Den Haag: Boom Lemma.
- Van den Berg, H. (2004). Discoursanalyse in de praktijk. *Tijdschrift Kwalon*, 9: 3.
- Van den Bosch, S. (2010). *Transition Experiments, Exploring societal changes towards sustainability.* Doctoral dissertation. Rotterdam: Erasmus University Rotterdam.

- Van den Bosch, S., & Neuteboom, J. (2017). The making of a transition program in the Dutch care sector. In: Broerse, J.E.W. & Grin, J. (Eds.). *Toward Sustainable Transitions in Healthcare Systems.* New York: Routledge.
- Van den Bosch, S. & Rotmans, J. (2008). *Deepening, Broadening and Scaling up: a framework for steering transition experiments.* Essay 02, Delft/ Rotterdam: Knowledge Centre for Sustainable System Innovations and Transitions (KCT).
- Van den Bosch, S. & Taanman, M. (2006). *How innovation impacts society. Patterns and mechanisms through which innovation projects contribute to transitions.* Innovation Pressure Conference 2006, 15-17 March, Tampere, Finland.
- Van de Poel, I, (2000). On the role of outsiders in technical development. *Technology Analysis & Strategic Management* 12 (3), 383–397.
- Van der Brugge, R. (2009). *Transition dynamics in social-ecological systems: the case of Dutch water management*. Doctoral dissertation. Rotterdam: Erasmus University Rotterdam.
- Van der Stel, J. (2016). Definitie 'gezondheid' aan herziening toe. *Medisch Contact*, 23: 18-19.
- Van Gerven, M., Huisman, J. & Nijnens, H. (red.) (2011) *Duurzame gezondheidszorg, Visies en praktijkervaringen*. Zeist: Christofoor.
- Van Hattem, M. (2014). *Buurtzorg Jong in beeld. Een literatuuronderzoek naar de werkwijze van Buurtzorg Jong.* Apeldoorn: Evaluatiebureau Publieke Gezondheid. Retrieved from: https://kennisnetjeugd.nl/?file=1238&m=1398695919&action=file.download
- Van Mierlo, B., & Beers, P.J. (2020). Understanding and governing learning in sustainability transitions: A review. *Environmental Innovation and Societal Transitions*, *34*, 255-269.
- Van Raak, R. (2010). The transition (management) perspective on long-term change in healthcare. In: Broerse, J.E.W. & Bunders, J.F. (Eds.) (2010). *Transitions in Health Systems: Dealing with Persistent Problems.* Amsterdam: VU University Press.
- Van Raak, R. (2016). *Transition Policies. Connecting system dynamics, governance and instruments in an application to Dutch Healthcare.* Doctoral dissertation. Rotterdam: Erasmus University Rotterdam.
- Van Raak, R., & de Haan, F.J. (2017). Key features of modern health systems: nature and historical evolution. In *Toward sustainable transitions in healthcare systems* (pp. 46-84). Routledge.
- Van Staa, A.L., Cardol, M., & Dam, A. van (2017). Positieve gezondheid kritisch beschouwd: Niet nieuw, onduidelijk, misleidend en niet zonder risico. *Positieve Psychologie*, 4: 33-39.
- Van Steenbergen, F. (2020). *Zonder marge geen centrum: Een pleidooi voor rechtvaardige transities*. Dissertatie. Rotterdam: Erasmus Universiteit Rotterdam.
- Van Vliet, M., Doornenbal, B.M., Boerema, S., & Akker-Van, E.M. van den (2021). Development and psychometric evaluation of a Positive Health measurement scale: a factor analysis study based on a Dutch population. *BMJ Open 2021*, 11 (2): e040816.
- Vermeer, A. & Wenting, B. (2014). *Zelfsturende teams in de praktijk*. Amsterdam: Reed Business.
- Vince, R., & Broussine, M. (1996). Paradox, defense and attachment: Accessing and working with emotions and relations underlying organizational change. *Organization Studies*, *17*(1), 1-21.
- Volmer, J. (2008). *Marktwerking in de gezondheidszorg: de doelmatigheid van een zelfstandig behandel centrum*. Master thesis Health Sciences. Universiteit Twente.
- Vonk, R.A.A., Hilderink, H.B.M., Plasmans, M.H.D., Kommer G.J & Polder J.J. (2020). *Toekomstverkenning zorguitgaven 2015-2060, RIVM-rapport 2020-0059*. Bilthoven: Rijksinstituut voor Volksgezondheid en Milieu.
- Vosman, F. (2017). Ongebreidelde zorg. Het gezondheidsconcept van Huber onder de loep. *Waardenwerk*, 68: 61-68

- VWS (2016). *Eindevaluatie Experiment regelarme instellingen (ERAI)*. Den Haag: Ministerie van Volksgezondheid, Welzijn en Sport.
- VWS (2020). *Landelijke Nota Gezondheidsbeleid 2020-2024*. Den Haag: Ministerie van Volksgezondheid, Welzijn en Sport.
- VWS (2021). *Discussienota Zorg voor de Toekomst*. Den Haag: Ministerie van Volksgezondheid, Welzijn en Sport.
- Walburg, J.A. (2010). Wat heeft de positieve psychologie te bieden? *Psychologie en Gezondheid*, 38 (1): 38-41.
- Walg, C. (2014). *Gezond centraal. Opschudding in de gezondheidszorg*. Barneveld: Uitgeverij Boekenbent.
- Walg, C. (2019). Een andere kijk op gezondheid en zorg. *Bijblijven*, 35 (8): 59-69.
- Watts, N., Amann, M., Ayeb-Karlsson, S., Belesova, K., Bouley, T., Boykoff, M., ... & Costello, A. (2018). The Lancet Countdown on health and climate change: from 25 years of inaction to a global transformation for public health. *The Lancet*, *391*(10120), 581-630.
- Weick, K.E. & Quinn, R.E. (1999). Organizational change and development. *Annual review of psychology*, *50*(1), 361-386.
- Whitmee, S., Haines, A., Beyrer, C., Boltz, F., Capon, A. G., de Souza Dias, B. F., ... & Yach, D. (2015). Safeguarding human health in the Anthropocene epoch: report of The Rockefeller Foundation–Lancet Commission on planetary health. *The Lancet*, *386*(10007), 1973-2028.
- Wittmayer, J.M. (2016). *Transition Management, Action Research and Actor Roles: Understanding local sustainability transitions*. Doctoral dissertation. Rotterdam: Erasmus University Rotterdam.
- World Health Organization (2000). *The world health report 2000 – Health systems: improving performance.* Geneva: World Health Organization.
- World Health Organization (2003). *The World health report: 2003: shaping the future*. Geneva: World Health Organization. Retrieved from: https://apps.who.int/iris/handle/10665/42789
- World Health Organization (2014), *Quantitative risk assessment of the effects of climate change on selected causes of death, 2030s and 2050s*, World Health Organization.
- World Health Organization (2022). *A health perspective on the role of the environment in One Health*. Geneva: World Health Organization. Retrieved from: https://www.who.int/europe/publications/i/item/WHO-EURO-2022-5290-45054-64214
- World Health Organization, Health Care Without Harm (WHO-HCWH) (2010), *Healthy hospitals, Healthy planet, Healthy people: Addressing climate change in health care settings*. Geneva: World Health Organization.
- WRR (2021). *Kiezen voor houdbare zorg*. Den Haag: Wetenschappelijke Raad voor het Regeringsbeleid.
- Yin, R. K. (2003). Case study research design and methods third edition. *Applied social research methods series*, *5*.
- Yin, R. K. (2009). How to do better case studies. *The SAGE handbook of applied social research methods*, *2*(254-282).
- Youngson, R., & Blennerhassett, M. (2016). Humanising healthcare. *BMJ* 2016;355:i6262
- ZIN (2022). *Kader passende Zorg.* Diemen: Zorginstituut Nederland.

APPENDIX: SUMMARY OF CHAPTER 5

Positive Health: from niche-discourse to government jargon

There is a shift discernable in discourse within the Dutch healthcare sector, moving from a focus on illness and disease to a focus on health and well-being. This shift is reflected in the concept of Positive Health, which emphasizes maintaining and improving health rather than simply treating diseases. The main research question is: *How can we understand the discursive shift within Dutch healthcare, using the example of Positive Health, from a transition perspective?* This research explores the development and rapid spread of the Positive Health concept through a discourse analysis and examines the strategies that have contributed to its diffusion.

The transition perspective suggests that the current healthcare regime (dominant ways of thinking, doing and organizing) is facing increasing pressure and persistent problems, leading to the search for alternative approaches such as Positive Health. The study aims to analyze the discursive shift within Dutch healthcare and its implications for the future of the transition in the sector.

The concept of Positive Health was introduced by Machteld Huber as a new approach to health that goes beyond the traditional definition of health as complete physical, mental, and social well-being. Positive Health focuses on the ability to adapt and self-manage in the face of social, physical, and emotional challenges. Since its introduction, Positive Health has gained growing attention and dissemination and has developed from niche-discourse to an important part of national health policy such as the National Health Policy Memorandum 2020-2024.

The development and diffusion of Positive Health can be understood through different mechanisms identified by transition researchers: growth, replicating, partnering, instrumentalizing, and embedding.

- Growth refers to the quantitative expansion of Positive Health, such as an increasing demand for training and publications about the concept.
- Replicating involves translating Positive Health ideas and practices into different contexts. This includes adapting the concept for specific target groups and expanding its application to other domains, such as work. The Institute for Positive Health (iPH) has been actively involved in translating and disseminating Positive Health at multiple levels, from individual to national.
- Partnering involves collaboration and resource-sharing with other innovators. IPH has sought cooperation with various organizations in the field of training, research,

and implementation processes. This partnership approach has helped garner support and broaden the reach of Positive Health.

- Instrumentalizing refers to strengthening the innovation by exploiting opportunities in the governance context. This includes leveraging chance encounters, influential ambassadors, and opportunities to inspire relevant stakeholders. These encounters have contributed to the diffusion of Positive Health and its integration into policy discussions.
- Embedding occurs when an innovation becomes part of the social structure through mainstreaming and institutionalization. Positive Health has been included in policy documents and reports at the national level, such as the National Health Policy Memorandum 2020-2024. This indicates the institutionalization and legitimacy of the concept within the healthcare system.

The overlapping discourse used by niche and regime actors illustrates how this diffusion process was supported by a similar outline of context and problem formulation as well as the contribution of Positive Health. The diffusion of Positive Health has been supported by various actions and strategies, including those deployed by iPH and unintentional activities that have collectively contributed to its spread. These actions have operated at strategic, tactical, and operational levels, influencing discourses, networks, and practices. Specific attention was paid to strengthening the concept.

While Positive Health has faced criticism, its flexibility and shared identity have been strengths. Positive Health offers a broad perspective and can serve as a common language to improve cooperation between professionals and domains. Positive Health is also aligned with related movements, such as positive psychology and positive healthcare, which overlap in problem formulation and objectives.

Overall, the development and dissemination of Positive Health have been influenced by the identified mechanisms of transformative innovation. The strategies employed by iPH and other stakeholders have contributed to the growth and acceptance of Positive Health, although challenges related to existing structures and interests remain.

PHD PORTFOLIO

Work-/field experience

- Consultant and manager consultancy & training at Facit (2003-2016)
- Company secretary and manager strategy & policy at Fonteynenburg (2016-2022)

PhD courses

- Hora est! Leren Promoveren (2013-2014) at Erasmus Academie
- Professionalism and integrity in research (2016) at EGS3H
- Making your research proposal work for you (2016) at EGS3H
- English academic writing for PhD candidates (2016) at EGS3H
- Proefschriftschrijfdriedaagse (2017) at Louter Communicatie
- Doing the literature review (2018) at EGS3H
- Discoursanalyse (2020) at Evers research & training

Conferences

- International Sustainability Transitions (IST) Annual Conference in Brighton (2015)
- European Health Management Association (EHMA) Annual Conference in Porto (2016)

Other

- Transition Training Day (2015) at DRIFT/ TAC

ABOUT THE AUTHOR

Françoise Johansen (1977) was trained as a nurse and went on to study Healthcare Policy and Management at Erasmus University Rotterdam, at what is now the Erasmus School of Health Policy and Management (ESHPM). After graduating in 2003, Françoise joined Facit where she developed a career as a consultant in (long-term) healthcare. She was a specialist in the area of quality management. From quality management on she developed an interest in corporate social and environmental responsibility. This interest eventually became the drive for this PhD project and book.

While working as a consultant and manager at Facit, Françoise started to work on her PhD project in 2014 and connected healthcare with transition studies through her supervising team with Derk Loorbach from DRIFT and Annemiek Stoopendaal from ESHPM.

In 2016, Françoise went on to become Company Secretary and Manager for Strategy and Policy at Fonteynenburg, a healthcare organization specializing in housing, support and participation activities for people with social and mental health challenges. PHD research and work was combined throughout the years.

While finishing her PhD work, since the beginning of 2023 Françoise has once again engaged with healthcare organizations as a consultant. Now working as a freelance consultant, often together with colleagues from DRIFT. Het project focus on synthesizing healthcare- and transition knowledge.

When not at work, Françoise enjoys hiking, reading, cooking and practicing 'living with less'. You can also find her helping out at her husband's chocolate factory in Rotterdam or volunteering in the garden at care farm 'BuitenGewoon'.