# The *Value* of Different *Values*

## Exploring the Role of Values in Interorganizational Care Networks

**Nick Zonneveld**

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# The Value of Different Values

Exploring the Role of Values in Interorganizational Care Networks

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# 1.
# Introduction

Contemporary societies face mounting challenges in health and social care: ageing populations, rising costs, and workforce shortages are placing increasing pressure on systems that already struggle to deliver timely, effective, and sustainable care (OECD/European Commission, 2024; World Health Organization, 2024). As societal complexity grows, traditional, siloed approaches to health and social care are proving inadequate (De Matos et al., 2024; Martínez-González et al., 2014; Raab, 2024). In response, collaboration between organizations, within and across sectors, is widely seen as a necessary condition for improving care. A growing number of policies and programs across various countries have long called for 'integration', 'alignment', 'joint responsibility' and similar terms (Amelung et al., 2021; Exley et al., 2024; World Health Organization, 2018).

In this context, the Netherlands has continued a long-standing trajectory of integration ambitions, most recently formalized and reinforced through the Integrated Care Agreement (in Dutch: Integraal Zorgakkoord, IZA), signed in 2022. The IZA represents a recent and prominent next step in a longer Dutch history of efforts toward collaboration and integration in health and social care (Nies et al., 2021). Signed in 2022 between the Ministry of Health and key stakeholders, including insurers, patient representatives, hospitals, and other providers of primary, mental health, and home care services, the IZA aims to build on existing collaborative practices while providing renewed policy attention, financial resources, and formal recognition. It carries high ambitions, aiming to address persistent challenges in health and social care by strengthening and scaling cross-sector collaboration. In seeking to strengthen cooperation across sectors that have long operated in silos, the IZA envisions a further shift in how healthcare is organized and delivered. The agreement advocates a more integrated, patient-centered approach, rethinking traditional boundaries and responsibilities. Importantly, it does not start from a blank slate: in many cases, collaborations already existed and are now being further developed, reoriented, or formalized, partly in response to the IZA's objectives and funding mechanisms. The IZA extends beyond traditional healthcare entities by explicitly calling for integration with housing, social services, and community support, as also reflected in related programs such as WOZO (Housing, Support and Care for Older People), HLO (Outline Agreement on Elderly Care), and AZWA (the Supplementary Care and Wellbeing Agreement, built on the IZA). Together, these agreements seek to provide an impulse to existing initiatives by enabling more durable partnerships, reconfiguring relationships, and fostering a more integrated and cohesive response to the diverse challenges in care (Keij et al., 2024; Ministerie van Volksgezondheid, Welzijn en Sport, 2022).

Despite the high ambitions of the IZA and other agreements, as well as the proliferation of collaborative initiatives and platforms in the health and social care landscape (Raab, 2024; Van der Woerd et al., 2024; Van Vooren et al., 2024), the outcomes are often ambiguous or still fall short of expectations. Many initiatives fail or struggle to demonstrate clear and consistent results, leaving us often uncertain about why certain efforts succeed or fail (Janse, 2018; Michgelsen et al., 2023, 2025; Nilsson et al., 2016; Novick, 2017; R. Peeters, 2025; Perkins et al., 2020; Wankah et al., 2020). This raises a pressing question: Are we genuinely addressing the root causes behind integrated care challenges, or merely layering on new integration efforts without understanding what makes them work or fail in practice? To explore these foundational issues, we need a complementary perspective that moves beyond implementation, effective elements, conceptual models, and projects, and attends to the relational and organizational complexities through which integrated care is enacted in everyday practice.

## 1.1 An organization studies perspective on integrated care

Building on this premise, this dissertation adopts an organization studies perspective on integrated care, with particular attention to relational approaches within this field. Such a perspective starts from the assumption that integration is not a technical or managerial project, but an ongoing relational process that unfolds among actors. Integrated care initiatives are often constellations of collaborating organizations and individuals, each with their own interests, values, and institutional logics, who interact, negotiate, and coordinate around a shared purpose. Understanding how these relationships are structured, maintained, and governed is essential to explaining why integration efforts succeed or fail in practice.

Whereas integrated care is often treated as a fixed intervention or program that can be implemented as a project, an organization studies perspective highlights that it is better understood as a dynamic web of relationships between actors pursuing shared goals. This perspective emphasizes the connections between these actors and the ways in which their collective purpose is structured, coordinated, and governed. Integrated care has become the go-to paradigm for addressing persistent fragmentation in health and social care. It promises more person-centered, efficient, and coordinated services, and is widely embraced in both policy and practice internationally (Breton et al., 2017; World Health Organization, 2018). In its simplest form, integrated care aims to overcome fragmentation, as Goodwin (2016, p. 2) succinctly puts it. Yet despite the term's widespread appeal, its practical realization remains elusive. The

field is populated by a growing number of networks, partnerships, and programs, but could we better understand what makes integration work if we looked more closely at its relational and organizational aspects?

Part of the difficulty lies in conceptual ambiguity. The literature overflows with overlapping terms, 'network care', 'transmural care', 'coordinated care', and others, each emphasizing different aspects (Armitage et al., 2009; Goodwin et al., 2017). Meanwhile, stakeholders across practice and policy attach diverging meanings to the concept of integrated care, depending on their institutional roles, priorities, and values (S. Shaw et al., 2011). While some ambiguity is inevitable in complex fields, this terminological sprawl also points to a deeper issue: the lack of shared conceptual clarity limits the ability to build on existing knowledge and makes it difficult to address the relational and organizational challenges of integrated care. Yet integrated care is more than semantic exercise. At its core, it represents a radically different way of thinking about how care should be organized: not around institutional boundaries, but around the lived realities and needs of individuals and their social networks (Goodwin, 2016; Minkman, 2017b). From this perspective, integration demands not only coordination of services but also a reimagining of the relationships between organizations, sectors, and communities (Leutz, 1999; S. Shaw et al., 2011). It is a fundamentally relational and organizational undertaking.

In this dissertation, I therefore approach integrated care as (1) a way of thinking and organizing; (2) involving multiple stakeholders and actors; and (3) consisting of a composite array of relationships, interventions and activities. I define integrated care as

> *"Organizing care and support in a coordinated way, around an individual or group of individuals (and their social network), where boundaries between organizations or sectors no longer serve as limitations."* (Zonneveld et al., 2024, p. 37)

This definition illustrates the conceptual breadth of integrated care: it specifies coordination around individuals and their social networks, but it does not prescribe any particular organizational form. Integrated care, as defined here, can therefore be realized within a single organization, through programs, or through collaboration across multiple organizations. Yet, given the increasing complexity of care needs and the competencies required, many integrated care initiatives today involve multiple organizations from different sectors (Amelung et al., 2021). In that sense, although the definition itself is organizationally open, it aligns well with the growing prominence of interorganizational networks in contemporary integrated care practice. In practice,

these initiatives are often referred to as 'care networks', and I use this term throughout the dissertation. However, it is important to note that not all initiatives referred to as 'care networks' operate according to the principles of integrated care. For example, some may primarily function as administrative or learning networks within the care sector. In this dissertation, I focus specifically on interorganizational networks that enact integrated care, using them as the empirical setting for the research presented here.

In the chapters of this dissertation, published in different journals, I have used a variety of terms alongside "integrated care" as an empirical setting and subject of study: integrated health services, integrated service delivery, integrated care networks, care networks, or interorganizational networks delivering care, reflecting the conventions and audience of the respective journal. For example, "integrated care" and "integrated, people-centered health services" in the International Journal of Integrated Care (Chapter 2 and 4), "integrated health services" in BMC Health Services Research (Chapter 3), and "interorganizational networks" in Public Policy & Administration (Chapter 5).

The Dutch context exemplifies both the ambitions and the ambiguity of integrated care. Over the past two decades, a range of initiatives such as disease management programs for people with conditions like diabetes, dementia, COPD, and stroke (Amelung et al., 2021; De Bruin et al., 2013; Nies et al., 2021; Voogdt-Pruis et al., 2021), 'Right Care in the Right Place' (JZOJP), and more recently the Integrated Care Agreement (IZA) (Keij et al., 2024; Ministerie van Volksgezondheid, Welzijn en Sport, 2022; Van Vooren et al., 2024), have demonstrated a strong policy commitment to fostering collaboration and integration in health and social care. Yet the history of such efforts also reveals how difficult it is to move from vision to realization. Many of these networks remain fragile, dependent on temporary funding and leadership, goodwill, and informal coordination. Evaluations conducted across various countries frequently highlight the same issues: unclear objectives, lack of ownership, and difficulties in measuring long-term impact (Baxter et al., 2018; Janse, 2018; Michgelsen et al., 2023; Nolte & Pitchforth, 2014; Rocks et al., 2020; Tsiachristas et al., 2016; Van der Weert et al., 2022; Wankah et al., 2020; World Health Organization, 2018). The so-called "black box" of integrated care remains firmly shut (Goodwin, 2019).

Over the past decades, a substantial body of knowledge on integrated care has been developed. To better understand and implement integrated care, numerous frameworks, models, and taxonomies outlining key activities and components have been proposed (Ahgren et al., 2009; Busetto et al., 2016; Harnett et al., 2020; Minkman et al., 2025; Valentijn, 2015). The Development Model for Integrated Care (DMIC), for example,

illustrates that the implementation and development of integrated care revolves around four interrelated dimensions, plotted on an x- and y-axis: (1) quality of care, (2) organization of care, (3) effective collaboration, and (4) results and impact (Minkman et al., 2025). However, despite the richness of this literature, most of the existing knowledge remains grounded in healthcare delivery rather than in relational or organizational perspectives or theories. Many interventions, tools, and instruments aimed at enhancing integration and optimizing services are primarily designed from a health service delivery standpoint such as information technologies and care coordination tools. Moreover, due to persistent organizational barriers, such initiatives often remain confined to collaboration within for example the health or social care sector, rather than extending across the broader network of organizations involved in integrated care (Benjamins, 2020; MacInnes et al., 2021; Robertson et al., 2022; Snow et al., 2024).

More fundamentally, many approaches to integrated care treat organizations as passive vehicles for implementation: technical instruments through which integration is executed. This perspective fails to recognize that organizations are active, strategic actors that shape, negotiate, and govern integrated care, while forming relationships with other actors in the network. Yet even this framing oversimplifies reality. In practice, it is often specific parts of organizations—teams, departments, professional groups, or individuals—that engage in networks. As Raab (2024, p. 35) puts it, this adds *"another organizational layer to our society of organizations."* As a result, the ways in which people and organizations connect, relate, collaborate, and organize within integrated care remain insufficiently understood.

This knowledge gap is particularly urgent given the current policy emphasis on collaboration as a panacea. When collaboration is uncritically framed as inherently beneficial, there is a risk of overlooking the relational and organizational complexity it entails. Research has shown that healthcare networks and partnerships often fail due to precisely those issues that organization studies have long investigated: conflicting goals, weak accountability, lack of legitimacy, and insufficient attention to governance (Minkman, 2017a; Perkins et al., 2020). These insights underscore the need for a deeper understanding of the relational dynamics and organizational foundations of integrated care that are grounded in organization studies, to ensure that networks function effectively in practice.

In summary, integrated care can be understood as both a relational and an organizational endeavor. It depends on how autonomous actors connect, coordinate, and align their practices across boundaries. These relational dynamics, however, do not occur in a vacuum: in practice they take shape within specific organizational

forms. Increasingly, these forms take the shape of interorganizational networks. The next section therefore turns to interorganizational networks to explore how these are structured and governed.

## 1.2 Interorganizational networks

If we understand integrated care primarily as a relational and organizational phenomenon, then interorganizational networks emerge as a central organizational form through which it is enacted in practice. Across health and social care systems, collaboration increasingly takes place through networks that link autonomous organizations in pursuit of shared goals. Over the past decades, a substantial body of literature within organization studies has examined such networks as distinct organizational forms of collaboration (Provan & Kenis, 2008; Provan & Milward, 1995; Raab, 2024). These insights are highly relevant to integrated care, where coordination and interdependence extend beyond traditional organizational and sectoral boundaries.

As in the field of integrated care, the vocabulary surrounding networks is diffuse. Various terms and labels, such as alliances and partnerships, are used to describe similar collaborative initiatives (Hearld et al., 2012; Raab, 2024; Roussos & Fawcett, 2000). Even the concept of a "network" itself carries multiple definitions (Lemaire et al., 2019). In this dissertation, I adopt a pragmatic definition that reflects the organizational reality of many integrated care initiatives:

> "*Groups of three or more legally autonomous organizations working together to achieve not only their own goals but also a collective goal*" (Provan & Kenis, 2008, p. 231).

I view organizations as autonomous entities that coordinate their own activities and resources, operating within interorganizational networks (Provan & Milward, 2001).

Recent work by Nowell and Milward (2022) offers a helpful typology that distinguishes between three types of networks in the context of public management and policy: structural-oriented networks, system-oriented networks, and purpose-oriented networks. Structural-oriented networks refer to loosely defined social structures without fixed boundaries, such as informal relationships between professionals. System-oriented networks involve networks of actors linked through shared policy issues, such as referral networks. Purpose-oriented networks, by

contrast, are intentionally formed around specific goals, possess a shared identity, and have clearly defined membership rules (Nowell & Milward, 2022; Raab, 2024). The networks examined in this dissertation fall within this latter category, as they were intentionally established to achieve defined goals, involve actors with a shared purpose, and operate under explicit membership and governance arrangements.

A central organizational challenge for such networks is how to function effectively in the absence of formal authority. Unlike single hierarchical organizations, interorganizational networks lack a central decision-maker such as a CEO (Gulati et al., 2012). Instead, they consist of legally autonomous organizations that must find ways to coordinate their efforts. Governance of networks encompasses:

> *"The use of institutions and structures of authority and collaboration to allocate resources and to coordinate and control joint action across the network as a whole"* (Provan & Kenis, 2008, p. 3).

Provan and Kenis (2008) identify three distinct modes of network governance: shared governance (where all members jointly manage the network), lead organization governance (where one member takes the lead), and Network Administrative Organization (NAO) governance (where a separate administrative entity is created). Their contingency framework proposes that the effectiveness of a governance mode depends on contextual factors such as trust, size, goal consensus, and the need for network-level competencies. This framework has become a central reference point in the field (Van den Oord et al., 2023).

Beyond governance, a growing body of research focuses on the effectiveness of networks. Provan and Milward (2001) argue that effectiveness can be assessed at multiple levels: community (the value created for the broader population), network (the strength of inter-organizational linkages), and participant (the benefits for individual member organizations). This multi-level view highlights that effectiveness in networks is not a single metric but a negotiated outcome that may differ across stakeholders. Earlier work (Provan & Milward, 1995) already pointed to two sets of factors shaping network effectiveness: structure and context. Structure relates to internal features of the network, including the degree of centralization and integration. Context refers to external conditions such as system stability and the availability of resources ("resource munificence"). Later work adds further complexity by emphasizing network legitimacy, multi-level involvement, design, and stability (Provan & Lemaire, 2012; Turrini et al., 2009).

Taken together, these studies offer a rich and structured account of what makes interorganizational networks effective. Yet, the lived reality of network practice often proves more complex than what is captured on paper. Moreover, as Provan and Milward (1995) already noted, perceptions of effectiveness may differ substantially depending on whose perspective is taken, be it that of clients, family members, or professionals.

## 1.3 Emphasis on integration

A recurring theme across both interorganizational networks and integrated care research is the central role of integration. Building on foundational work in organization studies, scholars such as Lawrence and Lorsch (1967), Puranam (2018), and Kenis and Raab (2020) argue that organizations and networks are shaped by two interdependent forces: differentiation and integration. Differentiation refers to the division of labor and the specialization of roles across departments or organizations. In networks, this manifests in the varied expertise and tasks of the participating organizations, such as hospitals, social care providers, or mental health institutions, each contributing distinct capacities. In single organizations, top-down management can deliberately divide the entity into formal units such as departments, teams, or clusters, creating clearly defined boundaries and hierarchies. In interorganizational networks, by contrast, differentiation emerges across legally autonomous organizations that voluntarily collaborate around a shared purpose. Similarly, while integration in single organizations can often be achieved through hierarchical coordination and standardized procedures, in networks it requires alternative integration mechanisms, such as collaborative processes and governance, to coordinate the activities of diverse and independent actors effectively (Kenis & Raab, 2020; Lawrence & Lorsch, 1967; Puranam, 2018; Puranam et al., 2014).

The emphasis on integration is particularly evident in research on network effectiveness. Provan and Milward (1995), for instance, highlight centralized integration as a key determinant of performance. They conceptualize integration in terms of density (how interconnected the network is) and centralization (how much coordination is concentrated in a few central actors). Strong ties, frequent interaction, and effective coordination are seen as hallmarks of high-performing networks. Other frameworks similarly point to different levels of integration: Leutz (1999), for example, distinguishes between linkage, coordination, and full integration, while identifying the practical and political tensions that arise in trying to merge services. The Rainbow Model of Integrated Care (RMIC) adds a distinction between

functional (e.g., IT systems, financial mechanisms) and normative (e.g., shared culture and values) integration (Valentijn, 2015). Despite distinguishing integration across multiple levels and dimensions, the RMIC does not account for differentiation, such as the diversity of tasks, roles, and values.

Empirical studies reinforce this integration-centric view. Studies typically focus on how to foster collaboration through structures, leadership, trust, and governance (Klijn & Koppenjan, 2015; Provan & Kenis, 2008; Provan & Milward, 1995). In the literature on integrated care, much attention goes to identifying facilitators and barriers to integration, and mapping step-by-step approaches to improve it (Harnett et al., 2020; Kerrissey et al., 2022; L. A. Nooteboom et al., 2021; Van der Weert et al., 2022). A recent review identified 283 determinants of network effectiveness in healthcare, with the majority focusing on integration-related factors such as coordination, leadership, governance, and network-level competencies (R. Peeters et al., 2022).

Taken together, these findings suggest that much of the existing knowledge, both in organization studies and integrated care, frames networks primarily through the lens of integration. This raises an important question: might the dominant focus on integration overshadow the role of differentiation? Integration is important for aligning efforts and creating coherence. But differentiation allows organizations to contribute their own identities, values, and expertise. Could an overemphasis on linking actors together, come at the expense of recognizing and leveraging the diversity that makes networks valuable in the first place? In addition, insufficient attention to differentiation may lead to unrealistic expectations. It may be assumed that all actors in the network will easily align with each other. In reality, however, their diverse values and perspectives may create challenges that deserve more careful exploration.

A more comprehensive approach, one that studies both differentiation and integration, is needed to understand how interorganizational networks in integrated care navigate the tension between unity and diversity. This dissertation builds on that idea. The next section turns to the role of values as an entry point for examining how actors' distinct value orientations could shape collaboration in interorganizational care networks.

## 1.4 The role of values in care networks

The previous sections have argued that understanding collaboration in care networks requires attention to both integration and differentiation. Yet existing perspectives tend to approach these dynamics primarily in structural or functional terms, focusing on tasks, roles, and positions. While such dimensions are crucial, they leave an important aspect underexplored: the normative, cultural or cognitive dimension of collaboration. What might we learn if we also study how differentiation and integration unfold in terms of values, that is, what actors consider important? In this dissertation, values are defined as:

> "*Meaningful beliefs, principles, or standards of behavior, referring to desirable goals that motivate action*" (Hitlin & Piliavin, 2004; Schwartz, 2012).

Traditionally, differentiation has been understood in terms of the division of labor and structurally distinct positions (Kenis & Raab, 2020; Lawrence & Lorsch, 1967; Puranam, 2018). Yet especially in care networks, it seems plausible that differentiation also emerges in less task-oriented ways. Functional specialization, for example, may foster professional subcultures within disciplines, organizations, or interorganizational networks, each shaped by distinct value orientations (Moyo et al., 2016). This may resemble processes of normative isomorphism (DiMaggio & Powell, 1983). Furthermore, individuals and organizations may be drawn to others who share similar characteristics, such as background, interests, or values, a phenomenon known as homophily (Granovetter, 1973; McPherson et al., 2001). What role might these mechanisms play in shaping the dynamics of care networks?

These considerations invite further inquiry. Even if values are not always directly visible, could they help us better understand the relational dimension of integrated care? Values are often invoked in policy and academic discourse, yet their concrete implications for collaboration remain ambiguous. On the one hand, some scholars stress the need to "*identify shared values*" (Ansell & Gash, 2008), pointing to consensus as a foundation for collaboration. Others highlight the importance of "*reconciling different values*" (Klijn & Koppenjan, 2015), suggesting that differences must be harmonized. Similarly, in the context of integrated care, the Rainbow Model of Integrated Care (RMIC) refers to "*coordination mechanisms based on shared values*" (Valentijn, 2015). These perspectives frame values primarily as an integration mechanism.

On the other hand, several scholars remind us that actors in organizational networks often exhibit value differentiation, "*bring different values to the table*" (Klijn

& Koppenjan, 2015; Vangen & Huxham, 2012), and that particularly wicked problems are characterized by "*entrenched value differences*" (Head & Alford, 2015; Rittel & Webber, 1973). Emerson et al. (2012), for example, stress the importance of "*mutual understanding*", knowing and acknowledging each other's values, without necessarily implying value consensus. These views highlight that values may differ and do not necessarily have to be shared.

Taken together, these two perspectives, values as mechanisms of integration and as markers of differentiation, present both a complex puzzle and a fascinating tension. Diversity among actors is often seen as an asset, especially in addressing complex challenges, because it brings together complementary knowledge, skills, and resources. Yet such diversity is also likely to introduce value differences that can complicate collaboration. At the same time, a certain degree of shared understanding may be needed to support coordinated action. This suggests that values may simultaneously function as a source of cohesion and a source of friction in collaborative settings.

This normative dimension of collaboration may also represent a uniquely human capacity. In his popular book *'Sapiens: a Brief History of Humankind'*, Yuval Noah Harari (2015) argues that humans are capable of large-scale cooperation, even among strangers, due to shared values, beliefs and collective narratives. According to Harari, this capacity, what he calls the Cognitive Revolution, enables humans to collaborate flexibly and at scale, based on intangible values. Examples include financial systems, nation-states, human rights, and religious institutions, systems built on shared understandings of abstract principles. In this view, values are not only a potential source of tension and conflict but also a fundamental enabler of collaboration, shaping how individuals and groups cooperate within complex social systems.

This opens up a series of intriguing questions for care networks. If values are to function as an integration mechanism, which values matter most in the context of integrated care, and how do they foster collaboration? At the same time, processes like professional socialization, institutional histories, and self-selection may lead to enduring value differences. Are such differences necessarily an obstacle, or might they in some cases be generative? How do these dynamics shape the capacity for joint action across boundaries? And if both value differentiation and value integration are present in networks that address contemporary challenges, how can we learn to navigate this dynamic space in practice? These questions call not only for closer examination but also highlight a largely uncharted area that truly merits in-depth investigation.

## 1.5 Main research question

These considerations underline the need for a more systematic understanding of how values play a role in interorganizational care networks. **The aim of this PhD research is to understand how values, both as differentiating factors and as an integration mechanism, play a role within interorganizational care networks.** Using the field of integrated care as an empirical setting, this research seeks to contribute not only to integrated care itself but also to broader debates on interorganizational networks and governance in organization studies. To achieve this goal, I explore integrated care practice through a relational and organization studies lens, examining how values shape both collaboration within and the effectiveness of interorganizational networks. The central research question guiding this investigation is:

> *What role do values play in care networks and how do they affect effectiveness in integrated care?*

Sub-questions are:

1. What values play a role in integrated care according to the existing literature?
2. What are the value orientations of actors in care networks, and how can similarities and differences in these orientations be explained?
3. How do individual values of actors and collective values at the network level manifest in care networks, what tensions arise, and how do actors address these tensions?
4. What combinations of conditions related to (value) differentiation and (value) integration are associated with network effectiveness?

## 1.6 Dissertation structure

This dissertation consists of five chapters, each addressing one of these topics. The chapters are written as separate articles, which can be read independently. However, together, they form a cohesive whole that sheds light on these questions. Given the nature of the research questions, I have used a mix of different methodologies in this dissertation. The dissertation is structured as follows. Chapter 2 and 3 explore the integrative role of values in integrated care. **Chapter 2** reviews the literature on values and integrated care as a concept, providing a deeper understanding of the concept of values and developing a set of core values that underpin integrated care. This chapter also characterizes and describes these values, offering a potential vocabulary for the subsequent studies. **Chapter 3** refines this set of values through expert

input and provides further insights into the relevance of these individual values at different levels of integration. **Chapter 4** shifts focus to the differentiation aspect of values. This chapter quantitatively explores the value orientations of various actor groups within networks pursuing integrated care. The study identifies significant value differentiation both among different actor groups and across European sub-regions. Additionally, the analysis uncovers two distinct value clusters, offering deeper insight into the possible relationships and interconnections between values. **Chapter 5** presents an empirical case study of an interorganizational pregnancy and childbirth care network, examining the role of values in network collaboration. The study reveals both different actor values and certain shared values at the network level. Furthermore, it highlights three key value tensions between actors, exploring the coping strategies employed by both network actors and the network leader to address these challenges. **Chapter 6** adopts a configurational approach to investigate the combinations of conditions related to (value) differentiation and integration that lead to network effectiveness. By studying 24 care networks, this chapter draws direct links between the (dis)alignment of shared values and the effectiveness of care networks, identifying when values should be shared and when they need not be, in order to maximize network outcomes. **Chapter 7** concludes the dissertation by summarizing the findings, answering the main research question, and discussing both the theoretical and practical implications of the study. It also reflects on the methodology and limitations of the dissertation. Lastly, it provides recommendations for practice, policy and further research based on the insights gained throughout the dissertation.

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# 2.

# Values of Integrated Care: A Systematic Review

Published as:

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## Abstract

**Introduction**: Although substantial generic knowledge about integrated care has been developed, better understanding of the factors that drive behavior, decision-making, collaboration and governance processes in integrated care networks is needed to take integrated care forward. To gain more insight into these topics and to understand integrated care in more depth, a set of underlying values of integrated care has been developed and defined in this study.

**Theory and methods**: A systematic literature review was conducted to identify the underlying values of integrated care. Values theory was used as a theoretical framework for the analysis.

**Results**: This study identified 23 values in the current body of knowledge. The most frequently identified values are 'collaborative', 'coordinated', 'transparent', 'empowering', 'comprehensive', 'co-produced' and 'shared responsibility and accountability'.

**Discussion and conclusion**: The set of values is presented as a potential basis for a values-driven approach to integrated care. This approach enables better understanding of the behaviors and collaboration in integrated care and may also be used to develop guidance or governance in this area. The practical application of the values and their use at multiple levels is discussed. The consequences of different stakeholder perceptions on the values is explored and an agenda for future research is proposed.

## 2.1 Introduction

Integrated care is often proposed as future direction for the development of healthcare systems in many countries. Because people are living longer with more chronic conditions, the number of people with multiple health and social care needs is growing (World Health Organization, 2015c). To meet these complex needs, knowledge and skills are required which span multiple disciplines in various sectors, for instance primary care, long-term care and social care. These developments put pressure on the delivery, management and funding of care services. In order to address this and to improve quality of care and quality of lives, integrated care is often introduced as a leading paradigm. The World Health Organization (WHO), for instance, acknowledges the importance of integrated care in its vision and global strategy for health services delivery (2015b), and there is a proliferation of integrated care initiatives in many different countries, settings and environments (De Bruin et al., 2018; Hébert et al., 2003; Lara Montero et al., 2016). The WHO defines integrated care (or integrated health services delivery) as

> *"an approach to strengthen people-centered health systems through the promotion of the comprehensive delivery of quality services across the life-course, designed according to the multidimensional needs of the population and the individual and delivered by a coordinated multidisciplinary team of providers working across settings and levels of care. It should be effectively managed to ensure optimal outcomes and the appropriate use of resources based on the best available evidence, with feedback loops to continuously improve performance and to tackle upstream causes of ill health and to promote well-being through intersectoral and multisectoral actions"* (World Health Organization, 2016b, p. 10).

Furthermore, integrated care aims to contribute towards improving population health, improving individual experiences of care, and reducing costs of care per capita, also known as the Triple Aim objectives (Berwick et al., 2008).

While the objective is promising, integrated care remains a complex phenomenon which takes place at multiple levels, with various interventions, stakeholders and contextual factors that can influence processes and results (Busetto et al., 2016; Goodwin, 2013b; Valentijn, Boesveld, et al., 2015; Valentijn, Vrijhoef, Ruwaard, Boesveld, et al., 2015). The evidence for positive outcomes in integrated care is mixed for various reasons (Armitage et al., 2009; Johri et al., 2003; Nolte & Pitchforth, 2014; World Health Organization, 2015a, 2016c). Furthermore, many different definitions of integrated care are used in scientific literature and in practice (Cash-Gibson &

Rosenmoller, 2014; Goodwin et al., 2017; Kodner & Spreeuwenberg, 2002; Leutz, 1999; Schrijvers, 2016; World Health Organization, 2015b, 2016b). The literature describes numerous concepts similar to integrated care, e.g. 'care coordination', 'collaborative care' or 'comprehensive care'. These definitions and concepts overlap to some extent, however the description of integrated care is not uniform and is still ambiguous.

Various efforts to analyze the complexity and provide a framework for the concept of integrated care, have led to the development of a substantial body of generic knowledge in recent years. As well as defining integrated care, several studies describe integrated care interventions, sets of measurements and generic ingredients (Ahgren et al., 2009; Bautista et al., 2016; Busetto et al., 2016; Minkman, 2012; Singer et al., 2011; Solinís & Stein, 2016; Tietschert et al., 2016; Valentijn, Boesveld, et al., 2015; Wagner et al., 1996). Some of these studies resulted in conceptual models and frameworks, and although the focus may be different, they contain many common factors; the descriptions of which are similar and may overlap. For instance, the role of inter-professional collaboration within and between organizations is reflected in multiple models (Bautista et al., 2016; Minkman, 2012; World Health Organization, 2016c). This generic knowledge is applicable in a broad range of integrated care settings. In practice, however, knowledge is tailored to local needs and circumstances, resulting in a variety of ways in which integrated care is executed.

Current knowledge about integrated care provides the basis for the development of integrated care initiatives, but to take integrated care a step further, deeper understanding of collaboration and behavior in integrated care is needed. Since integrated care is a collective process, its implementation and execution depends on collaboration between individuals and organizations, such as clients, their families, professionals, governments and health insurers. Although working together, these actors may have different views, interests and objectives (D'Amour et al., 2008). The identification of values in integrated care can therefore provide more insight into what drives the behaviors and decision-making of the various actors involved in integrated care processes (Hitlin & Piliavin, 2004; Schwartz, 2012).What values are considered to be important and which ones influence behaviors, decision-making and perception of quality? This study aims to identify the underlying values of integrated care described in the current literature.

## Value and values in integrated care

The concepts of 'value' and 'values' are being mentioned more frequently in health- and integrated care literature and practice, mostly in relation to defining quality, guiding professional behavior and aligning collaboration. When interpreting these

concepts, it is important to be aware that *value* and *values* are used as different concepts with different meanings. This study focuses on *values*, which can be defined as meaningful beliefs, principles or standards of behavior, referring to desirable goals that motivate action (Hitlin & Piliavin, 2004; Schwartz, 2012). The term *value*, used in for instance Value-based healthcare, refers to the degree of success shown by a provider in meeting the needs of clients, relative to costs (Porter, 2008, 2010; Porter & Teisberg, 2006).

When looking at *values*, the healthcare sector has a tradition of professional and ethical codes for professionals that prescribe values, principles and quality standards in relation to professional behavior (Meulenbergs et al., 2004). Professional codes facilitate and guide professionals in their daily work and form a template for professional decision-making and behavior (Hussey, 1996; Meulenbergs et al., 2004). In addition to professional codes, we also see codes which are used to guide organizations. An example is the Governance Code for healthcare providers in the Netherlands which states that care providers should define their values to determine their role in society. Besides common values, such as integrity, transparency and efficiency, every care provider should define their own individual values, corresponding to their specific position and objectives (Branchorganisaties Zorg, 2017).

The importance of values is also acknowledged in integrated care literature and practice. Values are regarded as essential for increasing staff commitment to delivering the best quality for clients in successful integrated care practices (Goodwin, 2013a). Shared values across professionals and organizations are considered to be important factors in informal coordination and collaboration processes (Valentijn et al., 2013). Furthermore, better understanding of the values of integrated care is necessary for the delivery of improved quality of care and client experiences (Minkman, 2016).

Despite the growing attention being paid to values in the literature and practice, there is a lack of information about the actual relevant values in integrated care and their definition. The WHO (2015b) recently published a strategic report that addresses values: *'Global strategy on people-centered and integrated health services'* (interim report). In this report it is stated that the different approaches in people-centered and integrated health service delivery *"should be grounded in a common set of principles. These provide a unifying values framework"* (World Health Organization, 2015b, p. 11). This report contains a first set of guiding principles of integrated care, developed in collaboration with the International Foundation for Integrated Care

(Ferrer & Goodwin, 2014; World Health Organization, 2015b). This set of principles was developed by considering the views of the partners involved in the development of the interim report, but the findings have not yet been systematically assessed.

### Study aims and objectives

Identification of the underlying values of integrated care enables better and deeper understanding of collaboration and behavior in integrated care, and could also help to define quality in integrated care. The theoretical contribution of this study is to identify the values of integrated care from a systematic review of the current literature. The research question posed in this study is: based on current literature, what values underpin integrated care, and how can these values be described?

## 2.2 Theoretical background

To identify the values which are associated with integrated care, it is necessary to have a deeper understanding of values as a theoretical concept. Many social scientists have been working on values in recent decades. In the 1950s Kluckhohn (1951, p. 395) referred to values as conceptions of the desirable that influence actions, distinguish individuals and characterize groups. Later, in the 1970s, Rokeach added that values give meaning to these actions and behaviors. He considered values to be the beliefs that specific end-states or modes are preferable to an opposite situation (Hitlin & Piliavin, 2004). In sociological theory, values are seen as moral compasses, determining what is important in our lives (Spates, 1983). Our values form the core of our identity (Hitlin, 2003) and our behavior can be a manifestation of our values (Ajzen & Fishbein, 1980). The role of values in organizational processes has also been studied (Connor & Becker, 1975). Rokeach distinguishes so-called supra-individual values - societal, institutional and organizational values - and discusses the relationships between these types of values (Rokeach, 2008). Since integrated care is about coordination across professionals, providers, settings and levels of care (Zazzali et al., 2007) and other societal and organizational processes, this supra-individual perspective could also be relevant for this study.

While classical theorists such as Kluckhohn and Rokeach contributed to the conceptualization of values, Schwartz contributed to the applicability and measurability of values in modern times. He drew on the work of Kluckhohn and Rokeach by developing a 'Theory of Basic Values' (Schwartz, 2012) and testing values empirically in many different countries (Schwartz, 1992). In the Schwartz Value Survey (SVS) he relates values explicitly to guiding principles, asking respondents

to rate the importance of values as a "guiding principle" in their lives on a 9-point scale (Schwartz, 1992). Schwartz and Bilsky (1987, p. 551) also introduced five common characteristics of values, based on the body of knowledge at that time:

(a) values are concepts or beliefs
(b) values refer to desirable goals, end states or behaviors
(c) values transcend specific situations and objects. E.g. contrary to attitudes, values remain relevant in multiple contexts: in personal relationships, in work or in politics.
(d) values are the guiding principles in life and, as such, are used in the selection or evaluation of events, policies or behavior. They serve as criteria for the preferred course of action.
(e) values are ordered by relative importance.

Individuals and groups of people vary in the importance they attach to particular values. In other words, they have different value hierarchies. In this way, values characterize individuals, groups and organizations, and can be used in the interpretation of their actions, behaviors and attitudes (Hitlin & Piliavin, 2004; Schwartz, 2012). For example: people who attach more importance to freedom and flexibility than to housing security, would rather rent a house than buy one. Values can also be used to elucidate organizational behavior and decision-making. For instance, the relative importance of the values 'safety' and 'privacy' may influence decisions about video surveillance in elderly care homes. If privacy prevails, the elderly care home may opt for an alternative solution.

Values theory may also be relevant in an integrated care setting, where decision-making processes and collaboration between multiple stakeholders with varying interests play a role (D'Amour et al., 2008). By the absence of formal hierarchy in more horizontal collaboration, other process of decision-making occur in which values could play a role. The aim of this study is to systematically identify underlying values of integrated care in the current literature, guided by the theoretical foundations described above. The search terms used in the systematic review were derived from Schwartz' publications (1987; 1992; 2012), and the content analysis was guided by the insights of Schwartz and Bilsky (1987). In this study, concepts or text fragments introduced in the literature are only considered to be values when they meet Schwartz and Bilsky's five common characteristics of values (1987). Lastly, the insights of Hitlin and Piliavin (2004), Schwartz (2012), Rokeach (2008) were used in the discussion section to reflect on the findings.

## 2.3 Methods

### Systematic review of the literature

The main objective of this study is to identify the values underpinning integrated care described in the current literature. A systematic electronic database search was conducted, in which we focused on papers in peer-reviewed journals. We searched the PubMed, PsycInfo and EBSCO Medline databases from 2006 to July 11th 2017. Articles and reports were also retrieved by tracking reference lists. Empirical, theoretical and conceptual articles, written in English, were included in the search strategy (see Appendix 2.1).

We searched for references that had the terms 'values', 'principles' or similar nomenclature (Schwartz, 2012) in the title, combined with frequently used definitions and terminologies of integrated care, such as 'coordinated care', 'person centered integrated care' and 'care coordination' (Goodwin et al., 2017). Some articles contain conceptual models that describe the building blocks or key elements of integrated care. These models may include certain values (Schwartz, 2012) and since they also support theory building, we also searched for articles with the terms "models" and "frameworks" in the title and abstract.

All search results were imported in MS Excel and duplicates were removed. Articles that contained definitions or descriptions of underlying values that fitted with Schwartz and Bilsky's five common characteristics of values (Schwartz & Bilsky, 1987, p. 551) were eligible for inclusion in the literature review. Two researchers independently screened the titles and abstracts of the search results. Disagreements were resolved by consensus discussions. If consensus could not be reached, a third researcher was consulted. The full-text articles were also independently assessed by two researchers. As before, any disagreements were resolved by discussion and when consensus could not be reached, a third researcher was consulted.

### Data extraction and content analysis

Two data types were extracted from the articles included in the review. First, of each article the author(s), year of publication, title, country, scope of the article, study design and perspective were noted (see Appendix 2.2). Thereafter, all included articles were subject to directed content analysis (Hsieh & Shannon, 2005).

All manuscripts were imported into MaxQDA software, and were independently reviewed by two researchers. Text fragments that contained all five features of values described by Schwartz and Bilsky (1987, p. 551) were highlighted. All

highlighted text was coded using a predetermined coding sheet wherever possible. The predetermined coding sheet was based on the set of 16 principles presented in the article 'Principles of Integrated Care' by Ferrer and Goodwin (2014). This set was chosen for the following reasons: 1) in his publications, Schwartz operationalizes values as "guiding principles in life" (Schwartz, 1992, 2012; Schwartz & Bilsky, 1987). This set specifically refers to guiding principles in integrated care, 2) Ferrer and Goodwin's principles were identified by consideration of the views and comments from international stakeholders and partners in the field of integrated care, and 3) the principles have been used in the policy report 'Global Strategy on People-Centered and Integrated Health Services' published by the WHO (2015b). Text fragments that could not be coded into one of the predetermined categories were coded with a new label that summarized the essence of the text fragment. The coding sheet was only extended with any new labels that emerged during the analysis if 1) both researchers agreed that the particular value was an addition to the existing coding sheet, and 2) the particular value met all five characteristics of values described by Schwartz and Bilsky (1987, p. 551). Subsequently, all coded text fragments were categorized and sorted per value label. Values supported by less than three articles were excluded. Any differences or disagreements to arise from the simultaneous coding were resolved by discussion between the two researchers. If no consensus was reached, a third researcher was consulted.

In the next step the values identified were described. First, all coded text fragments were sorted per value. Subsequently, two researchers independently divided the text fragments into segments representing the characteristics of the corresponding value. Thereafter, the characteristics of the values were discussed by the two researchers, resulting in a list of characteristics per value. Lastly, the lists of characteristics were processed into separate value descriptions. The descriptions of the 16 predetermined categories were developed by enhancing their initial descriptions (Ferrer & Goodwin, 2014) with the additional characteristics from the analysis. The complete analysis process was supervised by a fourth researcher.

## 2.4 Results

A total of 924 records were identified by searching the databases. Two records were added by tracking reference lists. After removing duplicates, 475 articles remained. After screening titles and abstracts, 62 full-text articles were assessed for eligibility. Out of these 62 articles, 40 articles were excluded. The reasons for exclusion were recorded, e.g. articles that describe models for implementation processes, but

no substantive elements of integrated care. Finally a total of 22 publications were retained for content analysis (see the PRISMA flow diagram in Figure 2.1).

The characteristics of the included full-texts are described in Table 2.1. Approximately 73% of the included articles originated from North America and 27% from Europe. The included articles are mostly qualitative descriptive papers (N=18), and most of the included full-texts are written from a researcher's or expert's perspective (N=18). Appendix 2.2 provides a list of the included full-texts.

**Table 2.1** Characteristics of the full-text articles (N=22).

| | **Full-texts (N=22)** | **In %** |
|---|---|---|
| **Countries of origin** | | |
| United States of America | 11 | 50.0 |
| Canada | 5 | 22.7 |
| The Netherlands | 2 | 9.1 |
| Belgium | 1 | 4.5 |
| England | 1 | 4.5 |
| Italy | 1 | 4.5 |
| Sweden | 1 | 4.5 |
| **Study designs** | | |
| Qualitative: descriptive | 18 | 81.8 |
| Systematic review | 3 | 13.6 |
| Mixed methods: embedded design | 1 | 4.5 |
| **Perspectives** | | |
| Researcher/expert | 18 | 81.8 |
| Professional | 3 | 13.6 |
| Client | 1 | 4.5 |

**Figure 2.1** PRISMA flow diagram showing the study selection process.

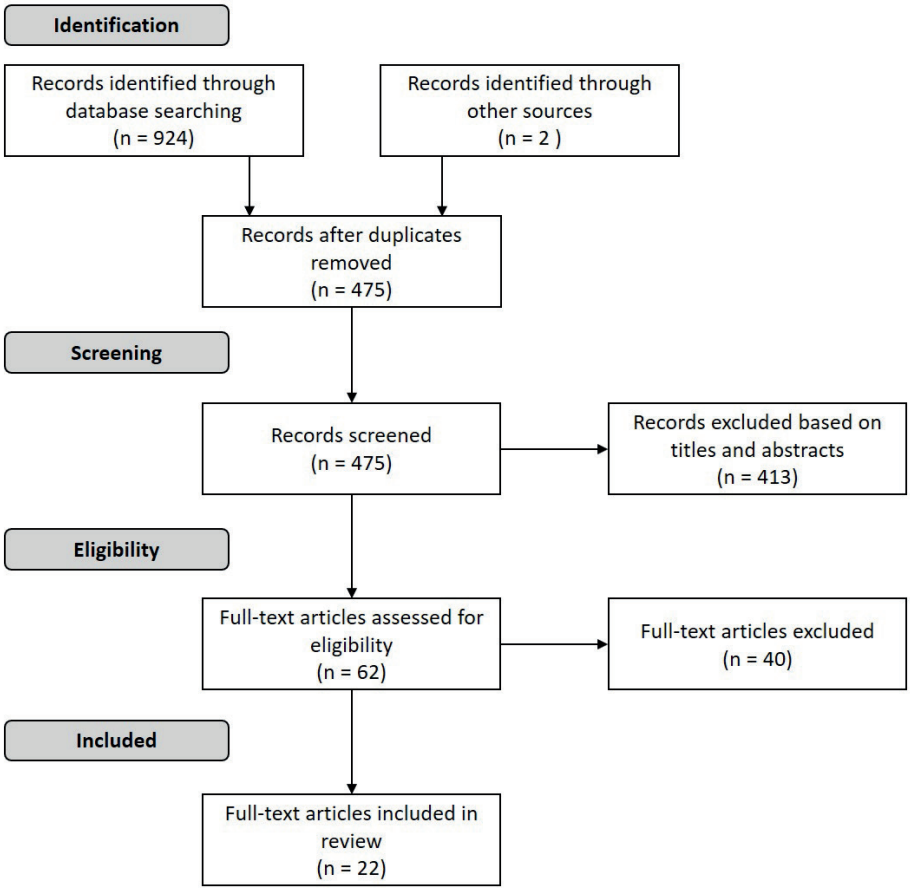

**Table 2.2** Values, descriptions and references.

| # | Value label | Brief description | References |
|---|---|---|---|
| 1 | **Collaborative** | Professionals work together in teams, in collaboration with clients, their families and communities, establishing and maintaining good (working) relationships. | (Baird et al., 2014; Bodenheimer et al., 2014; Butt et al., 2008; Callahan et al., 2011; Clark et al., 2007; Craig et al., 2015; Ferrer & Goodwin, 2014; Johnson, 2009; Kodner, 2008; Minkman et al., 2008; Mulvale et al., 2016; Poochikian-Sarkissian et al., 2008; Prokop, 2016; J. Shaw et al., 2016; Suter et al., 2008; Thornton, 2013; Valentijn et al., 2013; Van Houdt et al., 2013; Walker et al., 2013; Winge et al., 2010) (*n*=20) |
| 2 | **Coordinated** | Connection and alignment between the involved actors and elements in the care chain, matching the needs of the unique person. Between professionals, clients and/or families, within teams and across teams. | (Baird et al., 2014; Bodenheimer et al., 2014; Butt et al., 2008; Callahan et al., 2011; Ferrer & Goodwin, 2014; Johnson, 2009; Kodner, 2008; Lega, 2007; Minkman et al., 2008; Poochikian-Sarkissian et al., 2008; Prokop, 2016; Radwin et al., 2016; J. Shaw et al., 2016; Suter et al., 2008; Thornton, 2013; Valentijn et al., 2013; Van Houdt et al., 2013; Walker et al., 2013; Winge et al., 2010) (*n*=19) |
| 3 | **Transparent** | Openly and honestly giving insight in information, decisions, consequences and results, between clients, their families, professionals and providers. | (Baird et al., 2014; Butt et al., 2008; Craig et al., 2015; Johnson, 2009; Minkman et al., 2008; Mulvale et al., 2016; Poochikian-Sarkissian et al., 2008; Prokop, 2016; Radwin et al., 2016; J. Shaw et al., 2016; Suter et al., 2008; Thornton, 2013; Van Houdt et al., 2013; Walker et al., 2013; Winge et al., 2010) (*n*=15) |
| 4 | **Empowering** | Facilitating and supporting people to build on their strengths, make their own decisions, manage their own health and take responsibility for it. | (Bodenheimer et al., 2014; Callahan et al., 2011; Craig et al., 2015; Ferrer & Goodwin, 2014; Johnson, 2009; Kodner, 2008; Minkman et al., 2008; Poochikian-Sarkissian et al., 2008; Prokop, 2016; Suter et al., 2008; Thornton, 2013; Valentijn et al., 2013; Walker et al., 2013) (*n*=13) |
| 5 | **Comprehensive** | The availability of a wide range of services, tailored to the evolving needs and preferences of clients and their families. | (Baird et al., 2014; Bodenheimer et al., 2014; Butt et al., 2008; Ferrer & Goodwin, 2014; Johnson, 2009; Kodner, 2008; Lega, 2007; Poochikian-Sarkissian et al., 2008; Prokop, 2016; Thornton, 2013; Valentijn et al., 2013; Van Houdt et al., 2013; Walker et al., 2013) (*n*=13) |

**Table 2.2** Continued

| # | Value label | Brief description | References |
|---|---|---|---|
| 6 | **Co-produced** | Engaging clients, their families and communities in the design, implementation and improvement of services, through partnerships, in collaboration with professionals and providers. | (Baird et al., 2014; Bodenheimer et al., 2014; Butt et al., 2008; Callahan et al., 2011; Craig et al., 2015; Ferrer & Goodwin, 2014; Minkman et al., 2008; Poochikian-Sarkissian et al., 2008; Prokop, 2016; Suter et al., 2008; Thornton, 2013; Valentijn et al., 2013; Walker et al., 2013) (*n*=13) |
| 7 | **Shared responsibility and accountability** | The acknowledgment that multiple actors are responsible and accountable for the quality and outcomes of care, based on collective ownership of actions, goals and objectives, between clients, their families, professionals and providers. | (Baird et al., 2014; Bodenheimer et al., 2014; Butt et al., 2008; Clark et al., 2007; Ferrer & Goodwin, 2014; Kodner, 2008; Lega, 2007; Mulvale et al., 2016; Poochikian-Sarkissian et al., 2008; J. Shaw et al., 2016; Valentijn et al., 2013; Van Houdt et al., 2013; Walker et al., 2013) (*n*=13) |
| 8 | **Continuous** | Services that are consistent, coherent and connected, that address the needs and preferences of clients across their life course. | (Baird et al., 2014; Bodenheimer et al., 2014; Callahan et al., 2011; Ferrer & Goodwin, 2014; Johnson, 2009; Kodner, 2008; Lega, 2007; Minkman et al., 2008; Radwin et al., 2016; Valentijn et al., 2013; Van Houdt et al., 2013; Walker et al., 2013) (*n*=12) |
| 9 | **Holistic** | Putting the clients and their needs in the center of the service, whole person oriented, with an eye for physical, social, socio-economical, biomedical, psychological, spiritual and emotional dimensions. | (Baird et al., 2014; Butt et al., 2008; Callahan et al., 2011; Craig et al., 2015; Ferrer & Goodwin, 2014; Johnson, 2009; Prokop, 2016; Radwin et al., 2016; Suter et al., 2008; Thornton, 2013; Valentijn et al., 2013) (*n*=11) |
| 10 | **Goal oriented** | Working with clearly described, concrete, measurable, common goals and objectives for clients, their families, professionals and providers. | (Bodenheimer et al., 2014; Ferrer & Goodwin, 2014; Minkman et al., 2008; Mulvale et al., 2016; Poochikian-Sarkissian et al., 2008; Prokop, 2016; J. Shaw et al., 2016; Suter et al., 2008; Valentijn et al., 2013; Van Houdt et al., 2013; Winge et al., 2010) (*n*=11) |
| 11 | **Personal** | Delivering care by establishing personal contact and relationships, to ensure that services and communication are based on the unique situations of clients and their families. | (Baird et al., 2014; Bodenheimer et al., 2014; Johnson, 2009; Lega, 2007; Minkman et al., 2008; Prokop, 2016; Radwin et al., 2016; Suter et al., 2008; Valentijn et al., 2013; Walker et al., 2013) (*n*=10) |

**Table 2.2** Continued

| # | Value label | Brief description | References |
|---|---|---|---|
| 12 | **Evidence-informed** | Working processes, policies and strategies are guided by evidence-based knowledge, data and information, supported by technology and periodic assessment. | (Bodenheimer et al., 2014; Butt et al., 2008; Callahan et al., 2011; Ferrer & Goodwin, 2014; Johnson, 2009; Minkman et al., 2008; Mulvale et al., 2016, 2016; Poochikian-Sarkissian et al., 2008; Suter et al., 2008; Van Houdt et al., 2013) (*n*=10) |
| 13 | **Respectful** | Treating people with respect and dignity, being aware of their experiences, feelings, perceptions, culture and social circumstances. | (Bodenheimer et al., 2014; Butt et al., 2008; Clark et al., 2007; Craig et al., 2015; Ferrer & Goodwin, 2014; Poochikian-Sarkissian et al., 2008; Prokop, 2016; Radwin et al., 2016; Van Houdt et al., 2013; Walker et al., 2013) (*n*=10) |
| 14 | **Equitable** | Services are accessible and available for all people, and they are all treated equally. | (Baird et al., 2014; Bodenheimer et al., 2014; Callahan et al., 2011; Ferrer & Goodwin, 2014; Johnson, 2009; Lega, 2007; Valentijn et al., 2013; Van Houdt et al., 2013; Walker et al., 2013) (*n*=9) |
| 15 | **Sustainable** | Services are efficient, effective and economically viable, ensuring that they can adapt to evolving environments. | (Bodenheimer et al., 2014; Butt et al., 2008; Ferrer & Goodwin, 2014; Johnson, 2009; Kodner, 2008; Lega, 2007; Poochikian-Sarkissian et al., 2008; Van Houdt et al., 2013) (*n*=8) |
| 16 | **Led by whole-systems thinking** | Taking interrelatedness and interconnectedness into account, realizing changes in one part of the system can affect other parts. | (Butt et al., 2008; Callahan et al., 2011; Craig et al., 2015; Ferrer & Goodwin, 2014; Kodner, 2008; Prokop, 2016; Valentijn et al., 2013; Winge et al., 2010) (*n*=8) |
| 17 | **Flexible** | Care that is able to change quickly and effectively, to respond to the unique, evolving needs of clients and their families, both in professional teams and organizations. | (Butt et al., 2008; Lega, 2007; Mulvale et al., 2016; Poochikian-Sarkissian et al., 2008; Prokop, 2016; Radwin et al., 2016; Walker et al., 2013) (*n*=7) |
| 18 | **Preventative** | Early detection and action for clients and their families that promotes individual and public health. | (Callahan et al., 2011; Ferrer & Goodwin, 2014; Johnson, 2009; Lega, 2007; Suter et al., 2008; Thornton, 2013) (*n*=6) |

**Table 2.2** Continued

| # | Value label | Brief description | References |
|---|---|---|---|
| 19 | **Reciprocal** | Care based on equal, interdependent relationships between clients, their families, professionals and providers, and facilitate cooperative, mutual exchange of knowledge, information and other resources. | (Butt et al., 2008; Poochikian-Sarkissian et al., 2008; Prokop, 2016; J. Shaw et al., 2016; Winge et al., 2010) (*n*=5) |
| 20 | **Innovative** | Supporting, facilitating and creating space for innovation and future improvements in professional teams and organizations. | (Bodenheimer et al., 2014; Minkman et al., 2008; Mulvale et al., 2016; Poochikian-Sarkissian et al., 2008) (*n*=4) |
| 21 | **Trustful** | Enabling mutual trust between clients, their families, communities, professionals and organizations, in and across teams. | (Butt et al., 2008; Poochikian-Sarkissian et al., 2008; J. Shaw et al., 2016; Suter et al., 2008) (*n*=4) |
| 22 | **Proficient** | Knowledgeable and skillful services are provided by professionals, with a focus on quality. | (Baird et al., 2014; Mulvale et al., 2016; Radwin et al., 2016) (*n*=3) |
| 23 | **Safe** | Care services that are safe for clients, their families and professionals, including privacy and confidentiality protection. | (Baird et al., 2014; Callahan et al., 2011; Van Houdt et al., 2013) (*n*=3) |

Content analysis of the 22 articles resulted in 23 values and their corresponding descriptions (see Table 2.2). The 23 values identified have been generally described and can be applied to a broad range of circumstances. The values that were identified most frequently are 'collaborative' (N=20), 'coordinated' (N=19), 'transparent' (N=15), 'empowering' (N=13), 'comprehensive' (N=13), 'co-produced' (N=13) and 'shared responsibility and accountability' (N=13). The values 'innovative' (N=4), 'trustful' (N=4), 'proficient' (N=3) and 'safe' (N=3) were reported least of all.

## 2.5 Discussion

The main objective of this study was to identify the values underpinning integrated care that are evident in the current literature. A systematic literature review was performed which resulted in a set of 23 values and a description of each. Using insights from the articles of Hitlin and Piliavin (2004), Schwartz (2012), and Rokeach (2008), we discuss the interconnectedness of values, the perspectives of different stakeholders on values, and their applicability at different levels and in different contexts. Lastly, the practice and research implications and some methodological considerations are addressed.

### Interconnectedness of values

The list of values presented consists of both values specific to integrated care and values that are more generally related to healthcare delivery. Frequently identified values such as 'collaborative' (N=20), 'coordinated' (N=19) and 'transparent' (N=15) could specifically reflect the concept of integrated care. More general values, for example 'goal oriented' (N=11), 'evidence-informed' (N=10), 'innovative' (N=4) and 'safe' (N=3), have been identified less often. Although these values appear to be more generic, they are presumably just as relevant for integrated health services delivery. Thus, the complete set of 23 values consists of a mix of integrated care specific and more generic values with respect to healthcare.

The 23 values presented also seem to embrace themes or concepts that reflect certain goals. In the integrated care literature, these themes are related to the Triple Aim philosophy, in which three main types of goals can be distinguished: client experience, population health and cost-effectiveness (Berwick et al., 2008). As an example: the values 'personal' and 'respectful' relate to client experience; 'preventative' and 'equitable' to population health and 'sustainable' to cost-effectiveness. Thus, some of the values may relate to the same overarching themes. Since the Triple Aim goals are interdependent and highly linked to one another, it is arguable that some values

could serve as conditions for other values. For example, 'sustainable' (related to cost-effectiveness) in relation to 'continuous' (experience of care and population health). An integrated care practice that is not sustainable and may not be viable in a certain context is likely to experience problems in delivering continuous care. It would also be difficult to deliver 'continuous' care for patients, when care is not 'comprehensive'. Services cannot consistently address the needs and preferences across the life course of an individual, if some disciplines are not available. So when reviewing our analysis, the values identified would seem to be connected to one another to some extent.

### Stakeholder perspectives and value hierarchies

In integrated care practice, numerous groups of stakeholders are involved i.e. clients and their families, a variety of care organizations, governmental bodies, professionals, managers and volunteers. When looking at values literature, insights of Hitlin and Piliavin (2004), Schwartz (2012), and Rokeach (2008), suggest that different groups of people distinguish themselves by the relative importance they attach to certain values, also known as their value hierarchies (Hitlin & Piliavin, 2004; Schwartz, 2012). These value hierarchies can help to explain their behaviors and attitudes (Rokeach, 2008; Schwartz, 2012). Other research also supports the premise that different stakeholders can have different perceptions about the same situation. Research by Huber and colleagues illustrates that different stakeholders (patients, public health actors, healthcare providers, citizens, insurers, researchers and policy makers) vary in the importance they attach to various dimensions of health (Huber et al., 2016). Other studies show discrepancies between the health state preferences of clients and healthcare professionals (Hofman et al., 2015) and that stakeholders in the same integrated care network may assess the development of their network differently (Zonneveld et al., 2017).

Assuming that there is a relationship between value hierarchies and behaviors, it is interesting to reflect on the perspectives of stakeholders on the values. For instance, health insurers might attach more importance to values related to costs, such as 'sustainable', while clients and professionals might attach more importance to values related to the experience of care, such as 'trustful' and 'respectful'.

When looking at the presented results in this study, the majority of the articles included in the review is written from a researcher's or expert's point of view (N=18). Of a total of 22 included publications, one article elaborates on patient perceptions of integrated care (Walker et al., 2013) and three articles take the perspectives of health care professionals into account (Craig et al., 2015; Poochikian-Sarkissian et al., 2008; J. Shaw et al., 2016). It is, therefore, difficult to draw any hard conclusions on the values of professionals or clients.

Considering the insights of Hitlin and Piliavin (2004), Schwartz (2012), Rokeach (2008) and other available knowledge, it is likely that individuals and groups will have different perspectives on the 23 values identified in this study. This is a valuable insight into the explanation of behavior and collaboration processes in integrated care. More research on these different perspectives, for instance of clients, health care professionals or policymakers, could therefore be interesting.

### Values at different levels and in different contexts

Considering that integrated is practiced at multiple levels, some of the articles included in our analysis contain a distinction between different levels in the description of their findings (Clark et al., 2007; Kodner, 2008; Mulvale et al., 2016; Poochikian-Sarkissian et al., 2008; Valentijn et al., 2013). Clark and colleagues (2007), for example, distinguish individual, team and organization level, at which the application of a value as 'respectful' is described differently: "Develop self and disciplinary knowledge as basis for mutual respect among team members" (individual), "Promote respect, truth telling, beneficence, and justice in relationships with other team members" (team) and "Respect unique relationship between the team and the patient" (organization) (Clark et al., 2007, p. 594). Another example is Valentijn's Rainbow Model, that may also be helpful when considering integrated care from a multi-level perspective. This model identifies three levels of integration which are connected, namely the macro (system), meso (organizational, professional) and micro (clinical) levels (Valentijn et al., 2013).

Furthermore, in the articles included, the values identified are described on different levels of abstraction. For example, the value 'holistic' may be appropriate at the clinical micro-level, where an individual can be viewed holistically taking into account a wide range of factors (Johnson, 2009). This approach should be extended to apply to the meso-level where expertise is shared between professionals from different disciplines (Suter et al., 2008). In the articles analyzed in this study the value 'shared accountability and responsibility' was described at all levels: the macro-level between organizations (Lega, 2007), the meso-level between professionals (Baird et al., 2014; Craig et al., 2015; Poochikian-Sarkissian et al., 2008) and the micro-level between clients and professionals (Valentijn et al., 2013). These examples demonstrate that values can transcend multiple levels in integrated care. This is in line with the insights of Schwartz (2012) and Schwartz and Bilsky (1987) who state that values transcend specific situations and remain relevant in multiple contexts.

As well as transcending multiple levels, the values identified in this study may also be applicable in multiple contexts. Busetto's Context + Mechanism + Outcome

Model (COMIC model) stresses the importance of taking contexts into account and identifies different categories of contextual factors that can influence integrated care: i.e. innovation, factors with respect to the individual professional and patient, social context, organizational context, health system context and economic, political and legal contexts (Busetto et al., 2016). In our view, it is important to recognize that studies from seven different countries were included, therefore they probably reflect different economic, political and legal contexts. In this respect, although half of the articles are from the United States (N=11), the 22 articles cover a broad range of contexts. The value 'empowering', for instance, could be interpreted in different ways depending on the different social and political contexts.

Although used differently, the set of values identified for integrated care appears to be applicable and relevant at multiple levels and in multiple contexts. Furthermore, these values are subject to varying interpretation at different levels or in different contexts. By implication, it should be recognized that values can be applied differently in different situations, and that it could be beneficial to distinguish different levels and contexts in any guidance for collaboration in integrated care.

### Practice implications

Since values can help us understand individual behavior, the values-driven perspective presented in this study can provide insights into the drivers behind the behaviors of the various actors involved in integrated care. A deeper understanding of these underlying mechanisms, can help explain events, dynamics and behaviors in integrated care implementation and delivery. In our view, this can support the further development of integrated care.

Subsequently, values underpinning integrated care could form the basis on which to develop a framework for governance to serve as a guide or steering mechanisms in behavior, decision-making and evaluation of integrated care. It could be prudent to distinguish different levels and contexts in this respect. At the macro-level, values can help integrated care initiatives in the definition of a collective desirable goal (Schwartz & Bilsky, 1987), for instance concerning quality, and its evaluation. Values could serve as governance principles for the alignment between organizations in integrated care initiatives and partnerships. For instance by providing a backbone in decision-making processes or leadership behavior. They can also be used as guiding principles for strategy development and management. At the meso-level, values could also play a role in guiding multidisciplinary care professionals in their daily collaboration with colleagues and other parties involved in integrated care delivery, such as volunteers. At the micro-level, values could serve as professional guiding

principles in the delivery of healthcare services. For instance, if 'co-produced' is considered to be an important value, professionals could decide to engage clients and their families more. Lastly, a better understanding of the values of clients could facilitate their involvement in integrated care.

## Research implications

As a result of a systematic literature review, this study defines a set of 23 values which are applicable to integrated care. This study also considers the interconnectedness of values, different stakeholder perspectives on values and their applicability to different levels and in different contexts. The findings of this study broaden the existing body of knowledge on integrated care, by combining integrated care theory and values theory. There have been no systematic studies about values in integrated care published until now and this study therefore bridges this gap. The set of values presented can be seen as a potential basis for a values-driven approach to integrated care. From an academic perspective, the values identified can also contribute to the clarification and definition of integrated care as a concept.

Future research could examine the differences in value hierarchies of clients, professionals and decision-makers and the potential effect of different perspectives on integrated care. It would also be interesting to investigate the applicability of the set of values to different levels of integrated care and in different contexts. Another avenue of research could be to further determine which values are specific to integrated care, and to what extent the set of underlying values is suitable for use as a framework for governance or a steering mechanism in practice. Lastly, it would be interesting to study the extent to which values can be used to align collaboration in integrated care and their use in helping professionals to make decisions.

## Strengths and limitations

One of the strengths of this study is the systematic theory-driven approach to the research. It adds value by expanding the theoretical body of knowledge on integrated care described in current literature which includes definitions, conceptual models and interventions. Recent academic literature has been identified, assessed and analyzed using a defined method, executed by three independent researchers and a supervisor. A limitation of the study is that the 22 articles analyzed are predominantly written from an expert or academic perspective (N=18) and to a lesser extent from a client (N=1) or professional (N=3). Therefore, we cannot draw any hard conclusions about the perspectives of professionals, clients or their families with respect to the values of integrated care. This could be a topic for further research.

## 2.6 Conclusion

For better understanding of behavior, decision-making and collaboration in integrated care, more insight into the underlying values of integrated care is needed. Although more attention is being paid to values in integrated care, this topic has not been systematically studied until now. This study bridges this gap by applying values theory to the integrated care literature. A set of 23 values and a description of each are presented. This set of values is proposed as a potential basis for a values-driven approach to integrated care. The results of this research can be used as a basis for the guidance of collaboration and governance processes in integrated care and add to conceptual knowledge and theory building of integrated care.

# Appendix 2.1: Search strategies

**Table 2.3** Search strategy 1.

| | | | | | | |
|---|---|---|---|---|---|---|
| [Title] values OR principles OR fundament* OR key beliefs OR philosophy OR theor* OR concept* | AND | [Title] person centered OR person centred OR patient centered OR patient centred OR people centered OR people centred OR client centered OR client centred OR integrat* OR coordination OR interprofessional OR interorganizational OR interorganisational OR interdisciplinary OR collaboration OR cooperation | AND | [Title] care OR healthcare OR health services OR health delivery OR health service delivery | NOT | [Title] laboratory OR dental OR oncology OR surgery OR surgical OR pharmacy OR catholic OR radiology OR biomedical OR software OR electronic OR information system OR algorithm |

**Table 2.4** Search strategy 2.

| | | | | | | |
|---|---|---|---|---|---|---|
| [Title/ Abstract] model OR models OR framework OR frameworks | AND | [Title/Abstract] person centered OR person centred OR patient centered OR patient centred OR people centered OR people centred OR client centered OR client centred OR integrat* OR coordination OR interprofessional OR interorganizational OR interorganisational OR interdisciplinary OR collaboration OR cooperation | AND | [Title] care OR healthcare OR health services OR health delivery OR health service delivery | NOT | [Title] laboratory OR dental OR oncology OR surgery OR surgical OR pharmacy OR catholic OR radiology OR biomedical OR software OR electronic OR information system OR algorithm |

* [MeSH Major Topic] Models, Organizational

# Appendix 2.2: Articles included in the systematic review

**Table 2.5** Articles included in the systematic review.

| Ref. | Author | Year | Title | Scope of the article | Methods | Identified values (N) |
|---|---|---|---|---|---|---|
| (Baird et al., 2014) | Baird, M., Blount, A., Brungardt, S., Dickinson, P., Dietrich, A., Epperly, T., ... others. | 2014 | Joint principles: integrating behavioral health care into the patient-centered medical home. | The representatives from six American Family Medicine Organisations developed a set of Joint Principles for Integrating Behavioral Health Care into Patient-Centered Medical Home. | Experiences of experts, focus groups | Collaborative, Co-ordinated, Transparent, Comprehensive, Co-produced, Shared accountability and responsibility, Continuous, Holistic, Personal, Equitable, Proficient, Safe (N=12) |
| (Bodenheimer et al., 2014) | Bodenheimer, T., Ghorob, A., Willard-Grace, R., & Grumbach, K. | 2014 | The 10 building blocks of high-performing primary care. | Ten building blocks of high performing primary care (in coordination with other services) were developed by the review of literature, site visits and practical experience of the authors. | Literature review, experiences of experts, site visits | Collaborative, Co-ordinated, Empowering, Comprehensive, Co-produced, Shared accountability and responsibility, Continuous, Goal oriented, Personal, Evidence-informed, Respectful, Equitable, Sustainable, Innovative (N=14) |
| (Butt et al., 2008) | Butt, G., Markle-Reid, M., & Browne, G. | 2008 | Interprofessional partnerships in chronic illness care: a conceptual model for measuring partnership effectiveness | This paper presents a conceptual model for Interprofessional Health and Social Service Partnerships (IHSSP), derived from a systematic literature review. | Literature review | Collaborative, Co-ordinated, Transparent, Comprehensive, Co-produced, Shared accountability and responsibility, Holistic, Evidence-informed, Respectful, Sustainable, Led by whole-systems thinking, Flexible, Reciprocal, Trustful (N=14) |

**Table 2.5** Continued

| Ref. | Author | Year | Title | Scope of the article | Methods | Identified values (N) |
|---|---|---|---|---|---|---|
| (Callahan et al., 2011) | Callahan, C. M., Boustani, M. A., Weiner, M., Beck, R. A., Livin, L. R., Kellams, J. J., … Hendrie, H. C. | 2011 | Implementing dementia care models in primary care settings: The Aging Brain Care Medical Home. | This article describes the experiences in the implementation of a collaborative care model for dementia and depression. | Experiences of experts | Collaborative, Co-ordinated, Empowering, Co-produced, Continuous, Holistic, Evidence-informed, Equitable, Led by whole-systems thinking, Preventative, Safe (N=11) |
| (Clark et al., 2007) | Clark, P. G., Cott, C., & Drinka, T. J. | 2007 | Theory and practice in interprofessional ethics: A framework for understanding ethical issues in health care teams. | This article presents a framework for interprofessional teamwork in healthcare practice, based on a literature review and the experiences of experts. | Literature review, experiences of experts | Collaborative, Shared accountability and responsibility, Respectful (N=3) |
| (Craig et al., 2015) | Craig, S. L., Betancourt, I., & Muskat, B. Social Work & Healthcare | 2015 | Thinking big, supporting families and enabling coping: The value of social work in patient and family centered health care. | In this paper the value of social work in healthcare practice is described from the perspectives of health social workers. | Interviews, focus groups, | Collaborative, Transparent, Empowering, Co-produced, Holistic, Respectful, Led by whole-systems thinking (N=7) |
| (Ferrer & Goodwin, 2014) | Ferrer, L., & Goodwin, N. | 2014 | What are the principles that underpin integrated care? | Ferrer and Goodwin present 16 core principles of integrated care, by reflecting on the views and comments from international stakeholders involved in the development of the WHO Global Strategy on People-Centred and Integrated Health Service. | Experiences of experts, reflection on strategy development | Collaborative, Co-ordinated, Empowering, Comprehensive, Co-produced, Shared accountability and responsibility, Continuous, Holistic, Goal oriented, Evidence-informed, Respectful, Equitable, Sustainable, Led by whole-systems thinking, Preventative (N=15) |

**Table 2.5** Continued

| Ref. | Author | Year | Title | Scope of the article | Methods | Identified values (N) |
|---|---|---|---|---|---|---|
| (Johnson, 2009) | Johnson, C. | 2009 | Health care transitions: a review of integrated, integrative, and integration concepts. | This article presents a short review on the concepts integrated, integrative and integration in health care transitions. | Review/Concept analysis | Collaborative, Co-ordinated, Transparent, Empowering, Comprehensive, Continuous, Holistic, Personal, Evidence-informed, Equitable, Sustainable, Preventative (N=12) |
| (Kodner, 2008) | Kodner, D. L. | 2008 | All together now: a conceptual exploration of integrated care. | This article explores definitions, concepts, logics and methods found in health system and service integration. | Review/Concept analysis | Collaborative, Co-ordinated, Empowering, Comprehensive, Shared accountability and responsibility, Continuous, Sustainable, Led by whole-systems thinking (N=8) |
| (Lega, 2007) | Lega, F. | 2007 | Organisational design for health integrated delivery systems: theory and practice. | This paper presents an organisational design for health integrated delivery systems, based on an extensive literature review. | Literature review, experiences from action research | Co-ordinated, Comprehensive, Shared accountability and responsibility, Continuous, Personal, Equitable, Sustainable, Flexible, Preventative (N=9) |
| (Minkman et al., 2008) | Minkman, M., Ahaus, K., Fabbricotti, I., Nabitz, U., & Huijsman, R. | 2008 | A quality management model for integrated care: results of a Delphi and Concept Mapping study. | This study presents 89 elements of integrated care, grouped into nine core clusters. The elements and clusters are identified by experts, taking part in a Delphi Study and Concept Mapping. | Delphi Study, concept mapping | Collaborative, Co-ordinated, Transparent, Empowering, Co-produced, Continuous, Goal oriented, Personal, Evidence-informed, Innovative (N=10) |

**Table 2.5** Continued

| Ref. | Author | Year | Title | Scope of the article | Methods | Identified values (N) |
|---|---|---|---|---|---|---|
| (Mulvale et al., 2016, p. 201) | Mulvale, G., Embrett, M., & Razavi, S. D. | 2016 | 'Gearing Up' to improve interprofessional collaboration in primary care: a systematic review and conceptual framework | A systematic review of 25 years of peer-review literature was conducted to develop a conceptual framework for interprofessional collaboration in primay care. | Literature review | Collaborative, Transparent, Shared accountability and responsibility, Goal oriented, Evidence-informed, Flexible, Innovative, Proficient (N=8) |
| (Poochikian-Sarkissian et al., 2008) | Poochikian-Sarkissian, S., Hunter, J., Tully, S., Lazar, N. M., Sabo, K., & Cursio, C. | 2008 | Developing an innovative care delivery model: Interprofessional practice teams. | This paper presents an innovative care delivery model, by doing focus groups and surveys with members of interprofessional practice teams. | Focus groups, surveys | Collaborative, Co-ordinated, Transparent, Empowering, Comprehensive, Co-produced, Shared accountability and responsibility, Goal oriented, Evidence-informed, Respectful, Sustainable, Flexible, Reciprocal, Innovative, Trustful (N=15) |
| (Prokop, 2016) | Prokop, J. | 2016 | Care coordination strategies in reforming health care: a concept analysis. | This article describes a concept analysis of care coordination: definitions, attributes and antecedents. | Review/Concept analysis | Collaborative, Co-ordinated, Transparent, Empowering, Comprehensive, Co-produced, Holistic, Goal oriented, Personal, Respectful, Led by whole-systems thinking, Flexible, Reciprocal (N=13) |
| (Radwin et al., 2016) | Radwin, L. E., Castonguay, D., Keenan, C. B., & Hermann, C. | 2016 | An expanded theoretical framework of care coordination across transitions in care settings. | This study builds upon three existing models, in order to build an expanded theoretical framework of care coordination across transitions in care settings. | Review/Concept analysis | Co-ordinated, Transparent, Continuous, Holistic, Personal, Respectful, Flexible, Proficient (N=8) |

**Table 2.5** Continued

| Ref. | Author | Year | Title | Scope of the article | Methods | Identified values (N) |
|---|---|---|---|---|---|---|
| (J. Shaw et al., 2016) | Shaw, J., Kearney, C., Glenns, B., & McKay, S. | 2016 | Interprofessional team building in the palliative home care setting: Use of a conceptual framework to inform a pilot evaluation. | This paper presents a conceptual framework on interprofessional teams and an evaluation of interprofessional teams in palliative care by doing interviews. | Interviews | Collaborative, Co-ordinated, Transparent, Shared accountability and responsibility, Goal oriented, Reciprocal, Trustful (N=7) |
| (Suter et al., 2008) | Suter, P., Hennessey, B., Harrison, G., Fagan, M., Norman, B., & Suter, W. N. | 2008 | Home-Based Chronic Care: An Expanded Integrative Model for Home Health Professionals. | This article builds upon Wagner's Chronic Care Model and integrates salient theories from fields beyond medicine, resulting in an expanded Home-Based Chronic Care Model (HBCCM). | Review/Concept analysis | Collaborative, Co-ordinated, Transparent, Empowering, Co-produced, Holistic, Goal oriented, Personal, Evidence-informed, Preventative, Trustful (N=11) |
| (Thornton, 2013) | Thornton, L. | 2013 | Essentials of Integrative Health Care: Fundamental Principles for Caring& Healing. | This study presents a set of essential Components of Integrative Care, by reviewing existing models and practice experience. | Review/Concept analysis | Collaborative, Co-ordinated, Transparent, Empowering, Comprehensive, Co-produced, Holistic, Preventative (N=8) |
| (Valentijn et al., 2013) | Valentijn, P., Schepman, S. M., Opheij, W., & Bruijnzeels, M. A | 2013 | Understanding integrated care: a comprehensive conceptual framework based on the integrative functions of primary care | This article presents a conceptual framework on the integrative functions of primary care, based on a literature review and focus groups with experts. | Literature review, focus groups | Collaborative, Co-ordinated, Empowering, Comprehensive, Co-produced, Shared accountability and responsibility, Continuous, Holistic, Goal oriented, Personal, Equitable, Led by whole-systems thinking (N=12) |

**Table 2.5** Continued

| Ref. | Author | Year | Title | Scope of the article | Methods | Identified values (N) |
|---|---|---|---|---|---|---|
| (Van Houdt et al., 2013) | Van Houdt, S., Heyrman, J., Vanhaecht, K., Sermeus, W., & De Lepeleire, J. | 2013 | An in-depth analysis of theoretical frameworks for the study of care coordination | This study describes an update framework for care coordination, developed by performing a literature review on existing theoretical frameworks. | Literature review | Collaborative, Co-ordinated, Transparent, Comprehensive, Shared accountability and responsibility, Continuous, Goal oriented, Evidence-informed, Respectful, Equitable, Sustainable, Safe (N=12) |
| (Walker et al., 2013) | Walker, K. O., Labat, A., Choi, J., Schmittdiel, J., Stewart, A. L., & Grumbach, K. | 2013 | Patient perceptions of integrated care: confused by the term, clear on the concept. | This paper presents the results of seven focus groups on perceptions of the concept of integrated care with 44 patients. | Focus groups | Collaborative, Co-ordinated, Transparent, Empowering, Comprehensive, Co-produced, Shared accountability and responsibility, Continuous, Personal, Respectful, Equitable, Flexible (N=12) |
| (Winge et al., 2010) | Winge, M., Johansson, L.-\AAke, Nyström, M., Lindh-Waterworth, E., & Wangler, B. | 2010 | Need for a New Care Model-Getting to Grips with Collaborative Home Care. | This paper discusses that patients are increasingly treated in their homes by a set of collaborating organisations, and therefore underlines the need for a new collaborative care model. | Review/Concept analysis | Collaborative, Co-ordinated, Transparent, Goal oriented, Led by whole-systems thinking, Reciprocal (N=6) |

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# 3.

# Towards a Values Framework for Integrated Health Services: An International Delphi Study

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## Abstract

**Background**: In order to organize person-centered health services for a growing number of people with multiple complex health and social care needs, a shift from fragmented to integrated health services delivery has to take place. For the organization of governance in integrated health services, it is important to better understand the underlying factors that drive collaboration, decision-making and behavior between individuals and organizations. Therefore, this article focuses on these underlying normative aspects of integrated health services. This study investigates the values that underpin integrated health services delivery as a concept, by examining the extent to which an initial literature based set of underlying values underpins integrated care and the relevance of these values on the different levels of integration.

**Methods**: An international Delphi study with 33 experts from 13 different countries was carried out to examine the initial set of underlying values of integrated health services. In addition, the relevance of the values was assessed on the different levels of integration: personal level, professional level, management level and system level.

**Results**: The study resulted in a refined set of 18 values of integrated health services developed in three Delphi study rounds. In addition, the results provided insight into the relevance of these values on the personal level (e.g. 'trustful'), professional level (e.g. 'collaborative'), management level (e.g. 'efficient') and system level (e.g. 'comprehensive') of integration. Some of the values score consistent across the different levels of integration while other values score inconsistent across these levels.

**Conclusions**: The Delphi study resulted in an international normative basis for integrated health services delivery as a concept. The values can be used as ingredients for a values framework and provide a better understanding of the normative aspects of integrated health services delivery. Future research could focus on associated behaviors in practice, the relationship between normative integration and governance, and differences between the value priorities of stakeholder groups.

## 3.1 Background



Health systems are facing the challenges of aging populations and a growing number of people with multiple chronic conditions (OECD, 2011; World Health Organization, 2015c). An increasing number of people develops multiple complex health and social care needs, which require various types of services that transcend traditional sectors like primary care, long-term care and social care (Goodwin, 2015). This implies that actors and services have to be connected, coordinated and organized around a person (S. B. Axelsson & Axelsson, 2009; Wagner et al., 2005). However, fragmentation of health services is still a frequently encountered problem in many countries (Nilsson et al., 2016; Novick, 2017; World Health Organization, 2015b). Therefore, it is widely acknowledged that a shift towards integrated health services delivery has to take place (Armitage et al., 2009; Berwick et al., 2008; World Health Organization, 2015a, 2016b). Integrated health services delivery is defined as:

> *"an approach to strengthen people-centered health systems through the promotion of the comprehensive delivery of quality services across the life-course, designed according to the multidimensional needs of the population and the individual and delivered by a coordinated multidisciplinary team of providers working across settings and levels of care."* (World Health Organization, 2016b, p. 10)

While widely applied and under development in many countries, integrated health services delivery is often a complex and non-hierarchical undertaking with various implications (De Bruin et al., 2018; Goodwin et al., 2014; Nolte & Pitchforth, 2014; Van Duijn et al., 2018). In addition to the implementation of interventions, integration requires changes in healthcare workforce, behavior, organizational design, governance and funding on multiple organizational levels (Goodwin, 2013b; Goodwin et al., 2017; Minkman, 2012; Valentijn et al., 2013). Furthermore, as integrated health services delivery is a collective process, collaboration is needed between actors e.g. service users, informal carers, various care professionals and care providers, governments and health insurers. Although they are often interdependent and subsequently collaborate, at the same time these actors often have different institutional constraints, interests, professional backgrounds, views and objectives. This complicates the alignment of the collaboration processes (D'Amour et al., 2008). Since integrated health services delivery often takes place in collaborative networks in the absence of a formal hierarchy, traditional top-down governance within organizations is not always suitable or effective (S. B. Axelsson & Axelsson, 2009). Therefore, a shift towards less hierarchical network governance, focusing

on collaborative relationships between individuals and organizations, seems more appropriate (Hill & Lynn, 2004; Minkman, 2017a). This type of governance is known as collaborative or shared governance, implying that networks are jointly and horizontally governed by the interacting organizations in the network (Koppenjan & Klijn, 2004; Provan & Kenis, 2008).

To effectively organize shared governance in integrated health services delivery, it is important to be aware of the circumstances in the network. Provan and Kenis (2008) outline four critical contingencies for effective shared governance: 1) trust has to be widely shared among the network (high-density, decentralized trust), 2) there are relatively few network actors, 3) there is a high goal consensus and 4) there is a low need for network-level competencies. To understand shared governance and collaborative processes in integrated health services delivery more deeply, it is important to gain insight into the normative drivers behind the interactions between the actors in the network, and the relational contingencies, such as trust and goal consensus. This normative perspective may provide a better understanding of collaboration processes and the behaviors of actors, and thus insights into possible facilitating or hindering circumstances for effective network governance in different contexts.

The importance of the normative dimension of integration is also highlighted in conceptual frameworks on integrated care and integrated health services, developed to analyze their complexity. Fulop and colleagues (2005) identify four levels of integrated care: organizational, functional, service and clinical integration. Organizational integration refers to the formal structure of the organization, functional integration to non-clinical support and back-office functions, service integration to how clinical services are offered and clinical integration to the process of care delivery to service-users. In addition to the different levels, the authors present two crucial dimensions of integration: systemic integration, which includes the coherence of rules and policies in the health system, and normative integration, which comprises the role of shared values in co-ordination and collaboration (Fulop et al., 2005; R. Q. Lewis et al., 2010). Just as the conceptual model of Fulop and colleagues, the Rainbow Model of Integrated Care (RMIC), identifies four levels of integration: a system level, an organizational level, a professional level and a clinical level (Valentijn et al., 2013). The RMIC also distinguishes two additional crucial dimensions: functional integration, referring to key support functions and activities, and again normative integration, which is defined as *"the development and maintenance of a common frame of reference (i.e., shared mission, vision, values and culture) between organizations, professional groups and individuals"* (Valentijn et al., 2013, p. 8).

In addition to these conceptual frameworks, other integrated health services literature also mentions the role of values and normative integration. While some studies stress the importance of common values for cooperation in integrated health services delivery (Goodwin, 2013a; Minkman, 2016), other research shows that the level of normative integration in integrated health services interventions in practice is still negligible (Looman et al., 2018). Besides the attention for values and normative integration, there is a lack of information about what values are meant, and how they are defined. In the interim report *'Global strategy on people-centered and integrated health services'* the World Health Organization (2015b) stresses the need for a "unifying values framework" (World Health Organization, 2015b, p. 11). The report defines a first set of guiding principles of integrated health services as ingredients for such a framework. Therefore, although there is a desire to underpin normative integration and related behavior with a values framework, only a list of general principles has been compiled so far. Furthermore, this set has not been systematically assessed yet (Ferrer & Goodwin, 2014). Thus, it is relevant to develop more scientific knowledge on the values underpinning the integrated health services concept, and what concrete values are meant.

As a first step towards more systematically developed knowledge on the values underpinning the integrated health services concept, a systematic review we conducted earlier identified a set of 23 underlying values of integrated care (Zonneveld et al., 2018). In that study we define values "*as meaningful beliefs, principles or standards of behavior, referring to desirable goals that motivate action*" (Zonneveld et al., 2018, p. 2). While this systematic review provides a balanced overview of values in the literature, it does not incorporate knowledge that has not been scientifically published. The set of values has also not been systematically empirically validated. Therefore, our next step is to systematically assess to what extent this initial set underpins the integrated health service delivery concept according to experts from multiple countries and professional perspectives, since integrated health services are delivered in a variety of contexts, settings and countries.

Besides identifying a first set of values underpinning the integrated care concept, our previous article also addresses that the application of these values might vary on the different levels of integration. This reflection is in line with the approaches of Fulop et al. (2005) and Valentijn et al. (2013), which assume that normative integration is a crucial dimension in determining how integrated health services delivery takes place on multiple levels, such as the personal, the professional, the management and the system level. However, not much knowledge about the relationship between

values and levels of integration has been developed yet. Therefore, this study also investigates the relevance of the values on the different levels of integration.

The main research question of this study is: to what extent does the initial set of values underpin integrated care as a concept according to an international expert panel, and on what levels of integration are the values found to be relevant?

## 3.2 Methods

To investigate to what extent the initial set of values underpins the concept of integrated health services delivery, and the relevance of the values on the levels of integration, we conducted an international Delphi study. A Delphi study is a systematic research method that uses the judgements of an expert panel, in order to reach consensus (Boulkedid et al., 2011; J. Jones & Hunter, 1995). The findings of our systematic review on values of integrated care served as the basis for the study (Zonneveld et al., 2018). As these findings did not include knowledge that has not been scientifically published, refinement by an international expert panel is an important next step before applying the values in further empirical research. A list of potential panel members was composed by tracking integrated health services publications and presenter lists of relevant conferences on health services research or integrated care. We aimed for a balanced expert panel, with a broad variety of expertise, professional disciplines and country backgrounds. In order to avoid bias, we excluded any of the first authors of the studies included in the systematic review (Zonneveld et al., 2018). Out of 65 invited experts, 33 (51%) agreed to participate in the Delphi study. Reasons for not participating were mainly limited time, leave or unavailability during one of the three Delphi rounds timeframes. The 33 experts originated from 13 different countries. The panel had an average age of 47 and an average of 11 years of experience in integrated health services. Panelists with a practice (30%), patient representative (6%), research (82%), policy (45%) and other (27%, e.g. education or advocacy) background participated in the study (see Table 3.1). Two experts were co-author in one of the studies included in the systematic review (Zonneveld et al., 2018). The expert panel members were asked to reflect on the set of values identified in the literature in three anonymous Delphi rounds. In every Delphi round, each expert received a personally generated hyperlink to an online questionnaire.

The panel members were asked to indicate for each value whether it underpins integrated care. To avoid central tendency bias, dichotomous answer categories (yes/no) were used at each question. The in- and exclusion criteria were as follows: in each

round a value was included when a minimum of 80% of the panel members indicated it as underpinning, and excluded when a minimum of 50% of the panel members indicated it as not underpinning. These criteria were set based on methods used in comparable studies (Minkman et al., 2008). Values that were not included or excluded were presented again in the following round. Second, when assessing each value, the panel members had the opportunity to make a suggestion for reformulating the value and/or its description. All suggestions for reformulation were analyzed by the researcher, under the supervision of a second researcher. Minor suggestions, such as word order or replacement by synonyms (e.g. 'service user' instead of 'client'), were implemented when they were suggested by multiple experts. Major suggestions listed by multiple experts, such as the addition of actors or activities in the description, were analyzed and presented to the expert panel in the next round.

Additionally, the panel members had the opportunity to suggest new values in rounds one and two. Suggestions for new values (including their descriptions) were analyzed by the researcher, under the supervision of a second researcher. If consensus could not be reached, a third researcher was consulted. New values and their description were presented to the panel in the next round.

Lastly, the relevance of the values on the levels of integration was investigated. When the panel members indicated a value as underpinning, they subsequently were asked on what level of integration the value is relevant. The response categories (multiple answers possible) were: 'personal level', 'professional level', 'management level' and 'system level', based on the RMIC (Valentijn et al., 2013). The full Delphi questionnaire is provided in Supplementary File 1.

**Table 3.1** Delphi expert panel characteristics (N=33)

| Characteristic | Category | Panel, n=33 |
|---|---|---|
| Age | Min-max | 28-64 |
| | Average | 47 |
| | Median | 47 |
| | SD | 11 |
| Gender | Male | 36% |
| | Female | 63% |
| Years of experience in integrated health services | Min-max | 2-40 |
| | Average | 11 |
| | Median | 8 |
| | SD | 9 |
| Background* | Practice | 30% |
| | Patient representative | 6% |
| | Research | 82% |
| | Policy | 45% |
| | Other | 27% |
| Country | United Kingdom | 6 |
| | Australia | 4 |
| | Ireland | 4 |
| | Netherlands | 4 |
| | Canada | 3 |
| | Norway | 3 |
| | Belgium | 2 |
| | United States | 2 |
| | Austria | 1 |
| | Czech Republic | 1 |
| | New Zealand | 1 |
| | Spain | 1 |
| | Switzerland | 1 |
| Continent | Europe | 70% (23) |
| | North America | 15% (5) |
| | Oceania | 15% (5) |

* = Multiple answers were possible

## 3.3 Results

The Delphi study was conducted in three rounds. Delphi round one was completed by 33 experts. Two experts dropped out due to unexpected unavailability, resulting in a response rate of 94% in rounds two and three (see Table 3.2).

Eventually, 18 values were included in the refined set (see Table 3.3). In the first round, twelve values and descriptions were included: 'coordinated' (100%), 'trustful' (97%), 'shared responsibility and accountability' (94%), 'holistic' (94%), 'co-produced'

(91%), 'continuous' (91%), 'flexible' (91%), 'empowering' (85%), 'person-centered' (85%, as a reformulation of 'personal'), 'respectful' (85%), 'led by whole-systems thinking' (85%), and 'comprehensive' (82%). The expert panel included five values in round two: 'collaborative' (100%), 'preventative' (87%), 'efficient' (87%, newly suggested), 'reciprocal' (87%), and 'transparently shared' (80%, as a reformulation of 'transparent'). In round three of the Delphi study, one value was included: 'effective' (90%, newly suggested). Two value labels were reformulated: 'personal' was reformulated in 'person-centered', and 'transparent' was reformulated into 'transparently shared'.

In total, three new values were presented, all suggested in Delphi round one (see Table 3.2 and Figure 3.1). The new values 'effective' and 'efficient' were suggested as a splitting of the value 'sustainable' of the initial set, which had both effective and efficient in its description ('services are efficient, effective and economically viable, ensuring that they can adapt to evolving environments'). Furthermore, the new value 'realistic' was suggested and presented. Eventually, the new values 'effective' and 'efficient' were included in the refined set, and the value 'realistic' was excluded in the last round.

Eight values were excluded in round three of the Delphi study, due to not meeting the inclusion criteria. Seven of the excluded values were part of the initial set: 'goal oriented' (77%), 'evidence-informed' (73%), 'equitable'(67%), 'sustainable' (73%), 'innovative' (67%), 'proficient' (63%), and 'safe' (73%). One of the values was newly suggested in round one: 'realistic' (73%). The main reasons for exclusion were: 1) the value is not specific enough for integrated care/integrated health services delivery (n=8), and 2) the value is not essential for integrated health services delivery (n=4).

**Table 3.2** Delphi study rounds overview

| | **Round 1** | **Round 2** | **Round 3** |
|---|---|---|---|
| Response (N=33) | 100% (N=33) | 94% (N=31) | 94% (N=31) |
| Values (*n*) | 23 | 14 | 9 |
| Included | 12 | 5 | 1 |
| Excluded | 0 | 0 | 8 |
| New | 3 | 0 | 0 |

**Figure 3.1** Delphi study flow chart

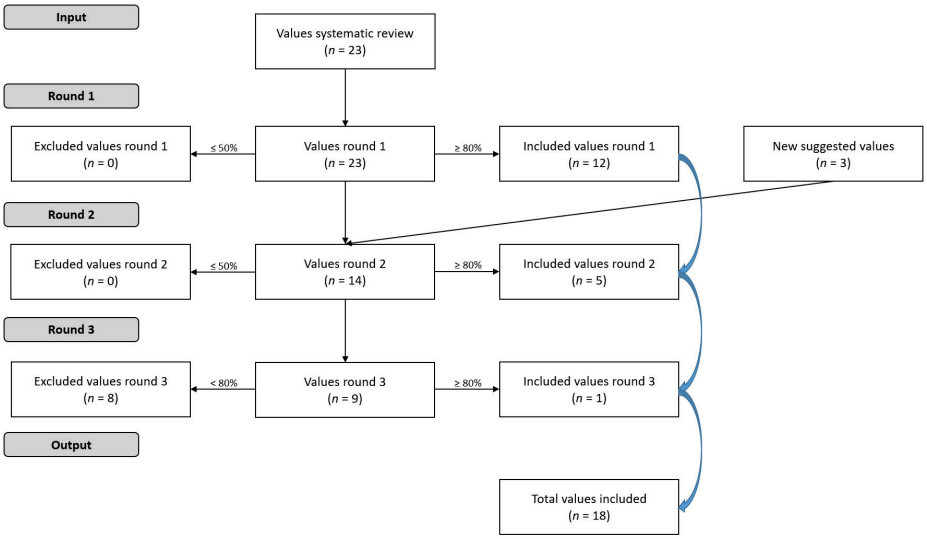



**Table 3.3** Delphi study results

| # | Value label | Description |
|---|---|---|
| 1 | Coordinated | Connection and alignment between users, informal carers, professionals and organizations in the care chain, in order to reach a common focus matching the needs of the unique person. |
| 2 | Trustful | Enabling mutual trusting between users, informal carers, communities, professionals and organizations, in and across teams. |
| 3 | Shared responsibility and accountability | The acknowledgment that multiple actors are responsible and accountable for the quality and outcomes of care, based on collective ownership of actions, goals and objectives, between users, informal carers, professionals and providers. |
| 4 | Holistic | Putting users and informal carers in the center of a service that is 'whole person' focused in terms of their physical, social, socio-economical, biomedical, psychological, spiritual and emotional needs. |
| 5 | Co-produced | Engaging users, informal carers and communities in the design, implementation and improvement of services, through partnerships, in collaboration with professionals and providers. |
| 6 | Continuous | Services that are consistent, coherent and connected, that address user's needs across their life course. |

**Table 3.3** Continued

| # | Value label | Description |
|---|---|---|
| 7 | Flexible | Care that is able to change quickly and effectively, to respond to the unique, evolving needs of users and informal carers, both in professional teams and organizations. |
| 8 | Empowering | Supporting people's ability and responsibility to build on their strengths, make their own decisions and manage their own health, depending on their needs and capacities. |
| 9 | Person-centered* | Valuing people through establishing and maintaining personal contact and relationships, to ensure that services and communication are based on the unique situations of users and informal carers. |
| 10 | Respectful | Treating people with respect and dignity, being aware of their experiences, feelings, perceptions, culture and social circumstances. |
| 11 | Led by whole-systems thinking | Taking interrelatedness and interconnectedness into account, realizing changes in one part of the system can affect other parts. |
| 12 | Comprehensive | Users and informal carers are provided with a full range of care services and resources designed to meet their evolving needs and preferences. |
| 13 | Collaborative | Establishing and maintaining good (working) relationships between users, informal carers, professionals and organizations – by working together across sectors, and in networks, teams and communities. |
| 14 | Preventative | There is an emphasis on promoting health and wellbeing and avoiding crises with timely detection and action by and with users, informal carers and communities. |
| 15 | Efficient** | Using resources as wisely as possible and avoiding duplication. |
| 16 | Reciprocal | Care is based on interdependent relationships between users, informal carers, professionals and providers, and facilitates cooperative, mutual exchange of knowledge, information and other resources. |
| 17 | Transparently shared* | Transparently sharing of information, decisions, consequences and results, between users, informal carers, professionals, providers, commissioners, funders, policy-makers and the public. |
| 18 | Effective** | Ensuring that care is designed in such a way that outcomes serve health outcomes, costs, user experience and professional experience. |

* = value label has been reformulated

** = value has been newly suggested in the Delphi study

## Levels of integration

In addition to studying to what extent the initial set of values underpins integrated care, the relevance of each value on the four levels of integration based on the RMIC was examined (Valentijn et al., 2013): the personal, the professional, the management and the system level.

On the personal level (see Figure 3.2), the values 'trustful', 'reciprocal', 'preventative', 'respectful', 'person-centered', 'holistic' and 'collaborative' achieved 100% relevance scores. This means that each panel member found these values relevant on the personal level. The values 'led by whole-systems thinking' (36%) and 'efficient' (62%) were assessed as least relevant on the personal level. The values with the highest relevance scores on the professional level (see Figure 3.3) are 'reciprocal' (100%), 'coordinated' (97%), 'flexible' (97%), 'collaborative' (97%), 'trustful' (94%), 'effective' (92%) and 'shared responsibility and accountability' (90%). 'Empowering' (57%), 'led by whole-systems thinking' (61%) and 'person-centered' (61%) were assessed as least relevant on the professional level by the expert panel. When looking at the management level, the values 'efficient' (96%), 'effective' (96%) and 'shared responsibility and accountability' (90%) were assessed as the most relevant (see Figure 3.4). The values with the lowest relevance scores are 'empowering' (25%), 'person-centered' (32%), 'respectful' (54%) and 'preventative' (58%). Lastly, on the system level (see Figure 3.5) 'led by whole-systems thinking' (97%), 'comprehensive' (89%), 'effective' (88%) and 'efficient' (85%) are assessed as the most relevant values. The lowest scoring values on the system level are 'person-centered' (18%), 'empowering' (25%), 'flexible' (27%), 'reciprocal' (42%) and 'respectful' (47%).

Furthermore, differences can be seen between the relevance scores of each value on each level of integration. Some of the values seem to be highly relevant at multiple levels of integration. For example, the value 'effective' scores respectively 85%, 92%, 96% and 88% on the personal, professional, organizational and system level. The relevance scores of other values are less equally distributed among the levels of integration. For example, the value 'person-centered' shows relevance scores of respectively 100%, 61%, 32% and 18% on the personal, professional, organizational and system level. Figure 6 presents the relevance scores of the values on each level.

**Figure 3.2** Average relevance scores of each value on the personal level

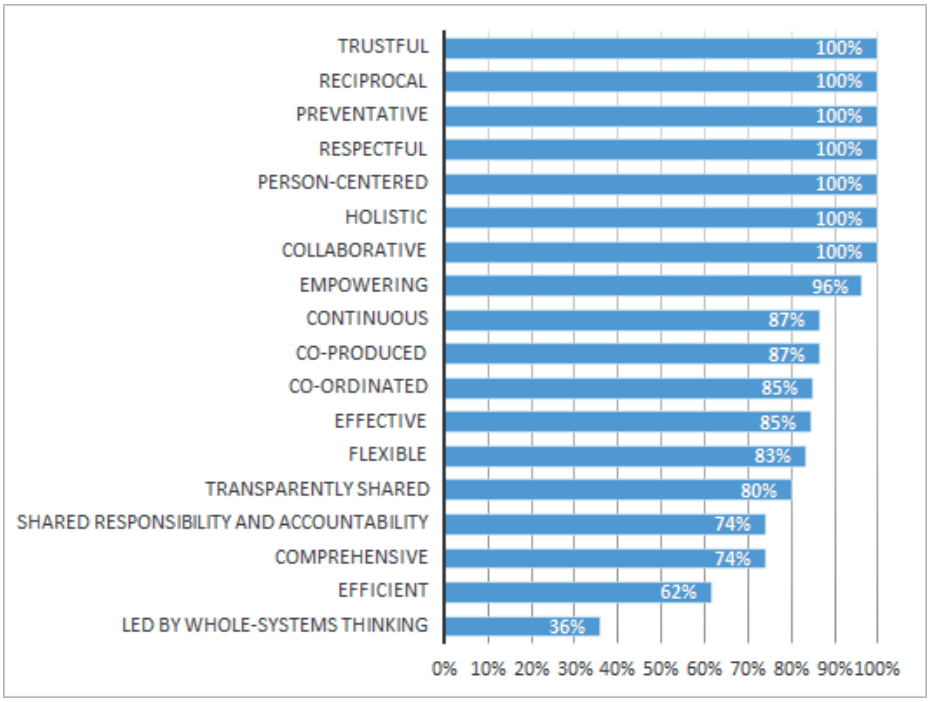



**Figure 3.3** Average relevance scores per value on the professional level

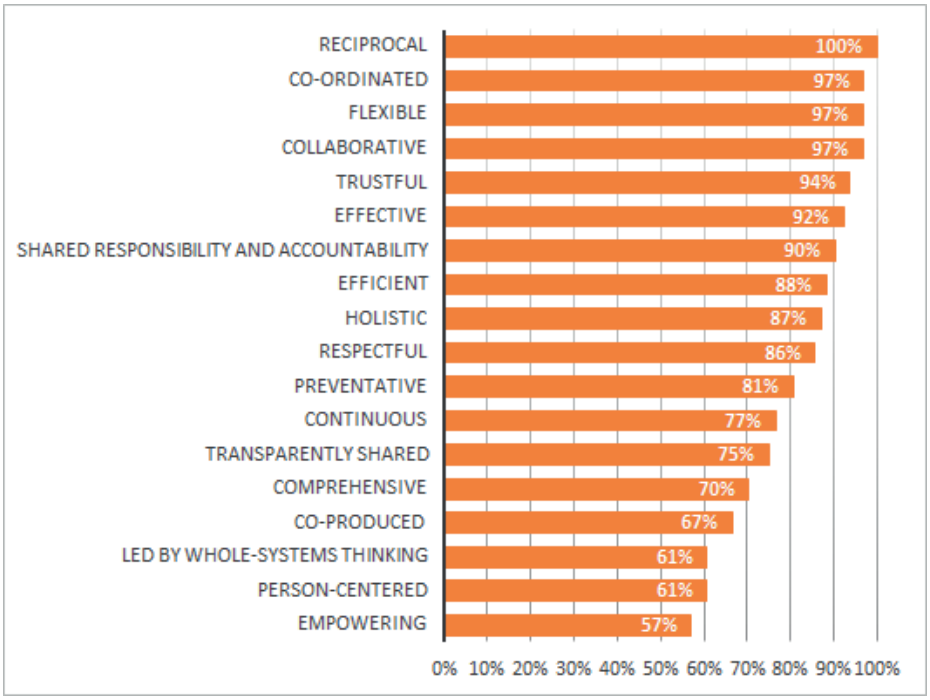


**Figure 3.4** Average relevance scores of each value on the management level

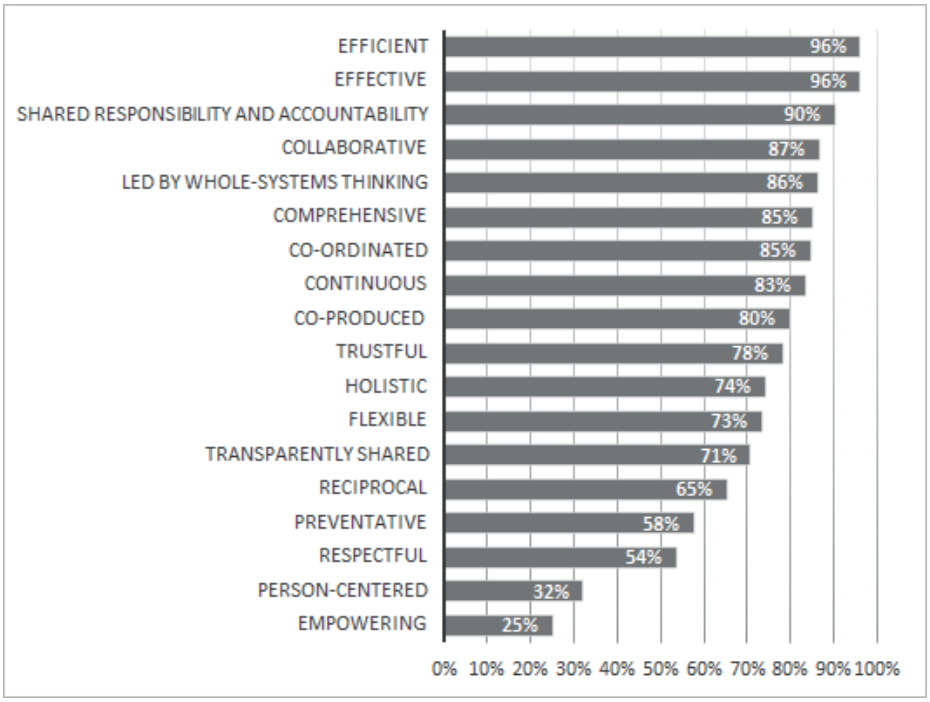
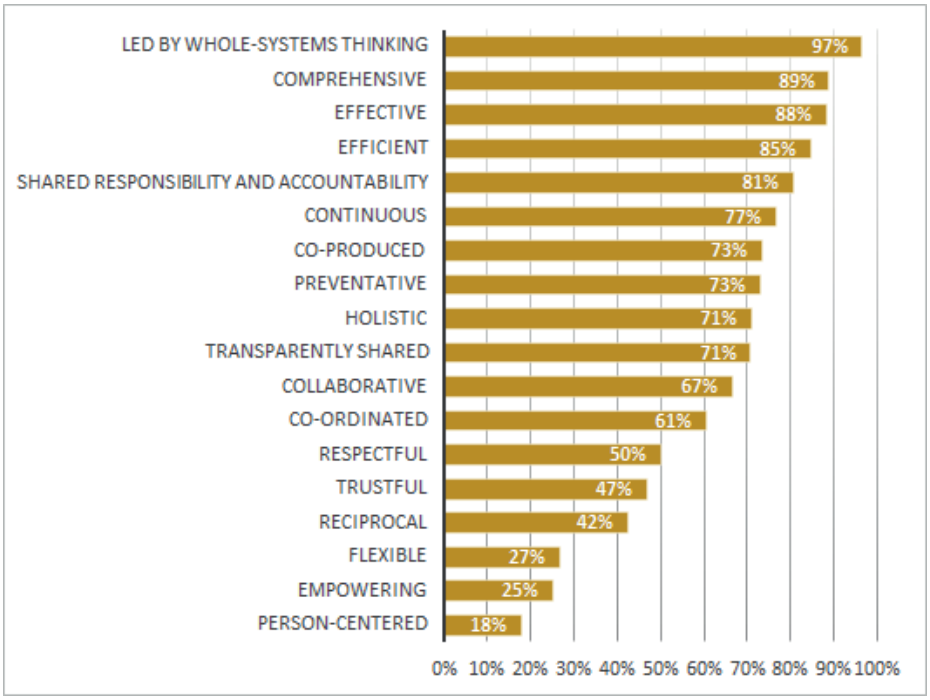
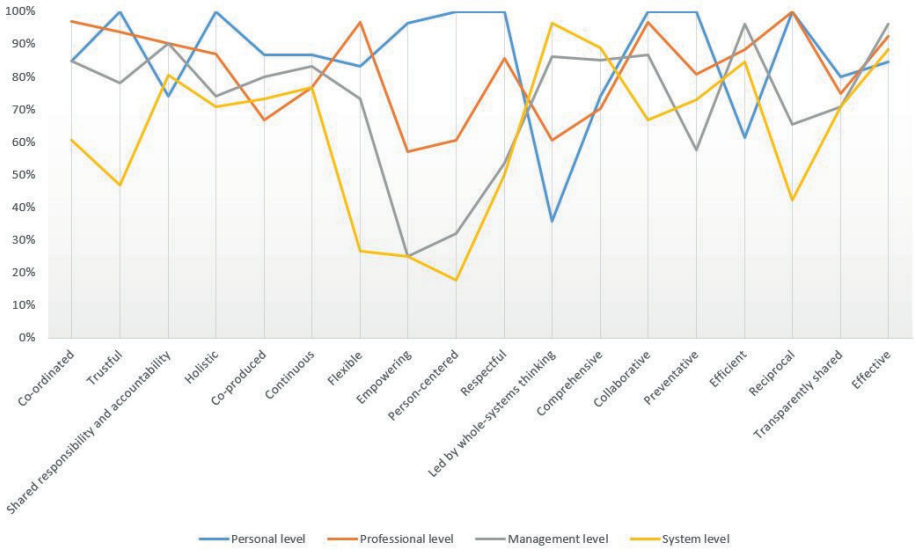



**Figure 3.5** Average relevance scores of each value on the system level






## 3.4 Discussion

The aim of this study was to develop elements for a conceptual values framework for integrated health services delivery, which contributes to our understanding of the normative aspects of integrated health services delivery. Our study refined and validated an initial set of values based on the literature. Furthermore, the relevance of the values on the levels of integration as defined by the RMIC was studied (Valentijn et al., 2013). The refined values set consists of 18 values of integrated health services, including a value label, a description of each value, and a relevance score on each level of integration. Of the initial set of 23 underlying values of integrated care, 16 values (70%) were included in the final set. Two value labels were reformulated and two new values were added. Eight values of the initial set were excluded by the expert panel because they were assessed as not specific or essential enough for integrated care/integrated health services delivery. The study resulted in an international normative basis for the concept of integrated health services delivery. While context, developments and interventions in integrated health services delivery may vary between and within countries, the study demonstrated that consensus can be reached about what values underpin integrated health services delivery or integrated care as a concept. By using the expertise of 33 experts from 13 different countries and multiple professional backgrounds, the developed set of values has a broad base. The results also demonstrate that the literature-based systematic review (Zonneveld et al., 2018) provided a strong basis for the initial set, because the number of new

values was limited and the added elements were partly present in the values of the initial set. The knowledge of the international experts provided additional insights for refinement.

The findings of this study also provide insight into which values are relevant on which levels of integration. On the personal level, values closely related to the interaction with service users are found to be most relevant. Examples are 'holistic', 'trustful', 'respectful' and 'empowering'. This corresponds to studies identifying core components of person-centered care that also recognize these dimensions (Mead & Bower, 2000; Morgan & Yoder, 2012; Scholl et al., 2014). When looking at the most relevant values on the professional level, such as 'collaborative', 'coordinated', 'reciprocal' and again 'trustful', they mostly relate to collaboration between professionals. These values are also found to be relevant in the literature that analyzes interprofessional collaboration as a concept (D'Amour et al., 2005, 2008; Reeves et al., 2011). On the management level, the highest scoring values 'effective', 'efficient' and 'shared responsibility and accountability' are correspondingly reflected in articles that approach healthcare delivery from a business or quality management approach e.g. the application of LEAN management (Glickman et al., 2007; Joosten et al., 2009). Lastly, the values that are identified as most relevant on the system level, like 'led by whole-systems thinking' and 'comprehensive', are also reflected in reports that describe strategic directions for health systems design (World Health Organization, 2015b, 2016b). Thus, the relevance scores of the values on the different levels of integration are underpinned by the existing literature. Moreover, these findings seem to demonstrate that the most relevant values on the personal and professional levels relate to interpersonal aspects, while the most relevant values on the management and system levels are associated with rational aspects.

Furthermore, this study illustrates that some of the values, like 'effective' (85%, 92%, 96%, 88%), score consistent across the different levels of integration, while other values, like 'empowering' (96%, 57%, 25%, 25%), score inconsistent across these levels. The consistent scores, on the one hand, may provide insight into the interconnectedness of values across different levels of integration. For example, supporting holistic ways of working on the professional level (e.g. multidisciplinary teams) facilitates the delivery of holistic care on a personal level. Vice versa, non-holistically organized funding streams or sector specific legislation may complicate the delivery of holistic health services on the micro level. Moreover, when for instance striving for efficiency on a system level, it is likely efficiency-driven incentives are present in the relationships between service users and professionals. While these consistent scores indicate that the 18 values are connected across the different levels

of integration, the more divided or inconsistent scores, on the other hand, suggest that there are also certain differences in emphasis on the values on these levels. A value like 'empowering' may, for instance, be more relevant on the personal level than on the system level. These insights suggest that it is important to consider the interconnectedness of values on multiple levels of integration in integrated health services networks, including particular differences in emphasis per level. When applying the values framework in practice, it is thus important to be aware on what level of integration you are operating. On some levels certain values could be more or less relevant.

When looking at the results from a values theory point of view, the 18 values presented appear to be instrumental values and might be underpinned by certain terminal values. Value theorists such as Rokeach, Schwartz and Bilsky (Rokeach, 2008; Schwartz, 1992; Schwartz & Bilsky, 1987) distinguish two categories of values: 1) values that represent terminal goals (end states), and 2) values that represent instrumental goals (modes of behavior). Terminal values are phrased as nouns, for instance 'freedom' or 'security', while instrumental values or phrased as adjectives such as 'free' or 'secure'. So, terminal values are end goals, whereas instrumental values represent the process by which these goals are achieved. Because integrated health services delivery can be considered as a process (World Health Organization, 2016b), we have chosen to formulate a set of instrumental values underpinning the concept of integrated health services delivery. The 18 values presented describe certain modes of behavior (instrumental goals). For example 'empowering', which refers to the process of supporting people's ability and responsibility. Furthermore, all values are phrased as adjectives e.g. 'holistic' and 'comprehensive'. On the other hand, considering the insights of Rokeach, Schwartz and Bilsky, it is likely that there are certain terminal values that underlie the 18 instrumental values of integrated health services delivery. Examples of these terminal values could be 'self-determination', 'freedom' or 'a healthy life'. Because these terminal values represent desirable end states, they may help describe impact and end goals. Terminal values could therefore play an important role in defining quality of services, impact on service users and informal carers, and objectives of integrated health services programs. It would be relevant to further investigate the dichotomy between terminal and instrumental values, and its practice implications.

Additionally, it is relevant to consider that the 18 values presented are determined by many factors. Although this study strongly focused on the identification of values underpinning the concept of integrated health services delivery, values are influenced by many factors. In addition to personal determinants such as age, gender and family

characteristics, there are also socio-cultural influences like education, previous experiences, occupation and culture (Hitlin & Piliavin, 2004; Rokeach, 2008). On the one hand, personal values can influence work behavior. For example, studies report on relationships between the personal values of employees and their decision-making styles (Connor & Becker, 2003), their ethical behavior (Suar & Khuntia, 2010) and their attitudes (Gibson et al., 2009). On the other hand, individuals also internalize professional and organizational values through socialization. This is described by studies that identified common professional values of nurses (Altun, 2002; Weis & Schank, 2000) and value systems of organizations (Padaki, 2000). Therefore, when using the presented set of 18 values, it is important to be aware that this set is a result of an interplay of individual, professional and organizational values. Since integrated health services delivery is an interorganizational undertaking, contrasting organizational values may complicate collaboration in networks.

By providing insight into the normative aspects of integrated health services, the presented set of values can also contribute to the understanding of its governance. Since integrated health services delivery is a multidimensional undertaking that transcends organizations, new governance mechanisms and instruments are needed (Minkman, 2016). These new governance mechanisms should connect organizations, sectors and people. Values may play an important role in this, since that behavior, interaction and decision-making in integrated health services networks are strongly influenced by the values of the stakeholders involved (Hitlin & Piliavin, 2004). However, those values lie underneath these processes and are not often made explicit. The set of values provides a vocabulary and framework for making the values of the stakeholders in the network more explicit. In this way, the underlying mechanisms of integrated health services networks can be understood more deeply. Similarities and differences in the value priorities of the stakeholders, known as value hierarchies (Hitlin & Piliavin, 2004; Rokeach, 2008; Schwartz, 2012), can be uncovered. Different interpretations of values can also be identified. For example, the meaning of a value like 'person-centeredness' may be different for individuals from different professional backgrounds. Explication of the value priorities and interpretations of the stakeholders provides insight into how the governance of integrated health services networks can be organized, and what the possible enabling circumstances or barriers are. On the one hand, a set of shared values and meanings might enable the development of common ground (Koppenjan & Klijn, 2004), mutual understanding and shared motivation (Emerson et al., 2012). All of these are known as important factors or contingencies for the organization of shared governance (Emerson et al., 2012; Koppenjan & Klijn, 2004; Provan & Kenis, 2008). On the other hand, clarification of the differences between the individual value priorities offers insights

into possible barriers, and may not necessarily affect trust or goal consensus in the network. When no shared governance values can be agreed upon, other network governance forms such as the centralized 'lead organization governance', might also be considered (Provan & Kenis, 2008). Value congruence might therefore form an additional network contingency.



## Practice implications

In order to understand and organize shared governance in integrated health services delivery, it is important to gain insight into the values of the different stakeholders in the network. Although this study presents a comprehensive framework of values underpinning the concept of integrated health services delivery, people may have different value priorities and interpretations. The values of service users, informal carers, professionals, managers or policymakers may sometimes even conflict. It is therefore relevant to be aware of the values and possible value conflicts in integrated health services and how to deal with those conflicts. In practice, the set of values can be used as a vocabulary tool to make values more tangible and explicit. It is important to start a fundamental discussion about which values are the most important for each stakeholder, what their meaning is, and what values are being missed in the current situation of the network. The most important values can be identified by prioritizing. Subsequently, similarities and differences in the value priorities and interpretations of the stakeholders can be uncovered, and the most important collective values can be identified. Additionally, the values that are seen as most important or the values with the least consensus, can be discussed more thoroughly by collectively giving meaning to them. This is important because people from different backgrounds and disciplines often have a different interpretation of values. This overview can be used to further align collaboration, governance and decision-making. Common collective values could be used as a shared point of departure for the further development of integrated health services networks. A set of leading values could, for instance, form the basis for the future strategy and policy. On the other hand, as organizations and networks are made up of people, conflicting values may also exist. Discussing these values can help to find mutual understanding and common ground. It could provide understanding of underlying drivers, views and interests.

Furthermore, the values can contribute to the evaluation of performance and the guidance of behavior in integrated health services. Because the values refer to desirable situations, they can form a basis for the evaluation of performance and quality on the four levels of integration (Fulop et al., 2005; Valentijn et al., 2013). When an integrated health service identifies 'respectful' as leading value, this could be monitored by measures related to respectfully delivering health services.

On the personal and professional level, values could be incorporated in the service user, informal carer and employee satisfaction surveys. On the management and system level, values could be developed into indicators which can be monitored and supervised over time. Correspondingly, values can form a frame of reference for individuals in daily work and decision-making. When, for example, a value as 'empowering' is identified as a leading value in an integrated health service, professional teams should continuously consider whether service users can make their own decisions in every activity or action we carry out. In this example, values provide a framework for professionals to make decisions based on a value consideration. This could make them more accountable for their decisions.

In conclusion, values can play an important role in the total package of governance functions in integrated health services: leadership, supervision and accountability (Minkman, 2017a). First, values can play a role in leadership by forming a backbone for determining the objectives, mission and vision of an integrated health service. Shared and conflicting values could also form a vocabulary for determining ethics and creating culture in integrated health services. Furthermore, values can form the basis for supervision and accountability functions. First, by providing both a basis for measures which can be supervised over time. Second, by providing a framework for daily practice which could make people more accountable.

## Further research

The set of 18 values presented forms a basis for empirical research in integrated health services delivery. For example, it would be valuable to further empirically examine how the values relate to the actual practical behavior and actions of people in integrated health services delivery, within and between organizations (Connor & Becker, 2003; Hitlin & Piliavin, 2004). Considering the insights of value theorists as Schwartz, Rokeach, Hitlin and Piliavin (Hitlin & Piliavin, 2004; Rokeach, 2008; Schwartz, 2012),values transcend specific situations. As they are not uniform, they can be interpreted and applied differently in different contexts. It could be relevant to gain more insight into these different appearances of values and their relationship to contextual factors. For instance, to study which values are specifically relevant in decision-making processes, and to what extent these values can be recognized in behavior and actions of stakeholders. This could be investigated in empirical case studies. Furthermore, it would be relevant to further study the relationship between the normative aspects of integration and the organization of governance in the network. For example, to examine the dynamics between organizational and network values, to investigate to what extent values need to be shared, in order to effectively govern integrated health services, or to study how normative integration

relates to the creation of a mutual understanding or trust (Emerson et al., 2012; Hill & Lynn, 2004; Koppenjan & Klijn, 2004; Minkman, 2017a; Provan & Kenis, 2008). Another direction for further research may be the examination of differences and similarities concerning the relative value priorities between stakeholder groups (beyond 'experts') in integrated health services delivery. Since values are determined by both personal and socio-cultural factors (Hitlin & Piliavin, 2004; Rokeach, 2008), differences between stakeholder groups (e.g. service users, informal carers, professionals, policymakers, managers) or geographical differences may appear. For the understanding of integrated health systems, it would also be valuable to gain insight into how value differences and contradictions on the different levels of integration influence one another and how this affects outcomes such as employee satisfaction or the effectiveness of the system.

## Strengths and limitations

A strength of this study is the basis of a systematic review as a starting point, enriched by expert knowledge. The Delphi panel included 33 international experts with a large experience from 13 different countries in the field integrated health services delivery. Only two experts dropped out, resulting in a 94% response rate. The experts also reached a satisfactory convergence of opinion and saturation after three Delphi rounds, whereas no more new values were suggested. Another strength of this study is its innovative nature and contribution to the existing body of knowledge. Although the relevance of normative integration is confirmed in the literature (Fulop et al., 2005; Goodwin, 2013a; R. Q. Lewis et al., 2010; Minkman, 2016; Valentijn et al., 2013), the WHO (2015b) stresses the need for a values framework, and professional and governance codes plead for values-driven approach (Branchorganisaties Zorg, 2017; Meulenbergs et al., 2004), no systematically assessed values set from a multi-organizational perspective was developed yet. This study adds to this gap in knowledge. By delivering ingredients for a values framework for the concept of integrated health services delivery, this study fills a gap in knowledge.

Our study also has its limitations. Although an international panel with high expertise was involved, the number of experts per country was limited. Some countries (Austria, Czech Republic, New Zealand, Spain and Switzerland) were, for instance, represented by only one expert. Another limitation is that the participating experts all originated from Western countries, which makes it difficult to draw any conclusions on a global scale. It would therefore be valuable to also validate the values framework in Africa, Asia, South America and low and middle income countries. Furthermore, the questionnaire was only available in the English language. Although all panel members had a good understanding of the English language, not every expert had

English as a native language. This could have led to different interpretations. Lastly, most of the participating experts had a background in research, policy or practice while the values of other stakeholders in integrated health services delivery (such as service users and informal carers) may be different. The examination of the service user or informal carer perspective on the developed values set is therefore an important suggestion for further research.

## 3.5 Conclusions

In order to organize health services delivery in a less fragmented and a more person-centered way, it is important to integrate health services. To align collaboration and shared governance in integrated health services networks efficiently, a deeper understanding of the normative dimension of health services integration is necessary. In addition to functional aspects such as activities and interventions, the values that drive the actors' behavior play a role in collaboration. Therefore, more knowledge on what values underpin the integrated health services concept is needed. This study systematically investigated to what extent an initial set of underlying values derived from literature underpins integrated health services by conducting an international Delphi study with 33 experts from 13 countries. Additionally, the relevance of the values on the levels of integration was studied. This resulted in ingredients for a values framework for integrated health services, consisting of 18 values and descriptions, including a relevance score on the levels of integration: personal level, professional level, management level and system level. The set of values forms an international normative basis for integrated health services delivery. It delivers ingredients for a framework that could form a basis for a better understanding of the normative dimension of integration and the dynamics in shared governance processes in integrated health services delivery networks.

### List of abbreviations

RMIC = Rainbow Model of Integrated Care
WHO = World Health Organization

### Declarations

#### *Ethics approval and consent to participate*

The study was performed in accordance with the guidelines of the Declaration of Helsinki (General Assembly of the World Medical Association, 2014). All participants gave informed consent to participate in the study. They participated voluntarily in

the research, without coercion or reward. The research team invited the experts to participate in the research. Only experts that gave their written consent were included to fill out the secured digital Delphi questionnaire. Only fully completed Delphi surveys were included in the study. No clients or patients were involved in this study. As agreed with the experts, the data was analyzed anonymously while respecting confidentiality and privacy, and has not been shared with other parties. The online questionnaire does not concern medical scientific research and there is no infringement of the physical and/or psychological integrity of the subject. Therefore, no ethical approval from an Ethical Review Board was required as confirmed by the Dutch Central Committee for Research Involving Human Subjects (CCMO). No ethical review was required in any of the other countries where experts participated, see for instance the Australian National Health and Medical Research Council (NHMRC), the British Health Research Authority (HRA) and regulations of the other countries (see also www.ceg.nl/en).

***Consent for publication***

Not applicable.

***Availability of data and material***

The datasets generated and/or analyzed during the current study are not publicly available due because the confidentiality and privacy of the expert panel members is respected.

***Competing interests***

The authors have no competing interests to declare.

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***Authors' contributions***

NZ: leading the writing process, research proposal, data collection, data-analysis, interpretation
JR: interpretation, writing
MM: supervisor, research proposal, data-analysis, interpretation, writing
All authors read and approved the final manuscript.

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We would like to warmly thank all the 33 experts who participated in the Delphi study.

***Supplementary material***
The file containing the full three-round Delphi online questionnaire associated with this study is available in the online version of the article at
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# 4.

# Values Underpinning Integrated, People-Centered Health Services: Similarities and Differences Among Actor Groups Across Europe

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## Abstract

**Introduction**: In addition to the functional aspects of healthcare integration, an understanding of its normative aspects is needed. This study explores the importance of values underpinning integrated, people-centered health services, and examines similarities and differences among the values prioritized by actors across Europe.

**Methods**: Explorative cross-sectional design with quantitative analysis. A questionnaire of 18 values was conducted across Europe. A total of 1,013 respondents indicated the importance of each of the values on a nine-point scale and selected three most important values. Respondents were clustered in four actor groups, and countries in four European sub-regions.

**Results**: The importance scores of values ranged from 7.62 to 8.55 on a nine-point scale. Statistically significant differences among actor groups were found for ten values. Statistically significant differences across European sub-regions were found for six values. Our analysis revealed two clusters of values: 'people related' and 'governance and organization'.

**Discussion and conclusion**: The study found that all 18 values in the set are considered important by the respondents. Additionally, it revealed distinctions in emphasis among the values prioritized by actor groups and across sub-regions. The study uncovered two clusters of values that contribute to a conceptually based definition of integrated, people-centered health services.

## 4.1 Introduction

An increasing number of individuals with multiple, complex conditions require services from numerous professionals, spanning disciplines and sectors. A 'solution' for this situation is often found by connecting and coordinating healthcare services, a process frequently referred to as integrated care (Kodner & Spreeuwenberg, 2002; World Health Organization, 2015b). The integration of healthcare services is widely seen as a promising strategy in the provision of good quality person centered care (Breton et al., 2017; Stoop et al., 2019; Wodchis et al., 2018). In practice, however, healthcare services are still fragmented in many countries (Nilsson et al., 2016; Novick, 2017; Youssef et al., 2020). The recent COVID-19 crisis has accentuated this fragmentation in healthcare services across the globe (L. Lewis & Ehrenberg, 2020). Responses are often not integrated, leading to poor health outcomes and greater inequality across populations (Stein et al., 2020).



The existing literature on integrated, people-centered health services often describes technical interventions, such as case-management (Stokes et al., 2015), payment models (Stokes et al., 2018; Tsiachristas, 2016) and information technology (Cameron et al., 2014). In the Rainbow Model of Integrated Care (RMIC), Valentijn refers to these aspects as key components of functional integration (Valentijn, 2015). However, if health services integration only involves functional aspects, then why is it so difficult to implement (Cameron et al., 2014; Goodwin, 2013b; Klinga et al., 2016; Ling et al., 2012) and so hard to demonstrate improved outcomes (Janse, 2018; Looman et al., 2018; Nolte & Pitchforth, 2014; Rocks et al., 2020; Tsiachristas et al., 2016; Wankah et al., 2020; World Health Organization, 2015a)?

The risk of mainly focusing on technical factors is that possible 'softer' human aspects may be glossed over. In the RMIC, these aspects are referred to as normative integration (Valentijn, 2015). This is relevant because, in addition to technical activities, the delivery of integrated, people-centered health services consists of several interactive processes that often take place in multi-level networks, among a variety of actors with different backgrounds, who are influenced by numerous contextual factors (Busetto et al., 2016; Valentijn, 2015). Goodwin (2019) describes this situation as a complex black box.

A better understanding of the factors that contribute to these complexities could provide important information in support of the integrated, people-centered health services agenda. In recent years, there has been growing evidence about the importance and the role of normative dimensions of integrated, people-centered

health services, such as communication (Lette et al., 2019), relationship dynamics (Valentijn, Vrijhoef, Ruwaard, de Bont, et al., 2015), trust (Marill, 2020), emotional dimensions (Hujala & Oksman, 2018) and shared culture, norms and goals (Poulsen et al., 2019). There is, however, still a lack of knowledge about how these aspects play out in practice (Goodwin, 2019).

To gain deeper insight into the normative aspects of integrated, people-centred health services, the concept of values is frequently used. We define values as "*meaningful beliefs, principles or standards of behavior, referring to desirable goals that motivate action*" (Zonneveld et al., 2018, p. 2) or in laymen's terms 'what is important to us' (Hitlin & Piliavin, 2004; Schwartz, 2012). Often cited conceptual frameworks and taxonomies of integrated, people-centred health services, such as the National Health Service (NHS) typology of healthcare integration (Fulop et al., 2005) and the RMIC (Valentijn, 2015), describe the role of shared values as crucial. Other integrated, people-centered health services studies relate shared values among actors to the performance of teams and organizational culture (Tietschert et al., 2019), professional decision-making (Miller et al., 2017) and staff commitment (Goodwin, 2013a).

The World Health Organization (WHO) stresses the need for a unifying values framework in its 'Global strategy on people-centered and integrated health services' (World Health Organization, 2015b) and the 'European Framework for Action on Integrated Health Services Delivery' (World Health Organization, 2016a), and proposes core principles to guide the development of people-centered and integrated health services. These principles are based on expert feedback (Ferrer & Goodwin, 2014; World Health Organization, 2015b). To develop a more scientific basis for a values framework, we refined the list of values by performing a systematic review of the literature (Zonneveld et al., 2018) and an international Delphi consensus study (Zonneveld et al., 2020), which resulted in a core set of 18 values (see Table 4.2). Our Delphi study demonstrated that an international consensus could be reached about a set of 18 values underpinning integrated, people-centered health services as a concept. However, it does not establish whether different actors in different contexts across Europe place different priorities on the individual values. Understanding similarities and differences could be useful for policy makers pursuing policies in support of integration of health services.

In this explorative study we address this knowledge gap by examining the priority values of different actor groups across different European sub-regions, using the set of 18 values underpinning the concept of integrated, people-centered health services developed in our previous studies (Zonneveld et al., 2018, 2020). This study

assesses the importance of these values as perceived by the key actors involved in integrated, people-centered health services, including service users, informal carers, professionals, policy- and decision makers and researchers. These actors have diverse backgrounds, roles and perspectives (Breton et al., 2019; Nolte & McKee, 2008; S. Shaw et al., 2011; Zonneveld et al., 2017). The theory of values states that such (sub)groups of people often vary in the relative importance they attach to particular values, also known as value hierarchies, which may guide their behavior (Hitlin & Piliavin, 2004; Rokeach, 2008; Schwartz, 2012). To gain insight into their behaviors and preferences, this study examines which values are considered most important by which actors. The study also explores possible variations among European sub-regions. Since integrated, people-centred health services are being implemented in numerous countries and settings (De Bruin et al., 2018; Kodner & Kyriacou, 2000; Rutten-van Mölken et al., 2020; Van Duijn et al., 2018; Wodchis et al., 2015), within a variety of social, economic, political, legal and health system contexts (Busetto et al., 2016; De Bruin et al., 2020), we assess whether there are differences in the values that are prioritized by respondents in different European sub-regions. Lastly, we explore possible relationships among the values prioritized by the respondents.



In sum, this study aims to advance the conceptual understanding of the values underpinning integrated, people-centered health services by examining four research questions: (a) How do European actors involved in integrated, people-centered health services assess the importance of the 18 values of integrated, people-centered health services? (b) What, if any, differences may be observed among the values prioritized by different actor groups? (c) What, if any, are the differences among the values prioritized across different European sub-regions? (d) Do relationships exist among the values prioritized by all respondents?

## 4.2 Methods

### Participants and data collection

The questionnaire was distributed among European service users/patients and informal carers (and their representatives), healthcare professionals, policy and decision makers, and researchers in integrated, people-centered health services with a good understanding of the English language. The actors were invited via the panels of official platforms and associations, both European and national, such as the International Foundation of Integrated Care (IFIC), the European Health Management Association (EHMA), European Patients Forum (EPF) and the AGE Platform. Most of these panels are representative for country, background, gender

and other characteristics. The online questionnaire was fielded between October 2019 and January 2020. A total of 1,013 respondents from 42 European countries were included.

## Measures

Participants were asked to fill out the questionnaire from the perspective of their actor role in integrated, people-centered health services. Respondents with multiple roles were asked to choose the role that most closely fits their current situation or position. First, respondents answered questions about their background including: (a) residential country, (b) actor role, (c) years of experience in health services, (d) gender, and (e) age. Second, after a brief explanation about the concept of values, the set of 18 values developed through a systematic review of the literature (Zonneveld et al., 2018) and an international Delphi study (Zonneveld et al., 2020) was used to measure priority values. Respondents were requested to indicate the importance of each of the 18 values from their perspective, by awarding a score on a nine-point scale (1 = completely unimportant, 9 = highly important). Then, the participants were asked to select the three most important values out of the set of 18. The full questionnaire is provided in Appendix 4.1.

## Analysis

The data were analyzed using SPSS Statistics for Windows, version 26.0 (International Business Machines (IBM) Corporation, Armonk, NY, United States). For assessment of the nine-point scale, the mean scores and interquartile ranges (IQRs) for each value were calculated to construct scores that reflect their importance. For the three most important selections, the percentages per value were calculated. Binary logistic regressions, including a multi-level model check, were conducted to investigate differences among actor groups and European sub-regions. Respondents were clustered in four actor groups: (a) service users/patients and informal carers, (b) professionals, (c) policy and decisionmakers, and (d) researchers.

Countries were clustered in four European sub-regions: (a) Western Europe, (b) Northern Europe, (c) Southern Europe, and (d) Eastern Europe. This grouping is based on the United Nations Geoscheme for Europe (United Nations Statistics Division, 1999). Multi-collinearity among independent variables was examined using Cramer's V, chi-square and Spearman's rho tests. For actor groups we controlled for sub-regional origin, gender, age and years of experience. European sub-regional control variables included actor group and gender. To investigate relationships among the 18 values, a principal components factor analysis (PCA) was conducted. The rotation method was Oblimin with Kaiser Normalization. The number of

factors was based on the number of Eigenvalues ≥ 1.0 in the PCA. The two factors were interpreted by the six researchers based on the ranking of values per factor, considering conceptual patterns. Disagreements were resolved by discussion.

### Ethical considerations

The study design as described above has been reviewed and approved by the Ethics Review Board of Tilburg School of Social and Behavioural Sciences (Ref. 'EC-2019. EX153'). Participation in this research was entirely voluntary. All respondents gave informed consent prior to participation in the study and were free to decline to answer a particular question for any reason. Survey answers were collected and stored through secured and password protected electronic software. No identifying information such as IP addresses or names was collected. All respondents remained anonymous.



## 4.3 Results

### Demographics

Table 4.1 shows the characteristics of the respondents. In total, 1,013 respondents from four actor groups and four European sub-regions completed the survey. Most respondents had twenty years of experience or more (46.3%) and were female (62.6%). The respondents had an average age of 48.4 years (SD=12.0).

**Table 4.1** Characteristics of the respondents

| | Total | Service users and informal carers | Professionals | Policy and decision makers | Researchers |
|---|---|---|---|---|---|
| **N** | 1,013 | 163 | 295 | 279 | 276 |
| **(%)** | 100.0 | 16.1 | 29.1 | 27.5 | 27.2 |
| **European sub-region of origin (%)** | | | | | |
| Western Europe | 24.6 | 30.1 | 15.6 | 27.2 | 28.3 |
| Northern Europe | 37.7 | 39.9 | 33.2 | 40.5 | 38.4 |
| Southern Europe | 30.1 | 20.9 | 47.1 | 22.9 | 24.6 |
| Eastern Europe | 7.6 | 9.2 | 4.1 | 9.3 | 8.7 |
| **Years of experience (%)** | | | | | |
| 0-5 years | 11.5 | 7.8 | 8.1 | 11.6 | 17.2 |
| 5-10 years | 13.2 | 13.1 | 12.2 | 11.2 | 16.4 |
| 10-15 years | 14.4 | 13.7 | 10.8 | 14.8 | 18.2 |

**Table 4.1** Continued

| | Total | Service users and informal carers | Professionals | Policy and decision makers | Researchers |
|---|---|---|---|---|---|
| 15-20 years | 14.5 | 11.1 | 13.6 | 17.3 | 14.6 |
| 20+ years | 46.3 | 54.2 | 55.3 | 45.1 | 33.6 |
| **Gender (%)** | | | | | |
| Male | 37.2 | 30.2 | 39.1 | 45.8 | 30.5 |
| Female | 62.6 | 69.8 | 60.5 | 53.8 | 69.5 |
| Non-binary | 0.2 | 0.0 | 0.3 | 0.4 | 0.0 |
| **Age (SD)** | 48.4 (12.0) | 53.8 (14.1) | 47.9 (11.3) | 48.8 (11.0) | 45.2 (11.3) |

## General importance scores

The mean importance scores of the values ranged from 7.62 to 8.55 on a scale from 1 to 9. 'transparently shared' was rated the lowest (mean 7.62, IQR 7-9) and 'coordinated' (mean 8.55, IQR 8-9) received the highest importance score. The percentages of the values selected as one of the three most important values out of the 18-item set ranged from 47.3% to 0.6%. 'Reciprocal' was the least selected value (0.6%) and 'person-centered' was included by most of the respondents (47.3%).

**Table 4.2** Priority values and importance scores (n=1,013)

| | Included in selection of 3 most important values (%) | Importance score on 1-9 scale |
|---|---|---|
| **Person-centered** - Valuing people through establishing and maintaining personal contact and relationships, to ensure that services and communication are based on the unique situations of users and informal carers. | 47.3 | 8.15 |
| **Coordinated** - Connection and alignment between users, informal carers, professionals and organizations in the care chain, to reach a common focus matching the needs of the unique person. | 34.1 | 8.55 |
| **Holistic** - Putting users and informal carers in the center of a service that is 'whole person' focused in terms of their physical, social, socio-economical, biomedical, psychological, spiritual and emotional needs. | 24.7 | 8.14 |

**Table 4.2** Continued

| | Included in selection of 3 most important values (%) | Importance score on 1-9 scale |
|---|---|---|
| **Effective** - Ensuring that care is designed in such a way that outcomes serve health outcomes, costs, user experience and professional experience. | 22.8 | 7.76 |
| **Trustful** - Enabling mutual trusting between users, informal carers, communities, professionals and organizations, in and across teams. | 21.3 | 8.35 |
| **Empowering** - Supporting people's ability and responsibility to build on their strengths, make their own decisions and manage their own health, depending on their needs and capacities. | 18.0 | 8.28 |
| **Respectful** - Treating people with respect and dignity, being aware of their experiences, feelings, perceptions, culture and social circumstances. | 17.8 | 8.17 |
| **Led by whole-systems thinking** - Taking interrelatedness and interconnectedness into account, realizing changes in one part of the system can affect other parts. | 15.2 | 8.10 |
| **Efficient** - Using resources as wisely as possible and avoiding duplication. | 15.2 | 7.98 |
| **Preventative** - There is an emphasis on promoting health and wellbeing and avoiding crises with timely detection and action by and with users, informal carers and communities. | 14.7 | 8.00 |
| **Shared responsibility and accountability** - The acknowledgment that multiple actors are responsible and accountable for the quality and outcomes of care, based on collective ownership of actions, goals and objectives, between users, informal carers, professionals and providers. | 13.5 | 8.29 |
| **Continuous** - Services that are consistent, coherent and connected, that address user's needs across their life course. | 13.4 | 8.38 |
| **Collaborative** - Establishing and maintaining good (working) relationships between users, informal carers, professionals and organizations – by working together across sectors, and in networks, teams and communities. | 12.3 | 8.24 |

**Table 4.2** Continued

| | Included in selection of 3 most important values (%) | Importance score on 1-9 scale |
|---|---|---|
| **Co-produced** - Engaging users, informal carers and communities in the design, implementation and improvement of services, through partnerships, in collaboration with professionals and providers. | 9.2 | 8.34 |
| **Comprehensive** - Users and informal carers are provided with a full range of care services and resources designed to meet their evolving needs and preferences. | 8.0 | 7.96 |
| **Flexible** - Care that is able to change quickly and effectively, to respond to the unique, evolving needs of users and informal carers, both in professional teams and organizations. | 7.5 | 8.22 |
| **Transparently shared** - Transparently sharing of information, decisions, consequences and results, between users, informal carers, professionals, providers, commissioners, funders, policy-makers and the public. | 4.2 | 7.62 |
| **Reciprocal** - Care is based on interdependent relationships between users, informal carers, professionals and providers, and facilitates cooperative, mutual exchange of knowledge, information and other resources. | 0.6 | 7.93 |

## Actor groups

After controlling for sub-regional origin, gender, age and years of experience, binary logistic regression identified statistically significant effects of the actor group of respondents for the prioritization of ten values. Figure 4.1 summarizes the association of the actor group with the priority values. Statistically significant effects are indicated by an asterisk (* $p \leq 0.05$, ** $p \leq 0.01$).

Controlled binary logistic regression demonstrated that service users and informal carers were significantly more likely to select the values 'co-produced', 'respectful' and 'trustful' as one of their three most important values, than all the other actor groups (all p-values ≤.033). Service users and informal carers, and researchers were significantly more likely to select 'continuous' than professionals and policy and decision makers (all p-values ≤.034).

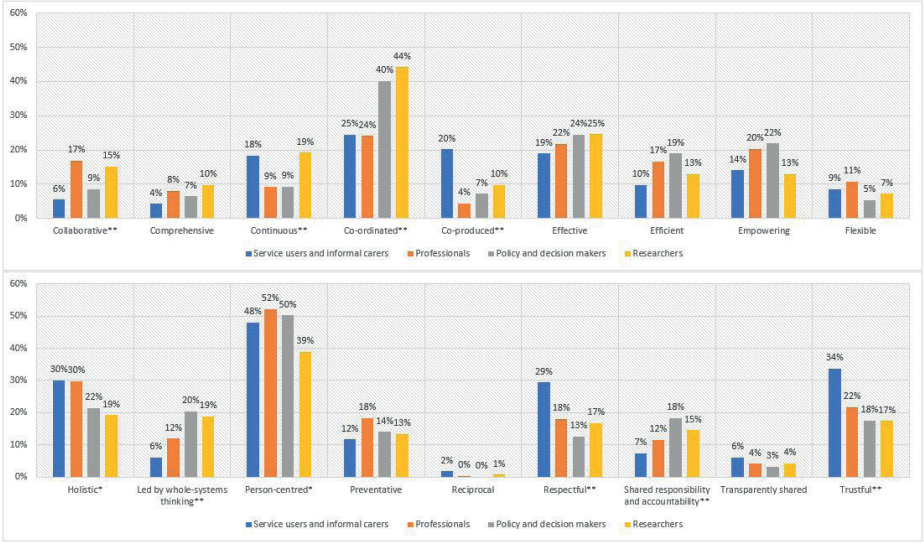
Professionals, service users and informal carers were significantly more likely to include 'holistic' in their selection of three most important values than the other actor

groups: policy and decision makers and researchers (all p-values ≤.020). Furthermore, professionals and researchers were more likely than the other actor groups to select 'collaborative' as one of their three most important values (all p-values ≤.002).

Policy and decision makers and researchers were more likely than the other actor groups to include 'coordinated' and 'led by whole systems thinking' in their selection of the three most important values (all p-values ≤.001). Furthermore, policy and decision makers and researchers were more likely to select 'shared responsibility and accountability' as one of their three most important values than service users and informal carers (all p-values ≤.015).



**Figure 4.1** Priority values of the actor groups



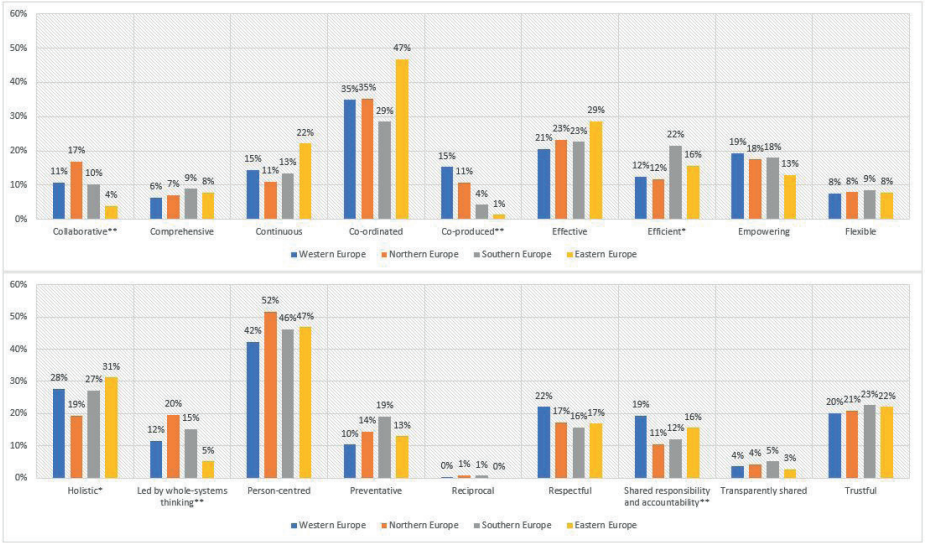

* p≤0.05, ** p≤0.01

## European sub-regions

After controlling for actor group and gender, binary logistic regression demonstrated statistically significant effects of the sub-regional origin of respondents for six values associated to integrated, people-centered health services. Figure 4.2 displays the association of sub-regional origin with the priority values. Statistically significant effects were found for 'collaborative', 'co-produced', 'efficient', 'led by whole systems thinking', 'holistic' and 'shared responsibility and accountability' (all p-values ≤.023), which are indicated by an asterisk (* p≤0.05, ** p≤0.01).

In comparison to other respondents, Western European respondents ranked 'efficient' (12%) relatively low, but 'co-produced' (15%) and 'shared responsibility and accountability' (19%) relatively high. Northern European participants awarded lower scores to 'shared responsibility and accountability' (11%), 'efficient' (12%) and 'holistic' (19%), while assessing 'collaborative' (19%) and 'led by whole systems thinking' (20%) relatively higher. Respondents from Southern Europe rated 'efficient' (22%) especially high. Eastern European respondents attached relatively lower scores to 'co-produced' (1%), 'collaborative' (4%) and 'led by whole systems thinking' (5%), and relatively higher scores to 'holistic' (31%).

**Figure 4.2** Priority values across European sub-regions




* p≤0.05, ** p≤0.01

## Relationships between values

The PCA resulted in a two-factor solution with a cumulative loading of 52.8%. The analysis revealed two clusters of values. Ten of the 18 values loaded on the first factor. The remaining eight values all loaded on the second factor (see Table 4.3). Factor 1, labelled as 'people related', mainly consists of items related to how people interact acknowledging a worthwhile relationship between a person and a health professional. Factor 2, labelled as 'governance and organization' contains items referring to the governance and organization of integrated, people-centered health services and to what it should contribute.

**Table 4.3** Results of PCA and Oblimin with Kaiser Normalization of the two factors

| | --- Factor --- | |
|---|---|---|
| | **People related** | **Governance and Organization** |
| | **Eigenvalues and cumulative proportion of variance explained by principal components analysis** | |
| Eigenvalue | 8.402 | 1.026 |
| Cum. variance | 46.678 | 52.375 |
| | **Factor pattern Oblimin with Kaiser Normalization** | |
| Empowering | **.805** | .064 |
| Holistic | **.790** | .064 |
| Person-centered | **.781** | .048 |
| Co-produced | **.701** | -,.70 |
| Respectful | **.608** | .015 |
| Trustful | **.536** | -.124 |
| Collaborative | **.528** | -.262 |
| Shared responsibility and accountability | **.438** | -.241 |
| Reciprocal | **.423** | -.415 |
| Flexible | **.408** | -.359 |
| Effective | -.179 | **-.908** |
| Efficient | -.105 | **-.877** |
| Continuous | .142 | **-.697** |
| Transparently shared | .190 | **-.556** |
| Preventative | .236 | **-.552** |
| Led by whole-systems thinking | .237 | **-.493** |
| Comprehensive | .331 | **-.472** |
| Coordinated | .288 | **-.465** |

## 4.4 Discussion

In this explorative study, we measured the value importance scores and selections of the three most important values of 1,013 actors across Europe to identify their priority values. We found that each of the 18 values associated to integrated, people-centered health services is considered important, receiving high ratings from every actor group from all the European sub-regions. With scores ranging from 7.62 to 8.55 on a nine-point scale, the absolute differences among these scores are small, indicating an absence of an overarching value hierarchy among all values. Each of the values in the set is considered important from all the included actor perspectives and geographical contexts, which confirms the consensus reached in our previous Delphi study (Zonneveld et al., 2020).

These similarities notwithstanding, the study did find statistically significant differences in the relative importance of different value scores across different actor groups, suggesting a distinction in emphasis that could be expected considering the different roles, responsibilities and perspectives of various actors (Breton et al., 2019; Nolte & McKee, 2008; S. Shaw et al., 2011; Zonneveld et al., 2017). Service users and informal carers, for example, attached a significantly higher priority to values, such as 'respectful', 'trustful' and 'co-produced', that express how they ideally would like to experience integrated, people-centered health services and the relationships with their carers. These findings are similar to those found in recent studies on the service user perspective in integrated, people-centered health services.

Recent studies by Kuluski et al (2019), Lawless et al (2020), and Youssef et al (2020), identify several attributes and themes that are important to service users. A major part of these components includes relational aspects (Lawless et al., 2020), such as feeling heard (Kuluski et al., 2019; Lawless et al., 2020), feeling respected (Lawless et al., 2020) having someone to count on (Kuluski et al., 2019), caring about the person (Youssef et al., 2020) and collaboration with the service user (Youssef et al., 2020). The priority values of the professionals in our study such as 'holistic' and 'collaborative', relate to their day-to-day work. Similar values underpin the foundations of interdisciplinary collaboration in the literature (Clark, 1994; Reeves et al., 2011; Winfield et al., 2017).

The policy and decision makers in the study prioritized values referring to how the organizational and governance aspects of integrated, people-centered health services should be shaped. Examples are 'coordinated', 'shared responsibility and accountability' and 'led by whole systems thinking'. These values can also be found

in articles on organizing and governing integrated, people-centered health services, which point to collaborative networks as organizational models and focus on relationships across instead of within organizations (Minkman, 2017a; Provan et al., 2007; Provan & Kenis, 2008; Provan & Milward, 2006).

The existing literature also highlights the variety of actor perspectives in integrated, people-centered health services. Referring to the work of Nolte and McKee (2008), Goodwin et al. (2017) state that the variety of interpretations and definitions of integrated, people-centered health services as a concept may (at least in part) be the result of the different viewpoints of its various actors (Amelung et al., 2021; Nolte & McKee, 2008). Similarly, Shaw, Rosen and Rumbold (2011) present multiple actor perspectives on integrated, people-centered health services, such as the perspectives of policy and decision makers (policies, regulations, financing arrangements, care systems), professionals (provision and co-ordination of care), and service users and informal carers (experience of access and navigation across the care system, information-sharing). Goodwin et al. (2017) stress that all these interpretations and definitions are potentially legitimate and that integrated, people-centered health services should not be defined narrowly. In line with this statement, our study demonstrates that although actors all seem to support integrated, people-centered health services as a concept, they observe integrated, people-centered health services from different angles and find different components of it particularly important.



These distinctions in emphasis are also demonstrated by the factor analysis in this study, which uncovers two clusters (factors) of values with different accents. The 'people related' values accentuate how people want to be treated within the relationship between service users and professionals. The 'governance and organization' values highlight what is considered important in organizing and governing health services integration, and to what such integration should contribute. These two clusters could be seen as two sides of the same coin of care integration. Both provide an important additional perspective for the realization of integrated health services delivery. On the one hand, to pursue 'people related' values in integrated, people-centered health services, it is also necessary to work on 'governance and organization' values. Values related to governance and organization may facilitate an enabling environment supporting the delivery of health services that are people-centered, illustrated by 'people related' values such as respectful, trustful and empowering. On the other hand, if we would only base the delivery care services on 'governance and organization' values, this could potentially limit important people related features of integrated health services. It is important to balance between these two clusters, and to accentuate particular values when needed. The existence

of these two factors therefore helps us to better understand distinctions in emphasis and how these values together form a whole. In this way, our study results contribute to the often incoherent definition(s) of integrated, people-centered health services, by providing the components for a conceptually based definition.

We see the pursuit of all values within both clusters as essential for realizing integrated, people-centered health services. This is in line with existing frameworks (World Health Organization, 2015b) and commonly used definitions (Armitage et al., 2009; Kodner & Spreeuwenberg, 2002; World Health Organization, 2016a) stressing that health services integration requires concerted efforts on different levels and among a diversity of actors, around individual persons, families and communities (resembling the people related factor), but also within the broader organization and governance of services and within regional or national health systems (factor governance and organization). The insights of our study provide a normative basis for such multi-level pursuits of health services integration and its definition.

For implementation of integrated, people-centered health services, the distinctions in emphasis by the actor groups suggest that we need to recognize and take into account a possible range of multiple values. We elaborate on two aspects of integration that could benefit from taking into consideration the findings of this study: (a) coordination by network facilitators and (b) collaborative attitudes and competencies of actors. First, care integration often takes place in networks of organizations and individuals. A network facilitator or broker, for example a lead organization or a network administrative organization (NAO) (Provan et al., 2004; Provan & Kenis, 2008), can play an important key connecting role in complex integrated, people-centered health services networks by, for example, resolving conflicts and building trust among actors in the collaborative network (McEvily & Zaheer, 2004; Provan & Kenis, 2008). Our study adds to this concept by demonstrating that network facilitators would benefit from uncovering and taking into account the values prioritized by all the different actors. Network facilitators should be able to acknowledge and understand what matters to the different actors in pursuing integrated, people-centered health services and how they define particular issues. They need to take the social constructions and perspectives of the collaborating actors into account. Examples of such facilitators are cultural brokers (Trevillion, 1992) and boundary spanners (Williams, 2002).

Second, our findings suggest that collaborating actors in care integration should also be aware of each other's values. Many studies demonstrate that interdisciplinary collaboration among professionals requires a collaborative attitude (Fickel et al.,

2007; Janssen et al., 2020; Marshall, 1998; Miller & Stein, 2020; Sunderji et al., 2016), described as *"being able and willing to work together with respect for partners"* by Janssen et al. (2020). Our study adds to this concept by showing that such an attitude should also include acknowledging and respecting each other's priority values. In the Model of Collaboration of D'Amour et al. (2005, 2008), this awareness of one another's value orientations is called internalization, helping actors to see the bigger picture which translates into mutual trust and understanding. Our study suggests that normative considerations, such as values, deserve attention in the development and education of collaborative attitudes and competencies (Clark, 1994, 1995, 1997).



Compared to the actor group analysis, there are fewer differences among prioritized values across European sub-regions. Significant differences were identified for six values. 'efficient', for example, is a highly ranked value in Eastern Europe, while 'co-produced' is more highly ranked in Western Europe. This suggests that the context in which integrated, people-centered health services take place matters, as also stated in the work of Busetto and colleagues (2016). Some of the observed differences in sub-regional variations in value scores are likely to reflect differences in the historical context of the countries in these sub-regions. For example, collaboration and co-creation were not values that characterized health services in the former communist countries in the eastern parts of the European region where centrally dictated norms and protocols were the custom, leaving limited room for collaboration and co-creation (Rechel et al., 2014). Furthermore, reform of the health systems in former communist countries with their heavy reliance on hospital-based care has to a large extent been driven by a focus on improving the efficiency (Rechel et al., 2014). It is therefore not surprising that respondents in these countries place relatively greater importance on this value than the respondents in countries that have experienced different pressures for reform.

## Practical implications

Our study demonstrates that all respondents consider the values associated to integrated, people-centered health services important. Additionally, it reveals distinctions in emphasis among the values prioritized by actor groups and across sub-regions. These distinctions in emphasis may also exist in practice. Each actor has their own perspectives and interests. The distinctions in emphasis may complement each other, which could lead to a whole that is greater than the sum of its parts. At the same time, actors may have different interpretations of values. It would therefore be helpful to make the priority values of the actors more explicit and tangible. Our set of 18 values can be used as a vocabulary in dialogues and exercises to facilitate different actors to put themselves in the shoes of others, enabling them to examine

the values that they find important in collaboration from both a personal and a collective perspective. Once each actor has selected 'their' values from the list of 18, the results can be discussed collectively and together the actors can explore what particular values mean to them and to the other actors. Possible differences in the interpretations of the values can also be clarified. For example, what does effectiveness or trust mean to the different partners, how do they apply these values in their daily work, and what do they expect from the other actors? On what values do they agree and disagree, and what does this mean for the collective service? For example, if all actors find efficiency important, what does this imply for service delivery? Box 1 contains a practice example of such a values dialogue. In this way, our set of values could form a shared vocabulary on which actors in integrated, people-centered health services could base their joint efforts.

**Box 1.** Practice example of values dialogue

The health and social care professionals in a Dutch dementia care network engaged in dialogue about their priority values. The majority of them attached most importance to person-centeredness. Their expectation was also that most of them would agree that this is a leading value. However, when the professionals explored the meaning of person-centeredness as a value, different interpretations arose. While some professionals associated person-centeredness with empowerment and self-management, others explained the concept as acting according to the service user's preferences. They also noted that service users and their families could have different views on this. In practice, these differences sometimes complement each other, but they could also complicate collaboration. It was therefore helpful to engage in dialogue about values and their meaning. The values were made concrete by using the set of 18 values as a vocabulary, enabling a deeper discussion of the interpretations of different professionals. In this way, professionals were able to step in the shoes others and understand the background of decisions and behaviors of others.

## Strengths and limitations

Several strengths and limitations of this study should be considered when interpreting its findings. A strength of our study is its large number of respondents (n=1,013). Second, the questionnaire used to assess priority values is based on a systematically developed set of values of integrated, people-centered health services (Zonneveld et al., 2018, 2020). A first study limitation is the varying number of respondents among both actor groups and European sub-regions. Second, the online questionnaire was

administrated in English. Although English is a widely spoken language in Europe, it is not the native language of all respondents, which could have led to differences in interpretation of the questions. Furthermore, the results may not be representative of non-English speakers in the regions.

### Future research

Multiple recommendations for future research can be made. First, although our study revealed relevant insights into priority values, it did not consider how these value orientations are constructed and what factors determine this. It would be valuable to better understand the factors behind the differences we found in this study, which could be achieved by in-depth qualitative research including methods such as focus groups and interviews. Second, as we recommend using our set of values as a vocabulary to engage in dialogue, it would be interesting to empirically study how this exchange might take place. By performing case study research, we could observe how actors exchange values and how this influences integration. These insights may reveal concrete opportunities for improving integrated, people-centered health services by using values as a vocabulary. Third, it would be worthwhile to gain more insight into how a values-driven perspective can drive the implementation of integrated, people-centered health services. We should investigate how a values-driven approach – as a methodology, e.g., alliance building and network development – can inform implementation and improvement in practice. This could be done by conducting empirical case studies.



## 4.5 Conclusion

Although much knowledge about the functional aspects of integrated, people-centered health services is available, the actual implementation of integrated, people-centered health services remains challenging. More insight into the normative dimension of integrated, people-centered health services is needed. The attention paid to values in integrated, people-centered health services has therefore increased. However, there is still a lack of information on how these values are prioritized by different actor groups across different European sub-regions. Our study confirms that the set of 18 values underpinning integrated, people-centered health services is considered important by all the participants in the study.

Additionally, our study documents that there are distinctions in emphasis among the values prioritized by actor groups and across sub-regions. Furthermore, our study reveals two clusters of values: 'people related' values and 'governance and organization'

values. Our study suggests that when integrating healthcare services, for example within co-ordination and collaboration processes, normative considerations, such as priority values, deserve more attention. A dialogue is needed to make the values of the different actors more explicit, to acknowledge the priority values of others, and to use them as a basis for promoting integrated, people-centered health services more effectively. Our set of 18 values underpinning integrated, people-centered health services can be used as a vocabulary for such a dialogue and the conceptual definition of integrated, people-centered health services.

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## Abbreviations

EHMA: European Health Management Association
EPF: European Patients Forum
IBM: International Business Machines
IFIC: International Foundation of Integrated Care
IQR: Inter Quartile Range
NAO: Network Administrative Organisation
NHS: National Health Service
PCA: Principal Components Analysis
RMIC: Rainbow Model of Integrated Care
SD: Standard Deviation SD
SCGS: Catalan Society of Healthcare Management
SEDISA: Sociedad Española de Directivos de la Salud
WHO: World Health Organisation

## Author Contributions

NZ: leading the writing process, research proposal, data collection, data analysis, interpretation.
LG: interpretation, writing.
PK: interpretation, writing.
NTP: writing
AJ: writing
MM: supervisor, research proposal, interpretation, writing.

All authors read and approved the final manuscript



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## Competing interests

The authors declare that they have no competing interests.

## Consent for publication

Not required.

## Ethics approval

The study protocol has been reviewed and approved by the Ethics Review Board of Tilburg School of Social and Behavioural Sciences (Ref. 'EC-2019.EX153').

## Data availability statement

Individual-level survey data generated during and/or analyzed during the study are not publicly available due to ethical and confidentiality reasons (Ref. 'EC-2019.EX153'). Subregional, country and actor group level data are available from the corresponding author on reasonable request.

# Appendix 4.1: Questionnaire

## Introduction

Throughout their lives, people often need different types of healthcare services from multiple professionals such as nurses, social workers and doctors. However, these healthcare services are not always properly aligned. These services therefore have to be coordinated around people's needs. In policy terms, this is called 'integrated health services'. Through this web-based survey we want to learn about what people find important in the delivery of integrated health services.

### Part 1/2: Respondent characteristics

**1. Country:**

| | | | |
|---|---|---|---|
| Austria | Estonia | Italy | Portugal |
| Belgium | Finland | Latvia | Romania |
| Bulgaria | France | Lithuania | Slovakia |
| Croatia | Germany | Luxembourg | Slovenia |
| Cyprus | Greece | Malta | Spain |
| Czech Republic | Hungary | The Netherlands | Sweden |
| Denmark | Ireland | Poland | United Kingdom |
| Other | | | |

**2. Background:**

From which perspective do you fill in this questionnaire? If you have multiple roles, please choose the role that most closely fits your current position.

| |
|---|
| User / Patient representative |
| Informal caregiver representative |
| Health professional / Practitioner (e.g. medical doctor, nurse) |
| Manager / Director in Health Services |
| Policymaker |
| Researcher |

**3. Years of experience regarding health services:**

| |
|---|
| 0-5 years |
| 5-10 years |
| 10-15 years |
| 15-20 years |
| 20 + years |
| Prefer not to answer |

**4. Gender:**

| |
|---|
| Female |
| Male |
| Nonbinary |
| Prefer not to answer |
| [Open] |

**5. Age:**

| |
|---|
| [Open] |
| Prefer not to answer |



**Part 2/2: Value priorities/hierarchies**

In this questionnaire we present you 18 values that could play a role in health services. First, we ask you to indicate how important each of the values is to you, by awarding a score on a 9-point scale (1 = completely unimportant, 9 = highly important). Thereafter, we ask you to select your 3 most important values. At the end, you also have the possibility to add any additional values.

**A. Please indicate how important each of the following values is to you, by awarding a score on a 9-point scale (1 = completely unimportant, 9 = highly important).**

**1.Co-ordinated**

Connection and alignment between users, their families, professionals and organizations in the care chain, in order to reach a common focus matching the needs of the unique person.

| Completely unimportant | | | | Highly important | | | | | Don't know |
|---|---|---|---|---|---|---|---|---|---|
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | |

**2. Trustful**

Enabling mutual trusting between users, their families, communities, professionals and organizations, in and across teams.

| Completely unimportant | | | | Highly important | | | | | Don't know |
|---|---|---|---|---|---|---|---|---|---|
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | |

**3. Shared responsibility and accountability**

The acknowledgment that multiple actors are responsible and accountable for the quality and outcomes of care, based on collective ownership of actions, goals and objectives, between users, their families, professionals and providers.

| Completely unimportant | | | | Highly important | | | | | Don't know |
|---|---|---|---|---|---|---|---|---|---|
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | |

**4. Holistic**

Putting users and their families in the centre of a service that is 'whole person' focused in terms of their physical, social, socio-economical, biomedical, psychological, spiritual and emotional needs.

| Completely unimportant | | | | Highly important | | | | | Don't know |
|---|---|---|---|---|---|---|---|---|---|
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | |

**5. Co-produced**

Engaging users, their families and communities in the design, implementation and improvement of services, through partnerships, in collaboration with professionals and providers.

| Completely unimportant | | | | Highly important | | | | | Don't know |
|---|---|---|---|---|---|---|---|---|---|
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | |

**6. Continuous**

Services that are consistent, coherent and connected, that address user's needs across their life course.

| Completely unimportant | | | | Highly important | | | | | Don't know |
|---|---|---|---|---|---|---|---|---|---|
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | |

**7. Flexible**

Care that is able to change quickly and effectively, to respond to the unique, evolving needs of users and their families, both in professional teams and organizations.

| Completely unimportant | | | | Highly important | | | | | Don't know |
|---|---|---|---|---|---|---|---|---|---|
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | |

**8. Empowering**

Supporting people's ability and responsibility to build on their strengths, make their own decisions and manage their own health, depending on their needs and capacities.

| Completely unimportant | | | | Highly important | | | | | Don't know |
|---|---|---|---|---|---|---|---|---|---|
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | |

**9. Person-centered**

Valuing people through establishing and maintaining personal contact and relationships, to ensure that services and communication are based on the unique situations of users and their families.

| Completely unimportant | | | | Highly important | | | | | Don't know |
|---|---|---|---|---|---|---|---|---|---|
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | |

**10. Respectful**

Treating people with respect and dignity, being aware of their experiences, feelings, perceptions, culture and social circumstances.

| Completely unimportant | | | | Highly important | | | | | Don't know |
|---|---|---|---|---|---|---|---|---|---|
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | |

**11. Led by whole-systems thinking**

Taking interrelatedness and interconnectedness into account, realizing changes in one part of the system can affect other parts.

| Completely unimportant | | | | Highly important | | | | | Don't know |
|---|---|---|---|---|---|---|---|---|---|
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | |

**12. Comprehensive**

Users and their families are provided with a full range of care services and resources designed to meet their evolving needs and preferences.

| Completely unimportant | | | | Highly important | | | | | Don't know |
|---|---|---|---|---|---|---|---|---|---|
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | |

**13. Collaborative**

Establishing and maintaining good (working) relationships between users, their families, professionals and organizations – by working together across sectors, and in networks, teams and communities.

| Completely unimportant | | | | Highly important | | | | | Don't know |
|---|---|---|---|---|---|---|---|---|---|
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | |



**14. Preventative**

There is an emphasis on promoting health and wellbeing and avoiding crises with timely detection and action by and with users, their families and their communities.

| Completely unimportant | | | | Highly important | | | | | Don't know |
|---|---|---|---|---|---|---|---|---|---|
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | |

**15. Efficient**

Using resources as wisely as possible and avoiding duplication.

| Completely unimportant | | | | Highly important | | | | | Don't know |
|---|---|---|---|---|---|---|---|---|---|
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | |

**16. Reciprocal**

Care is based on interdependent relationships between users, their families, professionals and providers, and facilitates cooperative, mutual exchange of knowledge, information and other resources.

| Completely unimportant | | | | Highly important | | | | | Don't know |
|---|---|---|---|---|---|---|---|---|---|
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | |

**17. Transparently shared**

Transparently sharing of information, decisions, consequences and results, between users, their families, professionals, providers, commissioners, funders, policy-makers and the public.

| Completely unimportant | | | | Highly important | | | | | Don't know |
|---|---|---|---|---|---|---|---|---|---|
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | |

**18. Effective**

Ensuring that care is designed in such a way that outcomes serve health outcomes, costs, user experience and professional experience.

| Completely unimportant | | | | Highly important | | | | | Don't know |
|---|---|---|---|---|---|---|---|---|---|
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | |

**B. Please select your 3 most important values:**

[Selection 3 of 18 values]

| | | |
|---|---|---|
| Co-ordinated | Flexible | Collaborative |
| Trustful | Empowering | Preventative |
| Shared responsibility and accountability | Person-centered | Efficient |
| Holistic | Respectful | Reciprocal |
| Co-produced | Led by whole-systems thinking | Transparently shared |
| Continuous | Comprehensive | Effective |

**C. Are there any additional values that you find important, that have not been presented above? If so please add:**

[Open]

# 5.

# The Role of Values in the Interorganizational Network Response to Wicked Problems

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## Abstract

Values are seen as important in both interorganizational networks and wicked problems. However, in both academia and practice the exact implications of these values remain unclear. In this article we examine the role of values in interorganizational networks dealing with wicked problems, by conducting a case study in a pregnancy and childbirth network. Our analysis identified both actor and network values, three value tensions among actors, and a variety of coping strategies to deal with these tensions. The findings indicate that value differentiation in networks should not be only seen as a problem, but also as an important ingredient for the achievement of network goals. Furthermore, our study revealed functional-structural and cognitive-cultural coping strategies to respond to value tensions among actors, applied by both the network administrative organization and the individual actors in the network. Lastly, we elaborate on the position and skill set of the network leader. We leverage these research results to formulate insights and recommendations for network practice.

## 5.1 Introduction

One of the core features of wicked problems is that entrenched value differences are regularly involved in many problem areas (Rittel & Webber, 1973). In this light, Head and Alford (2015, p. 713) point out that *"many difficult policy problems of the modern era"* should be understood as *"grounded in competing value frameworks"*. Bannink and Trommel (2019, p. 198-200) argue that the main characteristic of wicked problems is that *"they show conflict on the normative dimension next to complexity on the factual dimension."* In other words: *"Wicked problems are wicked because the factual and normative aspects of the issues are intertwined at actor-level."* This observation is shared by Vangen and Huxham (2012), who consider that the actors in interorganizational networks responding to wicked problems bring different values to the table, and may be even uncertain about what these actually are. This value differentiation may often occur in these networks, and is particularly relevant in the governance of wicked problems (Bannink & Trommel, 2019).



Value differentiation is seen as a core attribute of both wicked problems and interorganizational networks, suggesting that more insight into values helps us better understand how interorganizational networks address wicked problems. These insights could help organize more appropriate governance arrangements in these networks. Various efforts to order and analyze the complexity of governance in networks have led to a growing body of knowledge. Several well-known articles provide insight into key features and aspects (Ansell & Gash, 2008; Bryson et al., 2015; Emerson et al., 2012), structures, regimes, partner decision, and modes of governance (Klijn & Koppenjan, 2015; Provan & Kenis, 2008; Van der Heijden, 2022) and the effectiveness of interorganizational governance networks (Kenis & Raab, 2020; Provan & Kenis, 2008; Provan & Milward, 2001; Raab et al., 2015). This has resulted in useful models and typologies, which are used in academia and in practice. However, in the existing literature, there is a lack of information about the exact role and implications of values. When values, and especially value differentiation, are mentioned, different views about how to deal with them exist. Some approaches assume that collaborating actors must reconcile their values or work toward shared values for successful collaboration. Klijn and Koppenjan (2015, p. 7), for example, state that governance in networks is about *"reconciling different values as well as the different actors representing those values."* Ansell and Gash (2008) see the identification of common values as an important step toward a shared understanding in multi-party networks. However, other lines of reasoning do not strive toward the integration of values. Emerson et al. (2012, p. 14), state that instead of sharing a specific understanding, "mutual understanding" between actors may be more important: *"the ability to understand and respect others' positions and interests even when one might not agree."*

This article attempts to fill that gap by examining the role of values in interorganizational networks dealing with wicked problems, without assuming *a priori* that shared values are necessary for successful collaboration. We aim to contribute to the existing literature on the network response to wicked problems by introducing an additional perspective focusing on the values and normative considerations of actors in the network. A decentered actor perspective will give us insight into the values, viewpoints, understandings, and perspectives of individual actors in the network. Therefore, it is relevant to investigate possible tensions between these values, and how the actors in the network cope with these tensions (Huxham & Beech, 2003; Van Duijn et al., 2021).

The case study on which this article is built concerns an interorganizational pregnancy and childbirth network that aims to improve quality of care, to tackle the perinatal mortality in the Netherlands, which is very high compared to other European countries (Schölmerich et al., 2014). To improve quality-of-care services, various policies have been implemented to stimulate collaboration between actors and the integration of (Struijs et al., 2020). These policies aim to tackle a common wicked problem in many countries: fragmentation of care, which is a result of several other issues, such as insufficient alignment of care services, the lack of a shared language, inappropriate governance mechanisms, and hindering policies and payment arrangements. Hence, as with any other wicked problem, it could be seen as a symptom of other problems in the system. Furthermore, it can be an enduring, complex societal problem for which there is no definitive formulation (Head & Alford, 2015; S. E. Shaw & Rosen, 2013). Besides the high perinatal mortality, it has many negative implications, such as low patient satisfaction, increasing complexity of the care system, and cost-ineffectiveness. As a response to this, the pregnancy and childbirth network aims to integrate different care services: perinatal, birth, and maternity care.

The objective of this study is to advance the understanding of the role of values in the network response to wicked problems. The main research questions of this study are: 1) What values do the different actors in the network find important? 2) What value tensions arise? 3) How do the actors in the network cope with these value tensions?

## 5.2 Theory

Values play an important role in our everyday behaviors and decisions, but are also abstract and intangible. When looking at the work developed by sociological and

psychological theorists, values can be defined as "conceptions of the desirable" (Kluckhohn, 1951, p. 395) or "standards of preferences" (Rokeach, 2008). As Hitlin and Piliavin (2004) state, values describe a preferred outcome of a particular situation. They can be seen as beliefs that function as moral compasses (Spates, 1983) that form the core of our identity (Hitlin, 2003). Schwartz and Bilsky (1987) made the concept of values more concrete by formulating five core characteristics of values. Values 1) are concepts or beliefs, 2) refer to desirable goals, behaviors, or end states 3) transcend specific situations or objects, 4) are the guiding principles for actions and behaviors, and 5) are ordered by relative importance. In nonprofessionals terms, values are what we see as important and what we want to pursue.



Values theory distinguishes multiple types of values. First, a distinction between individual and supra-individual values can be made. With individual values, the personal values of people are meant (Schwartz, 1992) As mentioned above, a characteristic of values is that they are ordered by relative importance. People may often differ as to things' relative importance; this is called their personal value hierarchy (Schwartz, 2012). People and groups of people often relate their value hierarchies to their own identity and group membership. For example, friends and co-workers often share values. The construction of these value hierarchies is both determined by personal aspects and internalization. Research shows that age, family background, and sex have an influence on the values of people (Kalleberg & Marsden, 2019). Similarly, experiences related to certain events or professional and cultural development also influence the priority values of people (Suar & Khuntia, 2010). Thus, values develop throughout peoples' education, careers, and lives. Values theory also mentions so-called supra-individual values, going beyond individual values of people, such as societal and organizational values (Rokeach, 2008). Societal values refer to values that are deeply rooted in societies. For example, individualism, personal freedom, and self-reliance are considered as important in some societies and cultures, while other societies attach less importance to them (Hofstede, 2011). When looking at organizational values, a shared set of values within an organization is often mentioned, displaying the organization's identity and culture. The importance of aligning individual values of employees with the supra-individual values of an organization is often emphasized in the literature (Sullivan et al., 2001).

Values theory distinguishes terminal and instrumental values. While terminal values are end goals or end states, instrumental values represent modes of behavior by which these goals should be achieved. Terminal values are nouns—for example, safety or sustainability, whereas instrumental values are adjectives—for example, safe or sustainable. Sustainability is an end goal to pursue (terminal), and a process

could be organized in a sustainable way (instrumental) (Rokeach, 2008). In this study we look at terminal and instrumental values, because both may play an important in network collaboration.

## Values in public policy and interorganizational networks

The concepts of "value" and "values" are gaining greater attention in public policy and administration literature. First, a stream of literature addresses *public value*. These articles focus on public management and how this may contribute to society (Crosby et al., 2017; Moore, 1997; O'Flynn, 2007). Second, several studies focus on *public values*, looking at what citizens find important and to what extent there is public consensus about these values (Bozeman, 2007, 2019). Third, many articles about public policy pay attention to conflicting values underpinning policies, value trade-offs, and how to make policy decisions (Meijer & De Jong, 2020; Oldenhof et al., 2014). In this study, we take a decentered actor perspective by focusing on the values of individual actors in a specific context: an interorganizational network.

The interorganizational network context is specific, because different organizations collaborate and often aim to integrate services. We should therefore look more deeply into the role of values in both differentiation and integration in interorganizational networks (Kenis & Raab, 2020). By "differentiation," we mean the differences between the actors in the network. We define integration as the inclusion of actors within an organizational network to produce a collective output. Raab (1998) distinguishes two categories of differentiation: 1) functional differentiation, defined as the different functions of actors—in other words, the division of labor; and 2) structural differentiation, defined as the different structural positions of actors. In addition to these dimensions, this paper focuses on value differentiation, which can be defined as the different values or value hierarchies of actors (Schwartz, 2012). When looking from a differentiation point of view, interorganizational care networks often consist of a variety of people and organizations with different functions, roles, values, cultures, professional backgrounds, and perceptions (Bardach, 2001; Klijn & Koppenjan, 2015). Examples of participating actors are doctors, care providers, hospitals, governments, and insurers. In a recent study, Zonneveld et al. (2022) demonstrated the extent of value differentiation between actors in care integration.

The literature presents many mechanisms that could enhance integration. Roughly two groups of integrative mechanisms can be distinguished: 1) functional or structural mechanisms of integration, and 2) cognitive–cultural or normative mechanisms of integration (Raab, 1998; Valentijn, 2015). Functional and structural mechanisms of integration refer to connecting actors through structural coordination patterns,

such as communication, payments payment (Stokes et al., 2018; Tsiachristas, 2016), information provision (Kenis & Raab, 2020) information exchange technology (Cameron et al., 2014), organizational ingredients (Minkman, 2012) and governance models (Ansell & Gash, 2008; Emerson et al., 2012). Besides these functional mechanisms, there is a growing attention for cognitive–cultural integration mechanisms based on a common orientation toward values, cultures, goals, and purpose (Valentijn, 2015). These cognitive–cultural integration mechanisms are particularly important in interorganizational care networks, since a formal hierarchy is often absent and top-down steering is often not suitable in these networks (S. B. Axelsson & Axelsson, 2009; Raab, 1998).

## Values associated to care networks



In this study, we examine an interorganizational network that aims to integrate different care services. It is therefore useful to know which particular values are seen as relevant in pursuing care integration in networks. A systematic review followed by an international Delphi consensus study (Zonneveld et al., 2018, 2020) resulted in a list of 18 frequently occurring instrumental values in care networks (see Table 5.1), which has only been used so far in a quantitative cross-sectional study (Zonneveld et al., 2022).

**Table 5.1** Frequently occurring instrumental values in care networks (Zonneveld et al., 2022).

| | |
|---|---|
| **Collaborative** | *Establishing and maintaining good (working) relationships between users, informal caregivers, professionals, and organizations—by working together across sectors, and in networks, teams, and communities.* |
| **Comprehensive** | *Users and informal caregivers are provided with a full range of care services and resources designed to meet their evolving needs and preferences.* |
| **Continuous** | *Services that are consistent, coherent, and connected, and that address users' needs across their life course.* |
| **Co-ordinated** | *Connection and alignment between users, informal caregivers, professionals, and organizations in the care chain, to reach a common focus matching the unique needs of the individual.* |
| **Co-produced** | *Engaging users, informal caregivers, and communities in the design, implementation, and improvement of services through partnerships, in collaboration with professionals and providers.* |
| **Effective** | *Ensuring that care is designed in such a way that outcomes serve health outcomes, costs, the user experience, and professionals' experience.* |
| **Efficient** | *Using resources as wisely as possible while avoiding duplication.* |
| **Empowering** | *Supporting people's ability and responsibility to build on their strengths, make their own decisions, and manage their own health, depending on their needs and capacities.* |
| **Flexible** | *Care that can change quickly and effectively, to respond to the unique, evolving needs of users and informal caregivers, in both professional teams and organizations.* |

**Table 5.1** Continued

| | |
|---|---|
| **Holistic** | *Putting users and informal caregivers at the center of a service that is "whole-person"-focused in terms of their physical, social, socioeconomical, biomedical, psychological, spiritual, and emotional needs.* |
| **Led by whole-systems thinking** | *Taking interrelatedness and interconnectedness into account, realizing changes in one part of the system can affect other parts.* |
| **Person-centered** | *Valuing people through establishing and maintaining personal contact and relationships, to ensure that services and communication are based on the unique situations of users and informal caregivers.* |
| **Preventive** | *Emphasizing the promotion of health and well-being and avoiding crises with timely detection and action, by and with users, informal caregivers, and communities.* |
| **Reciprocal** | *Care is based on interdependent relationships between users, informal caregivers, professionals, and providers, and it facilitates a cooperative, mutual exchange of knowledge, information and other resources.* |
| **Respectful** | *Treating people with respect and dignity, being aware of their experiences, feelings, perceptions, culture, and social circumstances.* |
| **Shared responsibility and accountability** | *The acknowledgment that multiple actors are responsible and accountable for the quality and outcomes of care, based on collective ownership of actions, goals and objectives, between users, informal caregivers, professionals, and providers.* |
| **Transparently shared** | *Transparently sharing of information, decisions, consequences, and results, between users, informal caregivers, professionals, providers, commissioners, funders, policymakers, and the public.* |
| **Trustful** | *Enabling mutual trust between users, informal caregivers, communities, professionals and organizations, in and across teams.* |

## Application of theory in this study

The concept of values is abstract and intangible, and the definition of values relates to several other concepts such as beliefs, goals, views, and principles. Because these concepts are often intertwined in practice, it is difficult to precisely isolate or separate the concept of values from the other concepts in this study. This is important to consider when interpreting the results of our case study.

Another point to consider is the possible intertwinement of different types of values. In this study, we examine what values network actors find most important 1) as themselves as individual actors in the network, and 2) for the care network as a whole. We must be aware that people develop values throughout their lives, influenced by experiences such as childhood, education, or the organization they work for. Hence, actor values could be a combination of their personal, organizational and network values. It is therefore important to consider that it is difficult to precisely isolate these different types of values from each other.

## 5.3 Methods

### Case study and data collection

This article draws on a case study of an interorganizational pregnancy and childbirth network in the Netherlands. Historically, the Netherlands has a higher perinatal mortality than other European countries (Schölmerich et al., 2014). To improve the quality of care, the actors work together in a network pursuing the integration of perinatal, birth, and maternity care services, both in primary care and in the hospital (Struijs et al., 2020). Hence, the case in this study could be seen as a care services network.

The care network consists of 13 organizations, including a hospital, primary obstetrician practices, maternity care agencies, and ultrasound practices. Several professionals from these different organizations work together in practice. Examples of these professions are medical doctors, nurses, obstetricians, gynecologists, maternity nurses, and sonographers. The collective mission of the collaborating organizations is "putting the (future) pregnant woman, her partner, and the (unborn) child in the center of all services." The network has also formulated three overarching core values: broad scope on physical, medical, psychical, and social aspects of life (holism); prevention; and empowerment. Recently, the governance form of the network has evolved from shared governance (participant-governed network) to a network–administrative organization network (NAO) (Provan & Kenis, 2008).

To examine values and its implications we took a so-called decentered actor perspective (Parker et al., 2021, p. 20; Van Duijn et al., 2021), which means we took the individual professionals in the network as point of departure. We conducted 15 in-depth semi structured interviews with the actors (also see Table 5.2). Participants were invited to participate based on their key role and position in the network. To ensure representativity, at least 2 respondents from each professional group were included. Additionally, both two key figures of the NAO were interviewed. The duration of the interviews was between the 26 and 55 minutes (mean=42 minutes, median=43 minutes). The topic list of the interviews consisted of questions about their role in the network, their most and least important values for both themselves as actors and the network as a whole, the values of other actors and collaboration with the other actors. The interview guides for network actors and leaders are provided in Appendices 5.1 and 5.2.

**Table 5.2Respondents**

| | |
|---|---|
| Respondent 1 | Primary care obstetrician, practice A |
| Respondent 2 | Primary care obstetrician, practice B |
| Respondent 3 | Clinical obstetrician, hospital |
| Respondent 4 | Clinical obstetrician, hospital |
| Respondent 5 | Clinical obstetrician, hospital |
| Respondent 6 | Network leader NAO |
| Respondent 7 | Sonographer, organization C |
| Respondent 8 | Sonographer, organization D |
| Respondent 9 | Maternity nurse, organization E |
| Respondent 10 | Maternity nurse, organization F |
| Respondent 11 | Project manager NAO |
| Respondent 12 | Clinical obstetrician, hospital |
| Respondent 13 | Staff NAO |
| Respondent 14 | Primary care obstetrician, practice G |
| Respondent 15 | Primary care obstetrician, practice H |

### Analysis

For the analysis of the data, we followed an abductive approach. All interviews were coded through thematic analysis using MaxQDA software. To ensure quality we have used the systematic data analysis method of Corley and Gioia (2004). As a start, we identified first-order codes (concepts), which reflect the voice of the respondent (Corley & Gioia, 2004). After that, second order codes (themes) were assigned, reflecting the understanding of the researcher. For the second order coding, we used our set of 18 values as a basis (Zonneveld et al., 2020). As a last step, we grouped similar codes into overarching dimensions. The analysis was conducted by one researcher, supervised by three other researchers. Any disagreements were resolved through discussion.

## 5.4 Findings

The analysis of 15 interviews resulted in 357 coded text fragments, of which 301 related to values, tensions and coping strategies, and 56 to contextual information. In this section we present our findings. The coding structure is shown in Figure 5.1.

## Values

Our analysis revealed 1) values that actors find important as individual professionals, and 2) values that are seen as collective network values by the respondents.

### *Actor values*

When looking at what values respondents find important as an individual professional, several values emerged from the data. First, **person-centered** was frequently mentioned as important by a broad variety of respondents. Many actors underlined the importance of personal contact and relationships with the client, and delivering care tailored to the specific situation of the client. As two respondents stated:

> "For each patient, we have to look what care is needed, and what place is the best for the patient." (**R5**, clinical obstetrician in the hospital)

> "I think you should be able to estimate what someone needs and what is going well at that moment. That is the same when I work at someone's home and I know in advance that there are, for example, mental issues or a challenging history. You must take that into account; you have to be able to engage with that when you talk to people." (**R10**, maternity nurse)



Second, many respondents indicated that they find **collaborative** values important. Different actors stated that they believe that collaboration leads to best possible outcomes for clients. As one respondent declared:

> "So, from that perspective, we make sure that we collaborate well and that we arrange that together in the best way possible for the customer with their baby." (**R9**, maternity nurse)

Furthermore, **trustful** was broadly seen as an important value.

> "Referrals have to be done well, you have to trust each other, so yes, that is very important." (**R9**, maternity nurse)

Especially clinical obstetricians, working in the hospital, found the value **effective** to be important.

> "It just must be effective. Chop, chop, chop; that lady has to come for a check-up… I think very much, in that regard, black and white. The care question is: [respondent name], come and help me, because I think this child is in need. Then there is really only one solution: that child must be born." (**R5**, clinical obstetrician in the hospital)

> "I don't like that ECG [heart monitoring], I really want that baby to be born soon." (**R4**, clinical obstetrician in the hospital)

The value **transparently shared** is considered as important particularly by maternity nurses.

> "But it is precisely the transparency between such a maternity nurse and such an obstetrician and then finding a good solution together for both parties, that is the most important." (**R9**, maternity nurse)

A respondent indicates that transparency in the network is also an issue that should be considered as a point of improvement:

> "Then of course you also sign that we may exchange data with each other for better care. But we still don't know [referring to a lack of information]. And then they're like, hello, I've discussed all this. Why should I discuss that with you again?… I don't think this works well between us and the obstetricians." (**R10**, maternity nurse)

Furthermore, **preventive** is seen as an important value.

> "During pregnancy you also work partly preventive, either to be ahead of things, to inform women." (**R5**, clinical obstetrician in the hospital)

Other respondents also mentioned **respectful** as an important value. As illustrated by one respondent:

> "I think, above all, whether you like them or not where you're working at the time, that's beside the point. You just must always respect each other and be able to discuss and solve that together, so to speak, if there is something. Well, you don't hear often, but I think you're in people's houses, so you must adapt." (**R10**, maternity nurse)

Finally, **holistic** was frequently mentioned as an important value. Especially maternity nurses attached importance to this value.

> "When you work at people's homes because they have just had a baby, you see the whole picture. You see how the feedings are going, how the nights are going. How's mother? How's the baby? All that sort of things. An obstetrician who comes by and is there for ten minutes. She does the checks: is the temperature going well? Those kinds of things. And then that's it. We see the rest. (**R10**, maternity nurse)

***Network values***

When asked for the most important collective values in the network, respondents mentioned five overarching themes. First, respondents mentioned **person-centered** as a leading collective value. This is illustrated as follows by a respondent:



> "The pregnant woman and her unborn child or now-born child are in the center. Her wishes and needs are in the center." (**R11**, project manager NAO)

Second, the professionals in the network stated that **a pleasant experience** of the client is a leading network value. As a maternity nurse stated:

> "We simply want to create the most pleasant experience for them." (**R10**, maternity nurse)

A respondent emphasized that, although the interpretation may differ among the collaborating actors, a pleasant experience is the shared objective of the collective network:

> "Of course we all want a client to have a pleasant experience, that she feels heard and that we do what is necessary. Whether this should be done through way A or way B; in the end it comes down to the same. Not everyone will interpret it the same, but I do think that the outcome will be the same—or at least we try it to be the same." (**R2**, primary care obstetrician)

Third, respondents mention the most **suitable** care as an overarching value in the network. As a respondent mentioned:

> "Sure, I think we all have the goal in mind: to be able to provide the best suitable care for the client." (**R2**, primary care obstetrician)

When asked for network value, respondents also mentioned two network objectives, referring to desirable end goals. First, respondents referred broadly to a **best possible start** for both mother and child. As a respondent said:

> "Our [the network's] common goal is caring for mother and child, and the best possible start to a new life." (**R12**, hospital)

Lastly, **healthy mothers and babies** is seen as important collective value of the network.

> "We all have the same end goal, don't we? Healthy mother, healthy child." (**R5**, clinical obstetrician in the hospital)

## Value tensions

Our analysis identified three types of value tension. First, we describe value tensions between functionally heterogeneous actors in the network: between hospital and primary care obstetricians regarding joint births, and between maternity care and primary care obstetricians. After that, we describe a tension between functionally homogeneous actors in the network: the value tensions among different primary care obstetrician practices.

## Value tensions between functionally heterogeneous actors

### *Hospital versus primary care: joint births*

A value tension has emerged from the data between the clinical obstetricians working in the hospital on the one hand, and the obstetricians working in primary care on the other hand. In the interviews, clinical obstetricians have a more medically oriented value orientation, focusing on avoiding and excluding medical risks for mother and baby. In technical jargon, this is called "pathology." Obstetricians working in primary care take a different starting point: having confidence in the human body and a successful natural birth, without medical intervention. This is called focusing on "physiology" in technical jargon. As a primary care obstetrician put it:

> "What I stand for the most is for monitoring physiology. We are healthy when we are pregnant. Of course, there will be particularities—we will have to look at that, and we will work on that at that time—but

> the basis is still that we are built for this and that we can do this." (**R1**, primary care obstetrician)

This difference in value orientation may have grown because of different experiences during the careers of both clinical and primary obstetricians. A clinical obstetrician stated:

> "I think as a primary care obstetrician, you work from physiology. So, you always assume that everything will go well, unless… As a clinical obstetrician you usually treat people, pregnant women, or women in maternity with a medical indication. So, there is something pathologic going on: it can be a very mild pathology or it can be a very severe pathology. Because you're so used to that pathology, I think you're also more likely to see pathology in physiological deliveries. And vice versa." (**R5**, clinical obstetrician in the hospital)



These tensions are especially reflected when clinical and primary obstetricians work together during a so-called "joint birth." Although these value differences sometimes may complicate the collaboration, both clinical and primary obstetricians also emphasize the added value of a joint birth. Both professionals have different knowledge, expertise, and a different relationship with the client. The primary care obstetricians, for example, have already developed a deeper relationship with the client A clinical obstetrician stated:

> "I think two always know more than one. Those patients have known that primary care obstetrician for much longer. She [the primary care obstetrician] has already guided a lot of that birth, and then you join her as a new person….And they sometimes have a different relationship with those people, so that together you can get the best out of such a patient and her partner….We rate the heart film of course, that's something we do every day and what they see every now and then. And I think they [the primary care obstetricians] guard the physiology a little more now." (**R4**, clinical obstetrician in the hospital)

A primary care obstetrician says:

> "Studies have simply shown that if a woman is continuously guided, it brings benefits for childbirth, so in that sense it is of course not pleasant if a pregnant woman sees four faces during childbirth. You

> prefer to have just one or at most two if there is no other option, so that is the advantage of being allowed to do a joint birth [with the clinical obstetrician] and that you could finish something under the supervision of a clinical obstetrician." (**R2**, primary care obstetrician)

***Maternity care versus primary care obstetricians: an extra pair of eyes***

Besides value tensions between obstetricians in primary care and the hospital, the data also revealed a tension between maternity care nurses and primary care obstetricians. Maternity care nurses come into the picture shortly before the birth of a baby. After the child is born, they deliver a maximum of 80 hours of care in 10 days. Maternity care nurses have a broad value orientation, taking care at the whole household and social network: father, mother, possible other children, family and other relatives, or friends. Primary care obstetricians only have shorter contact moments with the client and focus on the health of newborns. These differences may sometimes lead to tensions at a home of a client. As a maternity nurse stated:

> "Because you don't see each other's entire picture, it can sometimes differ how you think about it. Those are things that you sometimes think: yes, easy to talk to if you come by for ten minutes, but we are sitting here with a very tired crying mother who is broken, so to speak… For example, some [mothers] are just overtired. Then the obstetrician can say, for example: 'just go to sleep and skip a feeding.' While I am just trying to get it all going… Sometimes that is difficult; if you've made a plan and it just gets messed up." (**R10**, maternity nurse)

Similarly, the respondents acknowledge that these differences may also complement each other. Because of their broad view, maternity nurses form an extra pair of eyes for the primary care obstetricians. As a primary care obstetrician states:

> "We do not necessarily come to people's homes, and sometimes maternity care still has information for us even during the pregnancy that we did not know ourselves yet. For example, sometimes maternity care goes on a home visit somewhere and afterwards calls us with, "there are actually very few things there, are you aware of the financial situation?" In fact, they are the first to come into someone's home situation, and you can get a lot of information from a home situation about the financial resources or hygiene, etc. That's always very important information for us. And certainly, also during the maternity week they are there all day, of course we visit a few times during the

> maternity week, but we are there for about half an hour, then we see so much less than the maternity care sees during the day, so no, I wouldn't know." (**R2**, primary care obstetrician)

This was also indicated by a maternity nurse during the interviews:

> "Well, I think maternity care brings a unique piece, which is that we work behind those people's front doors for eight days. And there we are with maternity nurses who really use those eyes and ears to see: what do I see and what is happening here? What worries me and what do I share with an obstetrician?" (**R9**, maternity nurse)

## Value tensions between functionally homogeneous actors



***Different values among primary care obstetrician practices***

The last value tension that emerged from the data, is a tension among the different primary care obstetrician practices in the network. Although these practices do the same work in a functional way, they may have different values and visions. These differences may for example relate to the extent of a physiological view. As the network leader stated:

> "I see a lot of differentiation between practices… For example, [practice X], which really works from a certain physiological view, is very close to the people and takes a lot of time for that. While [practice Y] is really different." (**R6**, network leader)

As a reason for these differences, the competition between primary care obstetrician practices is mentioned. In contrast to the hospital, for example, primary care obstetrician practices are small businesses owned by independent entrepreneurs. According to a primary care obstetrician, they must differentiate themselves to survive:

> "You must distinguish yourself as an obstetric practice, so we have a certain vision. I think every obstetric practice has a certain vision of what they think is important, what should work well for a client, but also should work well for her or his team… Yes, people ask for evening consultations. If one does and the other doesn't, then you may have lost that client." (**R1**, primary care obstetrician)

These differences among primary care obstetrician practices may lead to tensions. Collaboration partners, such as the clinical obstetricians in the hospital, must cope with the different values of primary care obstetricians. Some primary care practices have value orientations that are relatively more aligned with the hospital than others. As a clinical obstetrician put it:

> "Of course there is always a difference in practices, also in their vision, for sure… One moves much more along with the patients, even if they want to receive care outside the guidelines. Some practices are very easy [with moving along], because they believe that all this should be possible, and it is very physiologically oriented. Other practices follow the guidelines a bit more and look more for a compromise with a patient, for example… In every network there are [primary care] obstetrician practices of which I think: what the heck are you doing?" (**R4**, clinical obstetrician in the hospital)

Similarly, this differentiation between primary care obstetrician practices is also seen as an asset. Because of their different visions and identity, clients in the region can choose the practice that suits them best. There is a broad and balanced range of primary care obstetrician practices to choose from. As a project manager of the network stated:

> "Well, the primary care practices are not aligned, let me put it this way. And that's also a bit of balancing, because that's not a bad thing, because we don't want to make it one-size-fits-all. It's good that all those practices have their own identity and really differ from each other and that they run their own business operations, but the moment that gets in each other's way because, well, there are different ideas, that makes it a bit difficult." (**R11**, project manager NAO)

## Coping strategies

The analysis identified strategies to cope with value tensions applied by both professionals and the NAO. First, we will elaborate on the strategies applied by professionals. Thereafter, we will present the coping strategies used by the NAO.

### *Coping strategies by professionals*

In their daily work in the network, the professionals apply several coping strategies to deal with value tensions in practice. First, professionals have **interprofessional discussions** with each other to talk through possible differences and tensions. These

discussions take place between, for example, clinical obstetricians and primary care obstetricians during a joint birth, as one respondent indicated:

> "During that delivery [joint birth] we had so many discussions: Should we try that for a while? Shall we press on a different attitude for a moment? And then finally that child was born without artificial redemption. And yes, that was really just a nice collaboration." (**R5**, clinical obstetrician in the hospital)

Another example of such interprofessional discussions are exchanges between maternity nurses and primary care obstetricians, as illustrated by this respondent:

> "We have learned not to let it escalate, but to call each other [the maternity nurses and primary care obstetricians] at an early stage, to inform and discuss: What is going well here, what is going wrong here? What can we do to prevent it from happening again?" (**R9**, maternity nurse)



Besides interprofessional discussions, professionals also apply **guidelines and agreements about responsibilities** to cope with possible value tensions. These are guidelines agreed upon in network, providing functional clarity. When any value tensions occur, professionals can fall back on clear agreements and hierarchies, as illustrated by one respondent:

> "There is always a captain on the ship. We do have several situations, a bit of a gray area, in which case the primary care obstetrician can finish the delivery, but I have the final responsibility." (**R3**, clinical obstetrician in the hospital)

Third, after a collaboration such as a joint birth, professionals in the network **debrief one another and evaluate**. This objective of this moment of reflection is to learn about the collaboration and discuss possible tensions that may have occurred. As one respondent mentioned:

> "What has also been agreed is debriefing after the birth: What went well and what went wrong? And what can we learn from this? That's how you try to contribute to quality across the network" (**R12**, hospital)

Another respondent also stated that this debriefing and evaluation also contributes to mutual understanding between professionals with different backgrounds:

> "It is important to briefly discuss, actually debrief, after such a birth: What did I think about it? Because there is not always room to discuss everything next to a patient… It's really good to discuss that. Then you just understand a little more what the thinking of the other party was, so to speak." (**R5**, clinical obstetrician in the hospital)

Lastly, professionals indicated that they actively **build personal relationships** to get to know their collaborating partners and their values better. As a maternity nurse stated:

> "And especially now in [network name], it is clear, you know each other. And we sometimes have meetings [to coordinate], because you know the faces. We've just had a great symposium, including social services, so we're also working on getting to know each other better." (**R9**, maternity nurse)

It was also stated that a lack of personal relationships may complicate the collaboration:

> "We work with many practices. And there are a lot of regulars in those practices. But there are also a lot of changing observers… And that's a tricky one, isn't it? For example, if I hand over a joint birth and it's a familiar face to me, I'd rather say: "Please keep me posted. If I can do something…" And if it is an unknown observer to me of whom I do not know how she works, I find it more difficult to just bear the responsibility and not be present in that room." (**R5**, clinical obstetrician in the hospital)

***Coping strategies by NAO***

Besides the professionals applying coping strategies, the NAO also develops activities to stimulate smooth collaboration between professionals. First, the NAO compiled a board with representatives of each of the disciplines in the work. This **representative board** develops an annual plan in which the collective activities of the network partners are described. The network leader stated that the representativity of the board is an important issue:

> "I made sure I had, well, enough flavors on the board… I think we now have a really nice representation of primary care partners." (**R6**, network leader)

The role of the board members is to ensure support of the different participating organizations. This must result in a broadly supported annual plan with intended activities, the network leader said:

> "Once we receive what the board members have collected from their organizations and what they consider important for the coming year, we process that into an annual plan." (**R6**, network leader)

The board also monitors the achievement of these activities and compliance with the agreements that have been made.



Second, the actors agreed on a **collective mission and vision** of the network.

> "Well [our individual visions] became a collective vision, which we also put on paper with each other. We really discussed with the primary care obstetricians, the clinical obstetricians, etc., 'What is our collective vision concerning birth care?'" (**R12**, hospital)

This mission and vision are communicated in the annual plan by the NAO board members.

> "We always make an annual plan with the NAO, with a mission and a vision. That is what the members of the NAO board do. They are really very committed to that." (**R5**, clinical obstetrician in the hospital)

The collective mission and vision are underpinned by certain overarching values, related to the needs of the service user, as stated by this respondent:

> "It is in all our heads: it [the care service] must contribute to the [care of the] pregnant women. That is so ingrained in all of us… It's a common thread throughout the organization [NAO]" (**R12**, hospital)

Third, within the NAO there are several **working groups that develop network policy and guidelines**. These working groups consist of representative professionals from the different partner organizations. Each of these working groups addresses a

specific policy issue in the network, develops a policy proposal and reports back to the board. A respondent illustrated this organizational structure:

> "There's the board and later there are working groups such as Care, Quality, and Innovation. Then you have an umbrella working group in which I work. So, the issues that come from the board go to that overarching working group to see who will take care of it… In each group there are one or two representatives per primary care obstetricians, clinical obstetricians in the hospital, gynecologists. Let's say all those working groups are staffed by all disciplines." (**R5**, clinical obstetrician in hospital)

Finally, the **network leader** of the NAO pays attention to the different values in the network. The network leader aims to enhance the mutual understanding between the different organizations in the network. As the network leader stated:

> "It is mainly about being in connection, in listening, in taking it along, in picking it up again and showing each other's perspectives… I think that's my role. Show each other the vision and perspective of the other in the conversations… So yes, a chameleon." (**R6**, network leader)

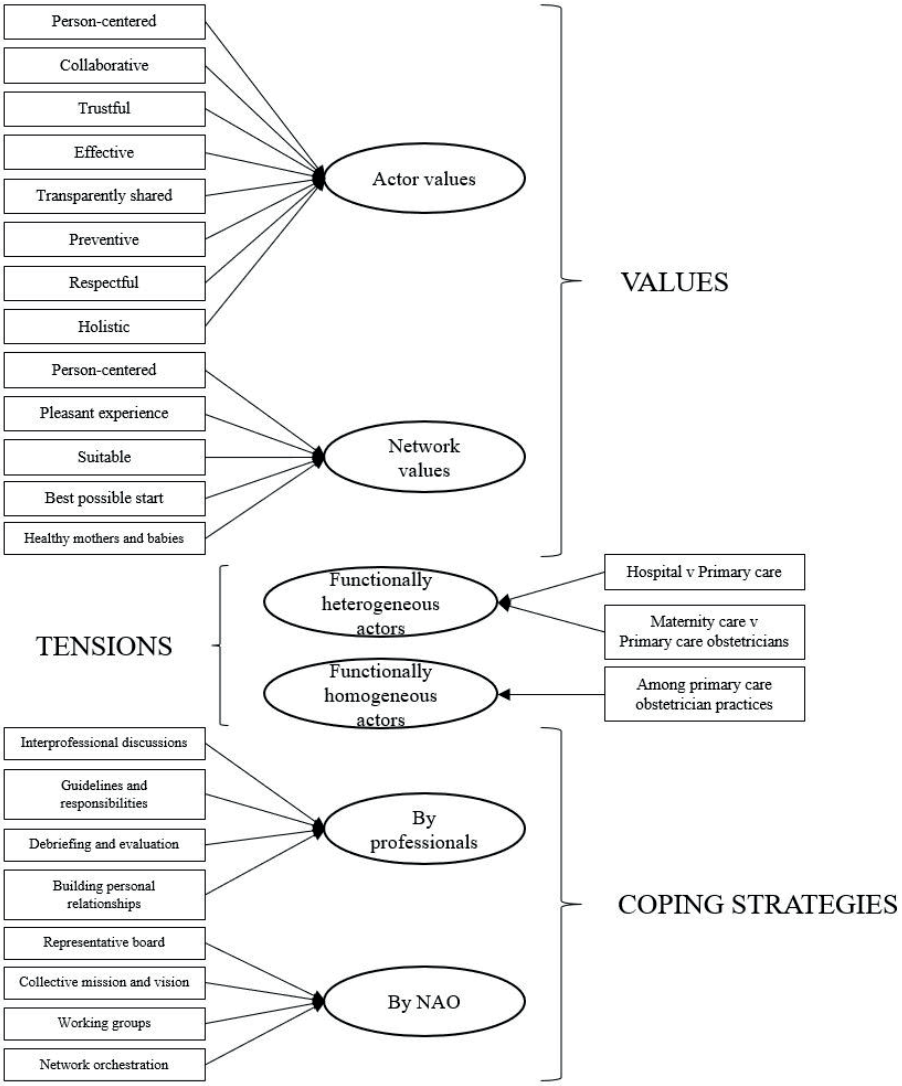
Besides showing the perspectives of other actors, the network leader also empowers the organizations to take the initiatives, as is illustrated in this example:

> "I think you are much stronger if you make sure that others always 'walk with the flowers' [take the credit]. So that people say, after you have whispered ten times, 'Maybe this is a good idea,' say: I have such a good idea." (**R6**, network leader)

The central position of the network leader between the different actors is also recognized by other professionals in the network, as is stated by a professional:

> "She [the network leader] is really just the spider in the web; the one with the helicopter view who does not deliver care, but who knows what is going on everywhere. And of course, she has a lot of experience from the other [networks]." (**R5**, clinical obstetrician in hospital)

**Figure 5.1** Coding structure




## 5.5 Discussion and conclusion

In this study, we examined the role of values in the response of an interorganizational care service network to wicked problems. We have identified both instrumental values, referring to modes of behavior, and terminal values, referring to end goals to pursue. We found that particular values such as "person-centered," "collaborative,"

and "trustful" were often seen as important by multiple individual actors in the network. There was less consensus among the individual actors about other values, for example "effective," "transparently shared," and "preventive." No clear hierarchy among these values was found. Subsequently, the respondents mentioned overarching values when asked for the most important collective values for the network as a whole. Only some of these supra-individual network values clearly overlap with frequently mentioned individual values of the respondents, such as "person-centered." Other network values refer to health outcomes or patient satisfaction. Examples are "healthy mothers and babies" and "a pleasant experience." These findings demonstrate that, in this case, although actors agree on certain overarching network values, value differentiation does indeed exist and persist.

Our analysis revealed three value tensions among actors in the network. These tensions may complicate the collaboration between the actors in the network. However, each of these tensions also leads to value-creation for the service user, contributing to the overarching goals of the network. First, the value differentiation among obstetrician practices may lead to different ways of working among these practices, making collaboration complex for the other partners. However, this differentiation also leads to a varied range of obstetric practices in the region, with different identities and values. Service users have a broader range of practices from which to choose, which may contribute to more suitable care. Second, although close collaboration between clinical and primary care obstetricians during joint births may lead to value tensions, the values of both professionals are also complementary. While a clinical obstetrician has a pathology-related focus, primary care obstetricians base their work on physiology values and clients' relationships. Hence, this combination of values may result in greater person-centeredness, which is an overarching network goal. Finally, our study revealed value tensions among maternity care professionals and primary care obstetricians. Again, the values of both professionals are complementary, focusing on different aspects of the family that they are supporting at home. While obstetricians focus on the health of mother and baby, maternity care professionals see the bigger picture of the whole household and social network. The three value tensions identified exist between separate (groups of) actors. This demonstrates value differentiation among actors on a network level (actor–actor). Our findings do not explicitly show value tensions between actors and the network as a whole (actor–network). However, this does not mean that value tensions between individual actors and an alliance of actors or the NAO could not arise on particular topics.

The study findings show that, in this case, value differentiation among actors is needed to pursue overarching network goals. Although value differentiation may lead to tensions in practice, it creates significant value for service users. The representative board of the NAO formulated a shared mission underpinned by a broad frame of overarching values on which each of the partners could agree, leaving enough space for value differentiation among the actors. This suggest that value differentiation in service networks should not only be seen as a problem that must be solved, but also as an important ingredient to achieve network goals. In the network governance literature, the importance of shared or common values among actors is often stressed. Our study adds to this by demonstrating that, besides agreeing on overarching network values, value differentiation among individual actors is needed to add value for service users. Our findings suggest that we do not have to reconcile different values in networks dealing with wicked problems (Klijn & Koppenjan, 2015, p. 7), but rather let them coexist. Nevertheless, it is crucial to understand and be aware of each other's values, which is also advocated by Emerson and colleagues (2012, p. 14).



Understanding that value differentiation could also be seen as an important element, it is relevant to know how to cope with value tensions in practice. Our study uncovered coping strategies to deal with value tensions between actors, applied by both the professionals themselves and the NAO network. These strategies could be distinguished in two categories 1) functional–structural strategies, referring to structural coordination patterns, and 2) cognitive–cultural strategies, referring to a common orientation toward values, culture, and goals.

In the center of Figure 5.2, in the middle of the four categories, we have positioned "network orchestration," referring to the role of the network leader. Orchestrational work in networks can be defined as creating value by bringing previously separate activities together through coordination and structuring (Bartelings et al., 2017; Paquin & Howard-Grenville, 2013). In this case, the network leader plays an important role by connecting different activities and actors in the network. The network leaders bridge the gap between the NAO network and the professionals, by for example composing a representative board. The network leader uses both functional–structural and cognitive–cultural strategies to integrate actors and activities. In this light, network orchestration could be seen as both a functional-structural and a cognitive–cultural undertaking. The network leader could be seen as both a function in the NAO network and an individual with cognitive–cultural competencies. These study findings align with the work of O'Leary et al. (2012), who argue that leaders in collaborative networks need interpersonal and group process skills. As O'Leary et al.

(2012, p. 81) state: *"People, process, and communication skills are not enough. In addition, successful collaboration requires an individual with an intricate set of relational attributes."* This balance between functional–structural and cognitive–cultural skills on the one hand, and the individual actors and the network as a whole on the other hand, makes network orchestration a complex task, comparable to "walking a tightrope." (O'Leary et al., 2012).

**Figure 5.2** Coping strategies

| **Coping strategies** | **Functional-Structural** | **Cognitive-Cultural** |
|---|---|---|
| **By the professionals** | - Guidelines and responsibilities<br>- Debriefing and evaluation | - Interprofessional discussions<br>- Building personal relationships |
| **By the Network Administrative Organization (NAO)** | - Board with representatives<br>- Working groups developing policy | - Collective mission and vision |

Network orchestration

## Strengths and limitations

This study illustrates how values play a role in the response of a care network to a wicked problem, why value differentiation is an important attribute in networks instead of only a difficulty, and how the actors cope with value tensions. A strength of this study is its in-depth qualitative research design, which provided rich and detailed information. Second, the analysis has been built on a systematic qualitative method (Corley & Gioia, 2004) and a systematically developed set of values (Zonneveld et al., 2020). These qualitative results add to previous quantitative work on values (Zonneveld et al., 2022). Although the study took place in a specific context, its findings contribute to our understanding of the role of values in networks responding to wicked problems. Acknowledging the limitations of generalizability, its insights in value differentiation in service networks could be relevant to other settings and policy fields.

## Practice implications

This study has several implications for practice. First, it implies that value differentiation within a collaborative network should not be seen as a problem only, but also as a vital component of working together in networks—at least, when the appropriate coping strategies are applied. Public professionals need to be aware of

this and learn to resist the urge to reduce value differentiation. Methods such as serious gaming, for example, offer the opportunity to experience both the challenges and importance of value differentiation: how can we work together despite our different values? Second, it demonstrates that orchestrational work in networks is all about the balance between making room for value differentiation among actors on the one hand, and connecting actors by applying integration strategies on the other hand. Our study identifies both functional–structural and cognitive–cultural strategies. Finally, the role of values on individual, organizational, and network-level deserve more attention in education and training of public professionals acting in interorganizational networks.

### Future research

Multiple recommendations for future research can be made. First, it would be relevant to conduct multiple case studies in care service networks with different objectives, target groups disciplines, other policy contexts, or other value compositions. This may provide information about the influence of these contextual characteristics. For example, what value tensions arise when a network provides services for different target groups? Do less complex target groups need a lower level of value differentiation among professional actors to achieve network goals? Qualitative Comparative Analysis (QCA) could be a promising methodology for the analysis of these multiple cases and may help explain why some cases are successful and others are not. Second, it would be interesting to specifically investigate governance modes in relation to value differentiation. The care network investigated in this case study, transformed from a participant-governed network to an NAO network (Provan & Kenis, 2008). What would the results have looked like if the network still used a shared governance approach, or if it was coordinated by a lead organization? What would be the implications for the coping mechanisms identified?

# Appendix 5.1: Interview guide semi-structured interviews network actors

**Interview questions**

- Can you tell us something about the network your organization participates in? What does the network focus on? How long has the network been in existence? What is the history of its origins? Why is your organization participating? How has the network developed? How far along in its development do you think the network has gone? What is going well in the network? What is going less well and could be improved?
- What function(s) does your organization have? What services does your organization provide? Can you tell us something about that? What distinguishes your organization?
- What position does your organization have? (For example, has control through legislation or resources, or is following). How does your organization fill this position?
- In the present list you could choose which 3 values are the most important in your organization, and which 3 values are the least important in your organization.
- Why did you choose these values? Can you tell us something about that? Why are these values important to your organization? How do you notice that? Can you give an example of that?
- How is the network coordinated? For example, are there regular meetings? With whom do you exchange information and how does this happen?
- How do you experience collaboration in the network? What things are going well? What things are not going well? To what extent do you think the network is successful in organizing integrated care?
- In the present list you could choose which 3 values are the most important in the network, and which 3 values are the least important in the network.
- Why did you choose these values? Can you tell us something about that? Why are these values important to the network? How do you notice that? Can you give an example of that?
- Has a collective network goal been agreed upon? If so, what do you think that networking goal is?
- To what extent do you agree with this goal, from the perspective of your organization? How does the network goal fit in with the objectives of your organization?
- To what extent are you aware of what the other partners consider important? If so, what values do you think guide your collaboration partners at organizational level? And which values do you think guide your collaboration partners at network level?

- Do you understand why the other partners attach importance to these values?
- What does the network leader/coordinator do in and for the network? What do you think the average working week of the network leader/coordinator looks like? When will you contact the network leader/coordinator? Can you give an example of those contact moments with the network leader/coordinator?
- What influence does the network leader/coordinator have on the collaboration? When does the network leader/coordinator influence/direct the collaboration? Can you give an example of such a moment? How do you experience that control?
- How does the network leader/coordinator deal with dilemmas or possible tensions between organizations or people? How does the network leader/coordinator deal with possible different value orientations?
- What competencies do you think a network leader/coordinator should have? Does the network leader/coordinator have those competencies? How does the network leader/coordinator use those competencies? Can you give an example of that?

## Appendix 5.2: Interview guide semi-structured interviews network leader

- **Interview questions**Can you tell us something about the network you work in? What does the network focus on? How long has the network been in existence? What is the history of its origins? Which organizations participate and how long have they been doing so? How has the network developed? How far along in its development do you think the network has gone? What is going well in the network? What is going less well and could be improved?
- Can you tell us something about your role/position? How do you fulfill the network coordinator/leadership role? What do you find important in this?
- What does an average working week look like for you? Can you give an example of such an average working week? What activities do you undertake, and how many hours do you spend on these different activities? What activities does it undertake to facilitate collaboration in the network? How does that work? What is going well and what is not going so well? What do you think of the development of the healthcare network? When do you influence/direct the collaboration? Can you give an example of such a moment?
- In the present list you could indicate which 3 values are the most important in the network/for the collective, and which 3 values are the least important in the network/for the collective.
- Why did you choose these values? Can you tell us something about that? Why are these values important in the network? How does that manifest itself? Can you give an example of that?
- Has a collective network goal been agreed upon? If so, what do you think that networking goal is? How did you arrive at this networking goal? What role did you play in that? Is it important to have a common networking goal? If so, why? If not, why not?
- To what extent are you aware of what the various partners consider important? If so, which values do you think guide the various partners at organizational level? And which values do you think guide the various partners at network level?
- Do you understand why the other partners attach importance to these values?
- How do you deal with possible contradictions in terms of value orientations? Have you ever had to deal with that? Can you give an example of that?
- What dilemmas do you encounter in daily practice? Can you give an example of that? How do you deal with that?
- What competencies do you consider important in your role? Do you have those competencies? How do you use those competencies? Can you give an example of that?

5

# 6.

# Differentiation and Integration as Conditions for Interorganizational Network Effectiveness

Submitted

## Abstract

Research on interorganizational collaboration has predominantly emphasized integration, understood as the alignment of efforts across organizations, while giving less attention to differentiation in terms of distinct roles, functions, structures or identities. Drawing on organization theory, differentiation and integration are conceptualized as two interdependent mechanisms through which complex organizations or networks of organizations manage internal diversity and coordination, both of which are essential for achieving effectiveness (Lawrence & Lorsch, 1967). We focus on functional differentiation (task division) as well as value differentiation (different value orientations among actors). While prior research has often emphasized the importance of shared value orientations in networks, their implications for network effectiveness remain understudied. In this study, we examine how actors differ in terms of function and values, and how these forms of differentiation, in combination with integration mechanisms, help us understand collaborative efforts among organizations. Using crisp-set Qualitative Comparative Analysis (csQCA) of 24 interorganizational networks in healthcare and wellbeing in the Netherlands, we identify two distinct pathways to effectiveness. The first combines functional differentiation with functional integration. The second builds on this foundation by adding value differentiation, value integration (i.e., consensus on collective values), and the presence of a separate network broker. These findings extend and confirm organization theory regarding the importance of coordination and managing diversity. More importantly, they affirm that these principles are also crucial for understanding effectiveness in interorganizational networks. Additionally, we reveal the pivotal role of values in organizing network collaboration, contributing novel insights to organization theory and the governance of interorganizational networks.

## 6.1 Introduction

In societies where climate change and healthcare crises dominate headlines, we are increasingly looking for new forms of organizing to tackle these wicked problems (Head & Alford, 2015; Mintzberg, 2023). To address the growing complexity of society, interorganizational networks are often established, involving the integration of efforts of multiple differentiated organizations (Lawrence & Lorsch, 1967; Puranam et al., 2014; Raab, 2024). Defined as "*three or more legally autonomous organizations that work together to achieve not only their own goals but also a collective goal*" (Provan & Kenis, 2008, p. 3), these networks are becoming increasingly prevalent in today's society. A trend commonly referred to as the network society (Castells, 2004) or the society of networks (Raab & Kenis, 2009).

The significance of interorganizational networks as an organizational form has grown, making it increasingly important to understand when and how they work effectively. Thirty years ago, Provan and Milward (1995) published their foundational article, "A Preliminary Theory of Interorganizational Network Effectiveness", in *Administrative Science Quarterly*. This work, which analyzed four community mental health systems (Provan & Milward, 1995), has inspired extensive research on network effectiveness. Since then, numerous studies have investigated the factors that contribute to network effectiveness, focusing on functional, structural, and contextual characteristics (Bryson et al., 2015; Human & Provan, 2000; Nowell & Kenis, 2019; Raab et al., 2015; Shumate et al., 2023; Turrini et al., 2009). Nevertheless, network effectiveness remains a complex, multifaceted concept that can be evaluated at various levels and from different perspectives (Provan & Milward, 2001). Moreover, many of the factors associated with network effectiveness are often discussed together or overlap, yet we still have an incomplete understanding of how they interact or which configurations yield the most effective outcomes (R. Peeters et al., 2022).



In our pursuit of deeper insights into network effectiveness, we draw on organization theory. Our research is set within the empirical field of integrated care, a field where the trend toward network formation is accelerating as organizations face heightened demands for collaboration across boundaries to overcome fragmentation (Meyer, 2025). In the editorial introducing the *Administrative Science Quarterly* Special Issue on "Healthcare and Organizational Theory," DiBenigno and D'Aunno (2024) argue that organization theory and healthcare mutually benefit from this intersection. They contend that healthcare's complexity provides a unique environment to study collaborative dynamics that span disciplines. In turn, healthcare serves as an ideal

case for advancing the field of organization theory, as networks are increasingly employed to address the complex challenges of today (DiBenigno & D'Aunno, 2024).

To investigate network effectiveness in healthcare, we revisit foundational organization theory and apply it to interorganizational networks comprising multiple autonomous organizations. Drawing on the work of Lawrence and Lorsch (1967) and the insights of Puranam, Alexy, and Reitzig (2014), and Puranam (2018), we focus on the core dimensions of differentiation and integration. Both organizations and interorganizational networks adapt to their environments through these mechanisms. Differentiation refers to the division of labor, whereby specialized units—or in networks, distinct organizations—develop unique roles, practices, and cultures. For example, within healthcare, hospitals, primary care providers, and social services each cultivate specialized expertise to address particular demands. Integration, by contrast, entails coordinating these differentiated actors to achieve shared objectives, requiring collaboration, alignment, and cohesion (Kenis & Raab, 2020; Lawrence & Lorsch, 1967; Puranam, 2018; Puranam et al., 2014). Yet differentiation and integration pull in opposing directions: the former fosters specialization, the latter demands unity. This tension poses a central puzzle: how do interorganizational networks simultaneously sustain differentiation and enable integration to produce effective outcomes?

In this context, much of the literature on network effectiveness focuses on integration-related factors such as network density, centralization, and governance. Provan and Milward (1995) explain network effectiveness through integration-related factors, and research has continued to emphasize structures and mechanisms that enhance integration: the process of bringing together. Examples include governance modes (Provan & Kenis, 2008), trust-building (Ansell & Gash, 2008), and common goals (Klijn & Koppenjan, 2015). Within healthcare, similar trends can be seen, with extensive studies focusing on network structure (Van der Weert et al., 2022), social features (Kerrissey et al., 2022), organizational culture (Tietschert et al., 2019), and facilitators and barriers to integration (L. A. Nooteboom et al., 2021). Additionally, frequently cited models and frameworks for integrated care outline key strategies and step-by-step guides for achieving integration (R. Axelsson & Axelsson, 2006; Harnett et al., 2020; Minkman et al., 2025; Valentijn, 2015). However, while these models and frameworks are comprehensive, they do not yet provide insights into how their elements, or their combinations and configurations, relate to optimizing network effectiveness.

The emphasis on integration is also reflected in a recent literature review on purpose-oriented networks in healthcare, which identified 283 determinants of network effectiveness (R. Peeters et al., 2022). These determinants predominantly focus on process outcomes such as integration, rather than the achievement of specific objectives or outcomes. The findings suggest that discussions of network effectiveness in healthcare often treat the process of integration and collaboration within networks as an end in itself, rather than a means to achieve broader goals. This focus on integration and process outcomes is unsurprising, given the term 'integrated care.' However, the high expectations for its success underscore the need for more evidence on whether these integrated care networks are truly effective in achieving their intended outcomes (Ahgren et al., 2009; Armitage et al., 2009; Bautista et al., 2016; Baxter et al., 2018; Janse, 2018; Michgelsen et al., 2022; Wankah et al., 2020).

While much of the focus in research and practice has been on maximizing integration in networks, the concept of differentiation and its implications—whether high or low—are not examined or considered in depth. Drawing on the foundational work of organization theorists such as Lawrence and Lorsch (1967), Puranam, Alexy, and Reitzig (2014), and Puranam (2018), we argue that it is equally important to consider differentiation alongside integration. In this study, we aim to address this gap by examining both differentiation, in relation to task requirements, and integration as key conditions for network effectiveness.



However, understanding differentiation and integration solely in structural and functional terms leaves unexplored an additional dimension: the role of values and normative orientations in affecting how network actors relate to one another. To address this second gap, we turn to how differentiation and integration unfold not only in tasks and positions, but also in the realm of values.

When examining differentiation more closely, it is often approached functionally and structurally, referring to the division of labor and tasks on the one hand, and the different structural positions actors occupy on the other (Kenis & Raab, 2020; Lawrence & Lorsch, 1967; Puranam, 2018). However, differentiation can also manifest in non-functional forms, such as actors developing distinct values and norms due to factors like education, professional background, or organizational culture. This form of differentiation, value differentiation, represents an additional dimension beyond functional or structural differentiation. Similarly, when considering integration mechanisms, the other side of the coin, a cognitive-cultural dimension emerges alongside structural coordination: normative integration mechanisms based on a

"common orientation towards similar values, goals, culture, norms, topics, etc." (Raab, 1998). The importance of "identifying shared values" (Ansell & Gash, 2008), "reconciling different values" (Klijn & Koppenjan, 2015), or "mutual understanding" (Emerson et al., 2012) is emphasized in many influential studies of effective collaboration in networks. However, prior research has shown that significant value differences often persist, especially in healthcare delivery contexts (Oldenhof et al., 2025; H. Peeters et al., 2023; Zonneveld et al., 2022). Value differentiation remains underexplored, and we propose to address both value differentiation and value integration by examining how value differences and commonalities affect network effectiveness. In this study, we propose to address both value differentiation and value integration (next to functional differentiation and integration) simultaneously by examining how they affect network effectiveness.

In this study, we advance organization theory in two interrelated ways. First, we develop a broader and deeper understanding of how differentiation and integration operate as interdependent mechanisms shaping the effectiveness of interorganizational networks. Rather than viewing differentiation (both functional and values-based) as a barrier to coordination, we examine it as a possible condition for network effectiveness in combination with integration-related factors. Second, the study contributes to broader debates on new forms of organizing. Contemporary organizational forms such as network organizations, holacracies, and platform organizations, cannot a priori rely on strong joint values, given their heterogeneous composition and the autonomy of their constituent actors. By distinguishing between value differentiation at the actor level and value integration at the network level, we conceptualize values as a critical organizing dimension that shapes interorganizational networks and their goal achievement. While prior work on functional differentiation (Puranam et al., 2014) illuminates task-based division of labor, our study extends this line of inquiry by highlighting the parallel importance of value-based differentiation, offering a more comprehensive lens for understanding how contemporary organizational forms balance diversity and coordination.

## 6.2 Theory

The central goal of this study is to answer the question: What combinations of conditions related to differentiation and integration of interorganizational networks contribute to their effectiveness? Therefore, we analyze 24 healthcare and wellbeing networks to identify configurations of functional and value differentiation and integration that are associated with network effectiveness. To set the stage, we first

clarify what we mean by network effectiveness, a concept that is often ambiguously defined in both research and practice. We then operationalize five core concepts—functional differentiation, functional integration, the presence of a separate network broker, value differentiation, and value integration—that serve as conditions in our analysis.

*Network effectiveness* is an ambiguous concept that is challenging to operationalize. In both literature and practice, there is often no consensus on the criteria for determining when a network can be considered effective. The outputs of interorganizational networks can be assessed at various levels and from multiple perspectives. From a multi-level perspective, we can evaluate the achievements of networks at the community, network, and organizational levels (Provan & Milward, 2001). At the community level, the focus is on the network's value to the communities it serves. In healthcare and wellbeing settings, which are the focus of this study, this may include outcomes such as improved public health, accessibility of services, or more efficient use of public resources. At the network level, effectiveness is often understood in terms of collaboration processes, such as coordination and integration of services, strong relationships between actors, and the avoidance of duplication. Finally, at the organizational level, effectiveness implies that network membership benefits the individual member organizations, for example through access to resources, enhanced legitimacy, or organizational survival.



Notwithstanding these different approaches, in this study we define network effectiveness as the degree to which an interorganizational network achieves its collective goal(s) (Provan & Kenis, 2008). This definition goes beyond a pragmatic focus on measurable outcomes; it captures the internal logic and strategic intent underlying the formation of interorganizational networks. The achievement of collective goals is not a random occurrence but reflects a deeper, underlying rationale: organizations deliberately engage in interorganizational networks because they seek to realize outcomes that cannot be achieved independently. From this perspective, collective goal attainment constitutes not merely an evaluative benchmark but the manifestation of the shared rationale that defines the network as an organizational form.

*Functional differentiation* refers to the division of activities into specialized tasks and the allocation of these tasks to different sub-units within an organization, such as individuals, teams, or departments (Lawrence & Lorsch, 1967; Puranam, 2018). In interorganizational networks, functional differentiation manifests as the distinct roles, functions, and expertise that member organizations contribute

to the collective tasks of the network. Achieving network goals therefore depends on effectively coordinating these specialized contributions (Kenis & Raab, 2020). In this study, we define functional differentiation as the degree to which actors in an interorganizational network differ in terms of their functions and structural positions vis-à-vis the collective tasks.

*Functional integration*, by contrast, refers to the coordination of activities across these specialized units or organizations. It involves mechanisms such as information exchange, joint planning, and alignment processes that link diverse contributions toward collective outcomes (Kenis & Raab, 2020; Lawrence & Lorsch, 1967; Puranam, 2018). In healthcare and wellbeing networks, integrative mechanisms may include information and communication technologies (Steele Gray, 2021; Tahsin et al., 2023), leadership practices (Gutberg et al., 2022), or logistical arrangements such as case management or a single point of contact (Minkman et al., 2025; Voogdt-Pruis et al., 2021). Structural network studies have highlighted integration through density and centralization (Provan & Milward, 1995). Density captures the degree of interconnectedness, while centralization reflects the concentration of ties and control in one or few organizations. In this study, we define functional integration as the extent and quality of ties among actors in an interorganizational network, distinguishing (1) referrals (back and forth), (2) case coordination among organizations, (3) shared service delivery, and (4) other contacts such as work meetings.

*A separate network broker* refers to a central actor performing governance functions through a distinct, separate entity. In this study, we conceptualize the network broker as a role, not as a specific organization or individual (Provan & Kenis, 2008). The brokering role may also be carried out internally—by a lead organization that is itself a network member—but when executed via a Network Administrative Organization (NAO), it becomes a separate, external manifestation of this role. In this study, we focus on the separate brokering role as it manifests itself in the NAO. Such an NAO plays a crucial role in coordinating the network, enhancing legitimacy, and addressing network-level issues. Following Provan and Kenis (2008), network governance can be distinguished along three primary forms:

Shared governance – Governance is fully decentralized. All network members participate directly in decision-making and coordination. Power is relatively symmetrical, and coordination occurs through formal mechanisms (e.g., regular meetings) or informal efforts by members. No distinct administrative entity exists, though some coordination may be undertaken by subsets of members.

Lead organization – One member organization assumes primary responsibility for network-level governance. This central actor performs strategic coordination and administrative tasks while other members focus on operational activities. Governance is highly centralized, with asymmetrical power, but the brokering role remains internal to the network.

Network Administrative Organization (NAO) – Governance is centralized through a separate, external entity established specifically to govern the network. The NAO fulfills the brokering role, coordinating activities and sustaining the network without providing services as a network member. NAOs may range from a single network facilitator to a formal organization with an executive director, staff, and board. This form enhances legitimacy, reduces complexity, and allows members to focus on operational tasks while the NAO handles network-level governance.

We define a separate network broker as the presence of a central actor performing governance functions through a distinct, separate entity, manifested as an NAO (Provan & Kenis, 2008).



*Value differentiation* refers to the extent to which actors in a network hold different values. These values are often shaped through professional socialization, education, and organizational membership, leading to distinct value orientations across individuals and groups (DiMaggio & Powell, 1983; Moyo et al., 2016; Poorchangizi et al., 2019; Sellman, 2011). In interorganizational networks, value differentiation captures the diversity of perspectives, priorities, and normative frameworks that actors bring to the collaboration. For example, within an interorganizational network in social care, different professionals (social workers, nurses, or educators) may prioritize client autonomy, efficiency, or holistic well-being differently, reflecting their training and professional norms. Importantly, in this study we approach these value differences neutrally and not a priori as sources of conflict; they can also potentially generate complementary perspectives that enhance network problem-solving and responsiveness to diverse user needs (Zonneveld et al., 2022). In this study, we define value differentiation as the degree to which actors in an interorganizational network differ in their value orientations.

*Value integration* refers to the extent to which actors in a network agree upon shared values on a collective level. Such collective values may go beyond individual or professional orientations and instead reflect the common identity, culture, or purpose of the network (Rokeach, 2008). Prior frameworks of collaborative governance emphasize the role of shared values, mutual understanding, or value

reconciliation as critical for effective collaboration (Ansell & Gash, 2008; Emerson et al., 2012; Klijn & Koppenjan, 2015), In this study, we define value integration as the degree of consensus among actors in an interorganizational network regarding collective network values.

## 6.3 Method

### Empirical Setting

The cases included in this study are interorganizational networks in the field of integrated care that focus on health and wellbeing for target populations in the Netherlands. These networks comprise diverse organizations, both public and private, small and large, ranging from hospitals, home care providers, and social care organizations to schools, and municipal agencies. They differ in size, scope, and geographical reach.

To ensure variety and comparability, we selected networks from five categories: curative care, stroke care, palliative care, youth care, and care for people with intellectual disabilities. Within each category, multiple networks that vary in size, number and types of participating organizations, governance modes, and geographical scale and distribution (urban/rural) were included.

The inclusion criteria for interorganizational networks were as follows: (1) the network aims to deliver health, care, wellbeing and/or support services to target groups with specific care and/or support needs; (2) it consists of at least three collaborating organizations, aligning with the Provan and Kenis (2008) definition of networks; (3) it has been operational for at least three years, a threshold identified as critical for developing mature and sustainable collaborations (Minkman et al., 2013; Raab et al., 2015); (4) the network has a key informant who plays a central role and possesses an overarching understanding of the network's structure, dynamics, and developments, facilitating data collection; and (5) the collaborating organizations work together at the professional level in the provision of care or support services. Networks that focus solely on knowledge exchange or board-level coordination were not included.

*Curative care*. The seven curative care networks are typically characterized by a large hospital serving as the central actor, substantially larger than other participating organizations. Depending on the network's specific focus, hospitals coordinate with home care providers, social care agencies, physiotherapy services, primary

care practices, or maternity care organizations. These networks range from 5 to 13 participating organizations, making them generally small to medium in size. Governance is brokered in all cases, with five networks coordinated by a lead organization (usually the hospital) and two by a Network Administrative Organization (NAO).

*Stroke care*. The five stroke care networks primarily function as logistical care chains, coordinating patient pathways across multiple organizations. Participating actors include rehabilitation centers, hospitals, nursing homes, primary care practices, and home care providers. These networks involve between 12 and 54 organizations, positioning them at the medium to larger end of the networks studied. Governance is brokered in all cases: in four cases an NAO governs the network, whereas in one case a lead organization fulfills this role.

*Palliative care*. The four palliative care networks comprise diverse organizations, such as primary care, home care, hospice care, and specialized care. They are large networks, ranging from 34 to 53 participating organizations. Governance arrangements are heterogeneous, including cases of shared governance, a lead organization, and an NAO.



*Youth care*. The five youth care networks include actors from multiple sectors, such as youth care providers, schools, mental health organizations, social services, and community organizations. These networks range in size from 5 to 30 organizations, reflecting substantial variation from small to large networks. Governance is most often brokered through an NAO (four cases), with one network coordinated through shared governance.

*Disability care*. The three disability care networks consist of disability care providers, hospitals, general practices, municipal agencies, and sheltered work organizations. They range from 3 to 15 participating organizations, making them small to medium in size. In all three cases, governance is organized through shared governance.

Collectively, these networks provide a rich empirical setting to examine how differentiation and integration shape interorganizational collaboration, as they vary in organizational composition, size, and governance modes.

**Table 6.1** Overview of Included Interorganizational Networks (N=24)

| Category | Included Networks (n) | Size (range, n orgs) | Governance Modes (n) |
|---|---|---|---|
| Curative care | 7 | 5 – 13 | Lead organization (5);<br>NAO (2) |
| Stroke care | 5 | 12 – 54 | NAO (4);<br>Lead organization (1) |
| Palliative care | 4 | 34 – 53 | Shared governance (1);<br>Lead organization (1);<br>NAO (2) |
| Youth care | 5 | 5 – 30 | NAO (4);<br>Shared governance (1) |
| Disability care | 3 | 3 – 15 | Shared governance (3) |

## Data Collection

To acquire a comprehensive understanding of all 24 cases, three methods were used. First, questionnaires were distributed to all actors within the 24 networks. To be included in the analysis, a minimum response rate of 50% from the actors in each network was required. Second, in-depth semi-structured interviews were conducted with key informants who play a central role in the network and possess an overarching understanding of its structure, dynamics, and developments. Third, relevant documents were analyzed. The number of documents per case varied. Some cases had multiple documents, some only one, and for a few cases no documents were available. This resulted in a total of 31 documents for the 24 cases. The combination of these methods (methods triangulation) ensured a broad and deep understanding of the cases. Through these three methods, data were collected on the following concepts: functional differentiation, functional integration, NAO, value differentiation, value integration at network level, and network effectiveness. All data were collected from April to December 2023. In Table 6.2, the collected data (and N) are presented.

Following Raab et al. (2015), the assessment of functional integration took place in two phases. In the first phase, actors from one network in each category underwent examination through a comprehensive questionnaire on functional integration, based on the questionnaire used in the study by Provan and Milward (1995). The questionnaire developed by Provan and Milward (1995) is one of the most widely cited and validated instruments for measuring functional integration in interorganizational networks. By using it, we align ourselves with an established research tradition and enhance the comparability of our findings with previous studies. This questionnaire was extended with four proxy questions, summarizing

the primary categories: referrals, coordination, shared services, and other contact. The proxy questions were validated by comparing their results with those from the comprehensive questionnaire. This led to the development of a condensed questionnaire comprising the four proxy statements on functional integration. In the second phase, this condensed questionnaire was administered across the remaining 19 networks. The assessment of value differentiation and value integration was based on a systematically developed questionnaire capturing values relevant to the delivery of integrated health and wellbeing services. Respondents were asked to indicate their three most and least prioritized values at the individual level, as well as the three most and least prioritized collective values at the network level. The full questionnaire and the interview guide are provided in Appendices 6.1 and 6.2.

**Table 6.2** Collected Data

| Source | N |
|---|---|
| Questionnaires with network actors | 282 |
| Semi structured interviews with key informants | 24 |
| Documents analyzed | 31 |



## Qualitative Comparative Analysis (QCA)

The data collected from the questionnaires, semi-structured interviews and documents were analyzed through Crisp-Set Qualitative Comparative Analysis (csQCA) (Fiss, 2007, 2011; Ragin, 2014; Rutten, 2023). QCA is a case-oriented, configurational method, which systematically compares cases to identify patterns in how different combinations of conditions lead to particular outcomes. It assumes that multiple configurations of conditions can lead to the same outcome. Grounded in set theory, QCA identifies which sets (combinations of conditions) are necessary or sufficient for a particular outcome. In this study, the outcome of interest is network effectiveness, with conditions including functional differentiation, functional integration, a separate network broker, value differentiation, and value integration.

Research on network effectiveness has identified a wide range of determinants influencing network effectiveness (Provan & Milward, 1995; Turrini et al., 2009), including studies specifically focused on healthcare and wellbeing networks (R. Peeters et al., 2022). However, despite this knowledge, there remains limited understanding of how these factors—or their combinations and configurations—jointly contribute to achieving effective outcomes. QCA allows us to explore such combinations. This configurational approach is particularly suited to the complexities of interorganizational networks, where the relationships between conditions are often

non-linear and interactive (Cristofoli & Markovic, 2016; Gerrits & Verweij, 2016; Gheduzzi et al., 2025; Li & Zhang, 2025; Raab et al., 2015; Shumate et al., 2023; Smith, 2020). The choice for QCA was also driven by the characteristics of our empirical sample. We analyze 24 interorganizational networks, a number too large for in-depth case study analysis but too small for conventional quantitative approaches. QCA is well-suited for small-to-medium sample sizes and accommodates the complexity and interplay of multiple potentially interrelated conditions

QCA offers multiple calibration strategies, most notably crisp-set QCA (csQCA) and fuzzy-set QCA (fsQCA), which allow researchers to represent conditions as either binary (present/absent) or graded degrees of membership, respectively (Ragin, 2014; Rutten, 2024). Both approaches were carefully considered. We ultimately opted for csQCA, primarily because we applied linguistic hedges such as "highly" or "somewhat", to capture nuanced variations within binary categories (also see Table 6.3). Rather than imposing a strict dichotomy, linguistic hedges allowed us to define multiple logical distinctions within each condition, reflecting the complex and varied nature of social reality (Rutten, 2024). This approach enabled us to draw on our in-depth case knowledge, gained through questionnaires, interviews, and document analysis, to establish theoretically informed and empirically grounded thresholds for each condition. By doing so, we preserved the interpretive richness of the cases while maintaining analytical clarity. This calibration strategy not only avoids reductive dichotomization but also enhances the explanatory power of our analysis by allowing us to capture meaningful distinctions in how differentiation and integration manifest across network cases.

To ensure that our calibration process was rigorous and consistent, we developed a clear csQCA calibration framework, which translates the nuanced interpretations from the previous step into specific thresholds for each condition. Initially, we established clear definitions for all concepts. For instance, in defining 'network effectiveness', we described what makes an effective network (see Table 6.3). The subsequent step in the calibration process involves addressing the dichotomous nature of csQCA. Through linguistic hedges, we set thresholds to determine the presence or absence of a condition. For instance, when assessing network effectiveness, we establish criteria for determining when a network is considered effective. The calibration of the core concepts is presented in Table 6.3.

During the coding process, data from all three sources were used, and a coding scheme with defined concepts and thresholds was applied (see Table 6.3). To ensure inter-rater reliability, an expert researcher from an external institution independently

coded all 24 networks for the outcome of 'Network effectiveness'. Any discrepancies (4 cases, 16.7%) were resolved through discussion. Following coding, results were cross-checked with the in-depth case knowledge, ensuring that the categorization and assessment of concepts were aligned with the data.

**Table 6.3** Operationalizing and Calibrating the Core Concepts

| Concept | Definition | Measurement Linguistic hedges | Example |
|---|---|---|---|
| **Outcome** | | | |
| Network effectiveness | The degree to which an interorganizational network achieves its collective goal(s) | 0 Not effective - No goals are achieved<br>0 Marginally effective - A start has been made on achieving goals<br>0 Somewhat effective - Some goals are achieved<br>-----<br>1 Moderately effective – A significant proportion of goals are achieved<br>1 Predominantly effective – Sufficient goals are achieved<br>1 Very effective – Most goals are achieved | - Network mean score = 6.00<br>- "I do think that collectively we are indeed making good progress towards that. Have we reached the goal yet? No, not yet."<br>→ Coded as network effectiveness = 0 |
| **Conditions** | | | |
| (1) Functional differentiation | The degree to which actors in an interorganizational network differ in terms of their functions and structural positions vis-à-vis the collective tasks | 0 Not-differentiated - Actors have similar functions and structural positions<br>0 Marginally-differentiated - There are at most two different functions and structural positions<br>0 Somewhat-differentiated – There are three different functions and structural positions<br>-----<br>1 Moderately-differentiated – There are four different functions and structural positions<br>1 Predominantly-differentiated – here are five or more different functions and structural positions<br>1 Highly-differentiated - There is a variety of actors with different functions and structural positions, for example from different sectors with different backgrounds | "Many organizations have been involved from various sectors. We have mental healthcare, an orthopedagogical treatment center, child psychiatry, care organizations for individuals with intellectual disabilities (ID), schools, and of course, youth care and youth support."<br>→ Coded as functional differentiation = 1 |

**Table 6.3** Continued

| Concept | Definition | Measurement Linguistic hedges | Example |
|---|---|---|---|
| (2) Functional integration | The extent and quality of ties among actors in an interorganizational network:<br>(1) referrals (back and forth),<br>(2) case coordination among organizations,<br>(3) shared service delivery, and<br>(4) other contacts such as work meetings | 0 Not-integrated – There are no referrals, case coordination, shared services or other contact among the organizations.<br>0 Marginally-integrated – The linkages among the organizations are marginal.<br>0 Somewhat-integrated – There are some linkages among the organizations.<br>---<br>1 Moderately-integrated – There are referrals, case coordination, shared services or other contact among the organizations, and these function moderately.<br>1 Predominantly-integrated – There are referrals, case coordination, shared services or other contact among the organizations, and these function sufficiently<br>1 Highly-integrated – There are referrals, case coordination, shared services or other contact among the organizations, and these function smoothly | - Network mean score = 8.17<br>- "All organizations ultimately collaborate with each other, especially when a client needs to be transferred. There is quite a bit of overlap in daily work […] essentially, each organization has to collaborate with another organization at some point."<br>→ Coded as functional integration = 1 |
| (3) Separate network broker | The presence of a central actor performing governance functions through a distinct, separate entity, manifested as an NAO | 0 Separate network broker is not present – There is no central actor performing governance functions through a distinct, separate entity<br>---<br>1 Separate network broker is present - There is a central actor performing governance functions through a distinct, separate entity | - "The network is ultimately molded into an independent entity."<br>→ Coded as separate network broker = 1 |

**Table 6.3** Continued

| Concept | Definition | Measurement Linguistic hedges | Example |
|---|---|---|---|
| (4) Value differentiation | The degree to which actors in an interorganizational network differ in their value orientations | 0 Not-differentiated - Actors have similar value orientations<br>0 Marginally-differentiated – The differences between the value orientations of the actors are negligible<br>0 Somewhat-differentiated – The differences between the value orientations of the actors are small<br>---<br>1 Moderately-differentiated – There are significant differences between the value orientations of the actors<br>1 Predominantly-differentiated – Most of the actors have different value orientations<br>1 Highly-differentiated – All actors have different value orientations | - Network score = 70% selected 6 values: effective, comprehensive, efficient, personal, empowering, flexible<br>- "Different organizations have different cultures and practices, things they find important, which sometimes causes friction."<br>→ Coded as value differentiation = 1 |
| (5) Value integration | The degree of consensus among actors in an interorganizational network regarding collective network values | 0 No-consensus – There is no consensus among actors on network values and these are not discussed<br>0 Barely-consensus - There is no consensus among actors on network values and these are not discussed<br>0 Some- consensus – There is a small coalition of actors with consensus on network values<br>0 Moderate- consensus – A moderate number of actors agree on a set of network values<br>---<br>1 High-consensus – Most actors agree on a set of collective network values<br>1 Full-consensus – All actors agree on a set of collective network values | - Network score = 70% selected 4 values: holistic, coproduced, empowering, collaborative<br>- "The shared vision and values ensured that it was the starting point. So… eventually, we had to bring all those people together for that assignment. Suddenly, you have all these new colleagues who all have to experience a new way of working. […] If we hadn't had that framework, I think it would have been even more daunting for those people. I think that was a accelerator and catalyst." (R no. 16).<br>→ Coded as value integration = 1 |

## 6.4 Findings

Tosmana 1.6.1 was used to conduct the Crisp-set QCA analysis. The analysis revealed the following configuration (intermediate solution) to network effectiveness:

(Functional differentiation ● Functional integration) + (Functional differentiation ● Functional integration ● Separate network broker ● Value differentiation ● Value integration) → Network effectiveness

● = AND
~ = NOT
+ = OR
→ = Implication

Interpreting the intermediate solution reveals two pathways to network effectiveness. First, networks that exhibit a high level of both functional differentiation and functional integration can achieve high network effectiveness, provided that value differentiation and value integration at network level are absent. Second, networks that combine the presence of functional differentiation, functional integration, value differentiation, value integration at network level, and a separate network broker, can also demonstrate network effectiveness (also see Table 6.4).



**Table 6.4** Configurations for Network Effectiveness

| | **Intermediate solution** | |
|---|---|---|
| | **1** | **2** |
| Functional differentiation | ● | ● |
| Functional integration | ● | ● |
| Separate network broker | | ● |
| Value differentiation | ⊗ | ● |
| Value integration | ⊗ | ● |
| Cases (n) | 4 | 4 |
| Raw coverage | 0.44 | 0.44 |
| Unique coverage | 0.44 | 0.44 |
| Consistency | 1.00 | 1.00 |
| Solution coverage | 0.89 | |
| Solution consistency | 1.00 | |

● = condition is present, ⊗ = condition is absent, blank = may be present or absent

Conversely, our csQCA analysis reveals four combinations of conditions under which networks can demonstrate ineffectiveness (see Table 6.5). First, functional differentiation alone: networks characterized solely by functional differentiation, lacking both functional integration and value integration at network level, exhibit ineffectiveness. Second, value differentiation alone: networks defined only by value differentiation, without a separate network broker, functional integration, and value integration at network level, also show ineffectiveness. Third, combined differentiation without a separate network broker: networks that have both functional differentiation and value differentiation, but lack a separate network broker and value integration at network level, are ineffective as well. Lastly, networks with a separate network broker and functional integration, lacking both types of differentiation and value integration at network level, are also ineffective.

**Table 6.5** Configurations for Network Ineffectiveness

| | **Intermediate solution** | | | |
|---|---|---|---|---|
| | **1** | **2** | **3** | **4** |
| Functional differentiation | ● | | ● | ⊗ |
| Functional integration | ⊗ | ⊗ | | ● |
| Separate network broker | | ⊗ | ⊗ | ● |
| Value differentiation | | ● | ● | ⊗ |
| Value integration | ⊗ | ⊗ | ⊗ | ⊗ |
| Cases (n) | 6 | 4 | 2 | 2 |
| Raw coverage | 0.40 | 0.27 | 0.13 | 0.13 |
| Unique coverage | 0.40 | 0.20 | 0.07 | 0.07 |
| Consistency | 1.00 | 1.00 | 1.00 | 1.00 |
| Solution coverage | 0.73 | | | |
| Solution consistency | 1.00 | | | |

● = condition is present, ⊗ = condition is absent, blank = may be present or absent

A total of 11 out of the 32 possible combinations of conditions were covered by empirical cases, meaning these 11 combinations were observed in the data. This is illustrated in the truth table (Table 6.6) and the QCA graphic (Figure 6.1). The remaining 21 configurations are referred to as 'logical remainders' (Ragin, 2014; Rutten, 2024). The solutions for both network effectiveness and ineffectiveness were developed without including these non-observed logical remainders.

In QCA, coverage indicates the proportion of cases explained by a particular configuration. Tables 6.4 and 6.5 distinguish between raw, unique, and solution coverage. Raw coverage represents the proportion of outcome cases accounted for by a specific configuration. Unique coverage reflects the proportion of outcome cases explained solely by that configuration and not by others. Solution coverage, on the other hand, denotes the proportion of outcome cases explained by the entire set of configurations in the solution. According to Rutten (2024), a solution coverage of ≤0.5 suggests insufficient explanatory power. The solution coverage for our intermediate solutions is 0.89 for network effectiveness and 0.73 for network ineffectiveness, indicating that these solutions adequately cover the cases and possess sufficient explanatory power.

Consistency is another crucial element in QCA, referring to the proportion of cases where the observed outcome aligns with the given configuration, without contradictions (Ragin, 2014). Solution consistency pertains to the consistency of the entire solution, encompassing all configurations within it. Rutten (2024) suggests a default consistency threshold of 0.8 in QCA. In our analysis, all configurations within both solutions, network effectiveness and network ineffectiveness, demonstrate a consistency of 1.0, resulting in a solution consistency of 1.0 for both solutions (see Tables 6.4 and 6.5).



In our analysis, we identified one contradictory case within a particular configuration where only 'functional integration' was present, while the other conditions were absent. This configuration is detailed in row 5 of the truth table (see Table 6.6). The contradiction is marked with a ‘C’ in Figure 6.1 and in the outcome column of the truth table. Out of the four cases associated with this configuration, three exhibited network ineffectiveness as the outcome, whereas one case was categorized as effective, representing the contradiction. Since this configuration was not included in the final solutions, it did not affect the consistency scores of either the overall solutions or the individual configurations within them.

**Table 6.6** Empirical Truth Table for Network Effectiveness (csQCA Results)

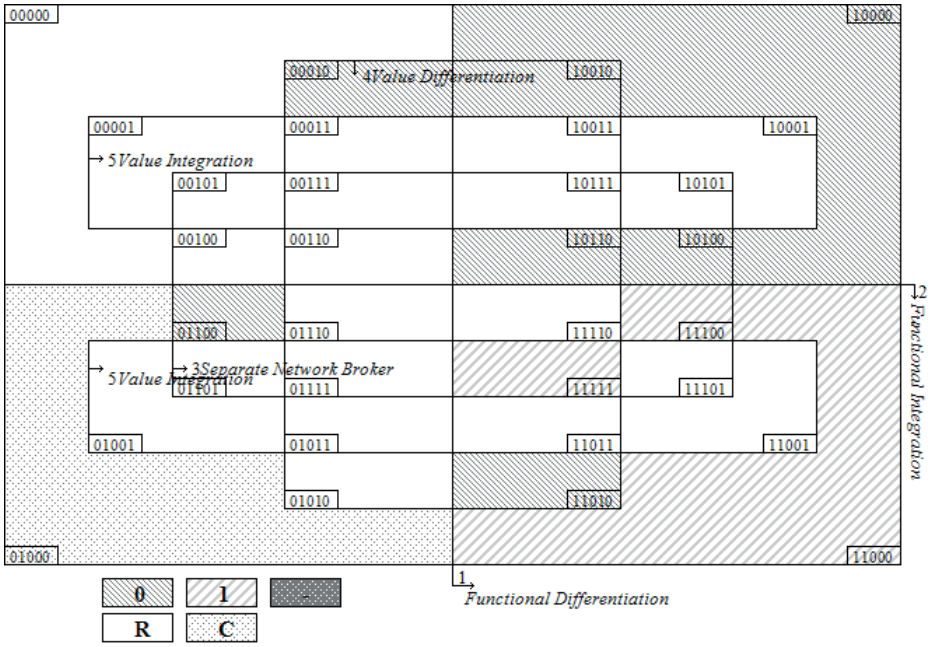
| No | Functional differentiation | Functional integration | Separate network broker | Value differentiation | Value integration | Network effectiveness |
|---|---|---|---|---|---|---|
| 1 | 0 | 0 | 0 | 0 | 0 | ? |
| 2 | 0 | 0 | 0 | 0 | 1 | ? |
| 3 | 0 | 0 | 0 | 1 | 0 | 0 |
| 4 | 0 | 0 | 0 | 1 | 1 | ? |
| 5 | 0 | 1 | 0 | 0 | 0 | C |
| 6 | 0 | 1 | 0 | 0 | 1 | ? |
| 7 | 0 | 1 | 0 | 1 | 0 | ? |
| 8 | 0 | 1 | 0 | 1 | 1 | ? |
| 9 | 1 | 0 | 0 | 0 | 0 | 0 |
| 10 | 1 | 0 | 0 | 0 | 1 | ? |
| 11 | 1 | 0 | 0 | 1 | 0 | 0 |
| 12 | 1 | 0 | 0 | 1 | 1 | ? |
| 13 | 1 | 1 | 0 | 0 | 0 | 1 |
| 14 | 1 | 1 | 0 | 0 | 1 | ? |
| 15 | 1 | 1 | 0 | 1 | 0 | 0 |
| 16 | 1 | 1 | 0 | 1 | 1 | ? |
| 17 | 0 | 0 | 1 | 0 | 0 | ? |
| 18 | 0 | 0 | 1 | 0 | 1 | ? |
| 19 | 0 | 0 | 1 | 1 | 0 | ? |
| 20 | 0 | 0 | 1 | 1 | 1 | ? |
| 21 | 0 | 1 | 1 | 0 | 0 | 0 |
| 22 | 0 | 1 | 1 | 0 | 1 | ? |
| 23 | 0 | 1 | 1 | 1 | 0 | ? |
| 24 | 0 | 1 | 1 | 1 | 1 | ? |
| 25 | 1 | 0 | 1 | 0 | 0 | 0 |
| 26 | 1 | 0 | 1 | 0 | 1 | ? |
| 27 | 1 | 0 | 1 | 1 | 0 | 0 |
| 28 | 1 | 0 | 1 | 1 | 1 | ? |
| 29 | 1 | 1 | 1 | 0 | 0 | 1 |
| 30 | 1 | 1 | 1 | 0 | 1 | ? |

**Table 6.6** Continued

| No | Functional differentiation | Functional integration | Separate network broker | Value differentiation | Value integration | Network effectiveness |
|---|---|---|---|---|---|---|
| 31 | 1 | 1 | 1 | 1 | 0 | ? |
| 32 | 1 | 1 | 1 | 1 | 1 | 1 |

**Notes.** The table presents the empirical truth table derived from the crisp-set Qualitative Comparative Analysis (csQCA). Each row represents a unique configuration of the five causal conditions: (1) functional differentiation, (2) functional integration, (3) separate network brokerage, (4) value differentiation, and (5) value integration. The final column indicates whether the configuration is associated with network effectiveness (1) or not (0). Cells marked with "C" denote contradictory configurations—combinations for which both the presence and absence of the outcome were observed across cases. Rows marked with "?" represent theoretically possible configurations that were not observed empirically. The table summarizes the logical space of empirically observed and unobserved combinations of conditions in relation to network effectiveness.

**Figure 6.1** Configurational Results of the Crisp-Set Qualitative Comparative Analysis (csQCA) for Network Effectiveness




**Notes.** This figure provides a visual representation of the configurational results from the crisp-set Qualitative Comparative Analysis (csQCA). Each cell depicts a unique configuration of the five causal conditions: (1) functional differentiation, (2) functional integration, (3) separate network brokerage, (4) value differentiation, and (5) value integration. Configurations are associated with the outcome of network effectiveness. Shaded cells indicate the presence (1) or absence (0) of the outcome: diagonal lines oriented from top right to bottom left represent configurations leading to network effectiveness (1), whereas diagonal lines in the opposite direction represent configurations without network effectiveness (0). White cells indicate combinations that do not occur empirically, and cells marked with "C" represent contradictory cases. The figure maps the observed logical space of configurations that link conditions to network effectiveness.

## 6.5 Discussion

With the increasing prominence of interorganizational networks as responses to contemporary challenges, it is essential to understand when and how they function effectively. By identifying two configurations that contribute to network effectiveness, focusing on combinations of conditions related to differentiation and integration, we make two key contributions. First, we shed light on the relatively underexplored aspect of differentiation within networks, advancing our understanding of its role for network effectiveness. Second, we extend existing conceptualizations of differentiation and integration by incorporating the concept of values, demonstrating how values play a role in these two dimensions.

Our analysis bridges multiple levels of inquiry by examining both individual actor perspectives within interorganizational networks, alongside the presence or absence of specific conditions across 24 networks as a whole. By analyzing these two levels, the actor level and the network level, this study provides insights into their interplay. This approach entails 'zooming in' on actors within each network while simultaneously 'zooming out' to compare networks as a whole (Van Duijn, 2022). While both levels are critical for understanding how networks function, collecting data at multiple levels across numerous networks is often challenging (Provan et al., 2007).



Existing research often prioritizes one level over the other: focusing on the actor level within a single or few case studies (Van der Woerd et al., 2022), applying QCA without cross-network comparisons (Van der Weert et al., 2024), analyzing a larger set of networks but limiting the scope to network leaders (Shumate et al., 2023) or relying on quantitative approaches (Brewster et al., 2018; Lan et al., 2022). Provan and Milward's (1995) seminal work, which informs our study, addressed both levels in their model of network effectiveness but was limited to four networks. By extending this line of inquiry across a larger sample, this study advances our understanding of the conditions that shape network effectiveness.

We identified two configurations that can lead to network effectiveness. The first configuration highlights that network effectiveness can be achieved through the combination of functional differentiation and functional integration, in the absence of value differentiation or value integration. This conclusion is supported by our analysis of pathways to network ineffectiveness, which demonstrates that the presence of either functional differentiation or functional integration alone, without the other, can lead to ineffectiveness. These insights suggest that achieving effective networks requires the simultaneous presence and balance of both functional

differentiation and functional integration. Integrating networks without a degree of differentiation is ineffective, as a combination of complementary tasks is necessary to achieve goals. Conversely, differentiated networks cannot attain effectiveness without the presence of integration mechanisms. These findings align with studies highlighting the value of heterogeneity in teams, organizations, and networks, while emphasizing that such diversity must be balanced with mechanisms that structure and coordinate activities (Corritore et al., 2020; Martínez-Alonso et al., 2022; B. Nooteboom et al., 2007; Tietschert et al., 2024).

The second configuration implies that network effectiveness can also be achieved through a combination of functional differentiation, functional integration, value differentiation, value integration at network level, and an NAO (i.e., all included conditions). Building on the first configuration, this suggests that, in addition to the combination of functional differentiation and functional integration, a normative-cognitive dimension may also play a crucial role in the effectiveness of networks: value differentiation and value integration. Our QCA results suggest that value differentiation among actors forms an important ingredient for network effectiveness, provided that (1) there is value integration: consensus among actors on collective values on the network level (condition no.5), and (2) there is an NAO (condition no. 3). These findings align with our previous research, which investigated a single case study (Zonneveld et al., 2024).

To better understand the two different configurations, the associated cases are examined in more detail below. Building on the findings, QCA's strength lies in its ability to revisit and closely examine individual cases, providing additional insights into network configurations. The first configuration (functional differentiation and functional integration) encompasses three curative care networks and one stroke network (CURA1, CURA2, CURA7, and STRO3), while the second configuration (which also adds value differentiation, value integration, and an NAO) includes three youth care networks and one curative care network (YOUTH2, YOUTH4, YOUTH5, and CURA5).

What differences can we observe between the interorganizational networks within these two configurations? The networks in the first configuration consist of actors with different tasks that need to be integrated. However, no significant differences among actor values have been identified. This can be explained by the nature of these networks, which primarily operate in medically oriented environments (oncology, stroke, paramedics, and brain injury). In these contexts, health outcomes are the primary concern for most actors, and the target group (older persons with a stroke)

is relatively homogeneous in terms of age and condition. Moreover, clear clinical guidelines and established standards of care provide shared reference points for what constitutes "good" care. The hospital, often a dominant and well-resourced actor, tends to coordinate or lead the collaboration. As a result, both the actor constellation and the target group are less differentiated, which reduces the likelihood of value conflicts among participating organizations.

The second group of cases, by contrast, focuses on topics that are less clearly defined and more multifaceted, such as youth care, which involves a heterogeneous group of children with diverse needs and is characterized by a wide range of perspectives and understandings. These cases also include a larger number of actors from various domains, engaging on a more equal footing within a horizontal relationship structure. This greater diversity of actors brings a wider range of values, opinions, and logics (Roth, 2025), resulting in networks characterized by higher normative complexity (H. Peeters et al., 2023). In the childbirth and pregnancy network (CURA5), which belongs to this group of cases, the value differentiation may stem from differences in visions and opinions between clinical obstetricians and primary care obstetricians. This finding aligns with insights from a previous in-depth case study (Zonneveld et al., 2024).



In addition to the differences between the cases regarding value differentiation, we observe that in the second configuration, this is accompanied by value integration and an NAO, alongside functional differentiation and functional integration. Examination of the data from the four relevant cases (YOUTH2, YOUTH4, YOUTH5, and CURA5) reveals that a separate network broker, manifested in a Network Administrative Organization, actively engages with value integration. In this way, aligning values at the network level serves as an integration mechanism. The separate network broker, affiliated with an NAO, plays a key role in establishing and maintaining these shared values while also recognizing value differentiation as an essential component for network effectiveness.

Several examples from the second group of cases illustrate the role of this separate network broker. For instance, the key informant of the 'YOUTH2' (youth care) network explicitly highlights the role of network values as an integration mechanism: "The shared vision and values ensured that it was the starting point. So… eventually, we had to bring all those people together for that assignment. Suddenly, you have all these new colleagues who all have to experience a new way of working. […] If we hadn't had that framework [of shared vision and values], I think it would have been even more daunting for those people. I think that was an accelerator and catalyst".

When discussing the role of the separate network broker in balancing actor-level value differentiation with network-level value integration, the key informant from the CURA5 network (focused on childbirth and pregnancy care) comments: "For me it is mainly about connecting, listening, taking things along, picking them up again and showing each other's perspectives." While the first quote highlights the role of the separate network broker, the key informant from the YOUTH5 network (focused on youth care) reflects more directly on the balance between actor-level value differentiation and network-level value integration: "Organizations large and small, their corporate culture plays a role in these forms of collaboration. […] Twice a year there is a kind of evaluation interview. Are we [as a network] still on the same shared track?".

An explanation for the importance of the separate network brokering role is that individual, autonomous actors within networks may find it challenging to discuss values with others, possibly because they lack independence and/or a comprehensive, 'helicopter view.' In contrast, independent network leaders performing the separate network brokering role, positioned 'above' the parties involved and working for a separate administrative entity (NAO), can maintain a broader perspective and formulate network-wide values. This perspective aligns with the earlier reflection that, in the case of value differentiation at the organizational level, (separate) network brokerage is essential for value integration, which, in turn, is crucial for achieving network effectiveness.

## Contributions to Theory

This study contributes to existing theory in several ways. Below, we elaborate on its contributions to (1) the broader understanding of organizing, (2) network governance, and (3) organization theory and healthcare.

First, our study contributes to organization theory by building on Puranam's (2018) framework of the four fundamental problems of organizing: task division and task allocation (both differentiation-related) as well as reward and information provision (both integration-related) (Kenis & Raab, 2020; Puranam, 2018). While these challenges have traditionally been conceptualized in terms of functional structures, focusing on how tasks, information, and rewards are allocated and integrated, our study adds a values dimension. We show that value differentiation, much like functional differentiation, requires integration mechanisms to maintain network effectiveness. However, unlike functional differentiation, which is often addressed through task-oriented coordination mechanisms, value differentiation necessitates relational forms of integration, such as shared sensemaking processes.

This distinction refines our understanding of how networks balance pluralism with coherence, particularly in complex, multi-stakeholder environments.

Existing theories on organizing cooperation among autonomous organizations have primarily emphasized integration-related and functional factors in explaining network effectiveness. Our study challenges and extends this perspective by demonstrating that differentiation and values play a central role in achieving network effectiveness. While our findings reaffirm Provan and Milward's (1995) model, particularly the necessity of functional integration—achieved through either density in smaller networks with shared governance or through centralization via a lead organization or NAO in larger networks—we extend this model in two key ways. First, we argue that effective networks require not only the integration of diverse tasks but also explicit attention to both functional and value differentiation. Second, when value differentiation exists, deliberate efforts toward value integration become necessary to ensure network effectiveness. By introducing a values perspective, we refine the scope of network effectiveness beyond structural and functional integration.



Second, our study advances existing theory on network governance by providing a more explicit account of how actor values influence how networks function and how governance can respond to value differentiation. While values are referenced in widely cited governance frameworks (Ansell & Gash, 2008; Emerson et al., 2012; Klijn & Koppenjan, 2015), these studies have largely conceptualized (shared) values as an underlying condition for collaboration rather than as an empirical question and explicit factor in network management or governance. Our findings demonstrate that value differentiation and integration are not peripheral concerns but play a fundamental role in achieving network effectiveness.

Specifically, when value differentiation is present at the actor level, network-level value integration becomes a necessary condition for effectiveness. Our results further show that network brokerage by a separate entity (NAO) is essential in contexts where actor-level value differentiation exists. In other words, network brokerage is not merely a coordinating function or role, but also a mechanism that facilitates value integration at the network level: a core task of the network broker that goes beyond process coordination. This implies that in networks characterized by value differentiation, governance forms with centralized external brokerage are more likely to be effective than decentralized structures.

This finding suggests that the NAO can play a key role in contributing to value integration, which may extend Provan and Kenis's (2008) modes of governance by highlighting how NAOs can respond to value differentiation within networks. Provan and Kenis (2008) identify three primary forms of network governance: (1) shared governance, in which decision-making is decentralized and relies on mutual trust and collaboration among network members; (2) lead organization, where a dominant organization assumes primary responsibility for coordination and direction, with other members playing supporting roles; and (3) Network Administrative Organization (NAO), where a separate administrative entity is established to oversee and facilitate network coordination. In their contingency framework, Provan and Kenis propose that the choice of a suitable governance mode depends on four factors: trust, number of participants, goal consensus, and the need for network-level competencies. Specifically, they argue that as trust becomes less evenly distributed, the number of participants increases, goal consensus declines, and network-level competency needs grow, centralized governance forms (e.g., NAOs and lead organizations) become more effective than shared governance.

Our study extends this contingency framework by identifying value differentiation as an additional contingency factor. Our findings suggest that when networks are characterized by value differentiation, shared governance structures may struggle to maintain coherence and alignment around values. In such cases, centralized network brokerage, particularly through an NAO, becomes a necessary condition for effectiveness. This insight refines and expands existing theory by demonstrating that, beyond functional and strategic considerations, the presence or absence of value differentiation fundamentally shapes the optimal governance structure of interorganizational networks.

Third, this study contributes to the dialogue at the intersection of organization theory and healthcare. It aligns with calls to utilize healthcare not merely as an applied field but as a rich empirical context for theorizing core organizational phenomena (DiBenigno & D'Aunno, 2024; Reay et al., 2021). By examining how interorganizational networks in healthcare and wellbeing navigate value differentiation, our research sheds light on mechanisms of organizing and governance in complex, pluralistic environments.

Building on the cross-level tradition exemplified by Provan and Milward (1995), and as highlighted in DiBenigno and D'Aunno's (2024) editorial, we employ both actor-level and network-level analysis across 24 networks. This multi-level empirical design responds directly to calls for more rigorous, multi-level research in healthcare

settings. Moreover, we introduce values as a novel analytical lens, extending previous work beyond structural or functional explanations of network effectiveness.

This approach resonates with prior studies that have leveraged healthcare to develop organization theory, for instance, Reay and Hinings' (2009) work on competing institutional logics, Kellogg's (2019) study of micro-level institutional change in hospital-based primary care, and Wiedner and Mantere's (2019) analysis of organizational separation in the English National Health Service (Kellogg, 2019; Reay & Hinings, 2009; Wiedner & Mantere, 2019).

At the same time, we contribute to healthcare scholarship by demonstrating how concepts from organization theory such as differentiation, integration, and network brokerage, offer analytic traction on persistent challenges in healthcare, and more specifically integrated care. Rather than treating value differences as problems, we show how network governance, especially brokerage by NAOs, can mediate and integrate competing values. This perspective offers a constructive, theory-informed lens for addressing fragmentation, professional silos, and institutional complexity: hallmarks of contemporary healthcare systems.



Taken together, these insights position our study as a bridge between healthcare and organization theory, showing how each domain can inform, refine, and deepen the other.

## Methodological Considerations and Limitations

From a QCA perspective, this study yields two methodologically relevant observations. First, the second configuration extends the first. One might ask: if the first configuration alone can lead to network effectiveness, why is a second configuration necessary? Second, the second configuration includes all conditions in the analysis, which is somewhat atypical for QCA, where configurations usually comprise only a subset of conditions sufficient for the outcome. Both methodological observations can be explained by the role of value differentiation in the second configuration. The combination of value integration and an NAO becomes critical only when actors hold different values. In cases without value differentiation, the first configuration suffices; when actors differ in values, this combination of conditions is necessary. In this sense, value integration combined with an NAO can be understood as a conditional response to value differentiation. This approach differs slightly from typical QCA, where conditions that are more independent are usually included.

Turning to the limitations of the study, two points are particularly noteworthy. First, network effectiveness was assessed using data drawn from documents, surveys, and interviews with key informants. To minimize potential bias, these data were independently reviewed by two researchers. However, it is important to acknowledge that effectiveness scores are based on stakeholders' perceptions, which may be shaped by their individual biases, roles, or vested interests. To mitigate these concerns, we triangulated the data across all three sources to achieve a more balanced and nuanced perspective. Furthermore, effectiveness was measured based on the specific goals of each network, which varied in terms of ambition, making direct comparisons challenging. Nevertheless, we aimed to minimize this issue by conducting independent assessments of the raw data. It is also possible that some respondents conflated process-related factors with the end goals of the network, as noted in prior research (R. Peeters et al., 2022). While this issue was partially addressed through follow-up questions during interviews, it remains a limitation to consider.

A second limitation is that our study examined 24 interorganizational networks at a single point in time, while networks and relationships are not static and evolve over time (Smith, 2020). Factors such as new actors, policy changes, or other developments may affect network conditions and outcomes. While we did not track the networks over time, we sought to mitigate this limitation by selecting a diverse sample of networks, varied in terms of sector, objectives, and actors. This diversity allowed for a broader and more comprehensive understanding of network dynamics at the time of the study.

## Future Research Directions

Future research is needed to further study and refine the theoretical insights developed in this paper.

First, the role of values in organizing opens several promising avenues for future research. Building on Puranam's (2018) work, scholars could further examine the interplay between value differentiation and functional differentiation across organizational forms. Future studies might investigate how different combinations of task and value diversity shape the demand for, and design of, integration mechanisms. This could involve comparative research across sectors, governance structures, or institutional contexts to determine under which conditions value integration becomes a critical driver of effective organizing.

Recent scholarship has already begun to explore how individual actors navigate governance networks (Van Duijn et al., 2021), and how sociodynamic mechanisms such as social comparison (Van der Weert et al., 2024), institutional logics (Roth, 2025), and behavioral dimensions (Saz-Carranza & Ospina, 2011) influence collaboration. Building on this, we encourage future research to investigate how the role of values is experienced and dealt with in everyday organizing (La Grouw et al., 2024; Van der Woerd, 2024). Ethnographic or practice-based studies, for example, could shed light on how actors make sense of and respond to competing values, and how organizations navigate, reconcile, or institutionalize these tensions in the course of routine collaboration.

A second promising direction for future research concerns the role of values in network governance. While widely cited frameworks in the governance literature acknowledge shared values as a background condition for collaboration (Ansell & Gash, 2008; Emerson et al., 2012; Klijn & Koppenjan, 2015), our study suggests that value differentiation is not merely a contextual variable but a key contingency that affects governance needs. Future research could further investigate how different governance modes respond to varying degrees and types of value differentiation, and whether certain forms such as the NAO, are better suited to facilitate value integration in specific contexts. Comparative studies of networks across sectors, institutional regimes, or policy domains could help identify when and why network brokerage becomes important.



Third, our findings invite scholars to revisit and refine Provan and Kenis's (2008) contingency framework (Van den Oord et al., 2023) by empirically testing value differentiation as an additional contingency, alongside trust, goal consensus, number of participants, and the need for network-level competencies. Such research would deepen our understanding of how governance structures mediate pluralism and enable coordination in increasingly complex, value-diverse interorganizational settings.

A fourth avenue for future research lies at the intersection of healthcare and organization studies. This study responds to recent calls to use healthcare not just as a site of application, but as a theoretically generative context for organizational research (DiBenigno & D'Aunno, 2024; Reay et al., 2021). Future research could further explore how the distinctive features of healthcare, its multi-level complexity, institutional pluralism, and persistent coordination challenges, can be leveraged to refine core organizational concepts such as governance, coordination, and integration. In particular, our cross-level analysis of 24 interorganizational networks

in healthcare and wellbeing, drawing on both actor-level and network-level data, demonstrates the potential of healthcare settings to generate new insights.

## Practical Recommendations

This study offers two key practical recommendations for practice and policy. First, we advise placing greater emphasis on understanding and mapping differentiation within interorganizational networks. Rather than treating differentiation as a problem to be eliminated, policy and decision makers should recognize that different forms of differentiation, whether functional (e.g., tasks, roles, activities) or value-related (e.g., beliefs, principles, standards of behavior), shape the kinds of integration mechanisms that are required for effective network functioning. Drawing on Klijn and Koppenjan's (2015) notion of 'creating substantive variety' in network management, we emphasize that fostering a diversity of perspectives, functions, and values can enhance a network's capacity to address complex, multi-faceted challenges. To do so, policy and decision makers should invest in understanding the composition of their networks: mapping the actors involved, their specific contributions, and the values they represent. This diagnostic effort enables targeted and strategic network governance interventions, identifying which combinations of actors are essential to achieving shared goals, and where alignment may be necessary. Importantly, while integration mechanisms remain crucial, these should not come at the expense of differentiation; rather, the challenge lies in balancing both forces.

Second, we recommend placing greater emphasis on values as a key element in the governance of networks. While values are often treated as implicit or background conditions for collaboration, our findings show that value differentiation is a fundamental feature of many networks, especially in complex domains like healthcare, and must be actively addressed. When value differences are left unattended, they could undermine coherence and progress toward shared goals. Therefore, individuals in a brokering role should take a proactive role in surfacing and mediating. This may involve creating spaces for reflective dialogue, fostering shared sensemaking, and embedding value-related considerations in governance practices. In contexts with pronounced value differences, the presence of a dedicated separate network broker working for an independent administrative entity such as an NAO, can be particularly valuable in facilitating value integration and supporting long-term effectiveness. Ultimately, cultivating a balance between value differentiation and integration can strengthen network cohesion while respecting the pluralism that gives networks their richness and relevance.

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# Appendix 6.1: Network actor questionnaire

## Part A: Functional integration and collaborative activities

When collaborating within a network, you may carry out various activities together, such as meetings, referrals, or coordination.

For each of the following four statements, please indicate the extent to which you agree or disagree on a 9-point scale (1 = strongly disagree, 9 = strongly agree).

1. Professionals have contact with professionals from other organizations in the network (e.g., face-to-face, email, meetings, etc.).

| Strongly Disagree | | | | | | | | Strongly Agree | Don't know |
|---|---|---|---|---|---|---|---|---|---|
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | |

2. Professionals from different organizations in the network know how to reach each other when referring clients or service users.

| Strongly Disagree | | | | | | | | Strongly Agree | Don't know |
|---|---|---|---|---|---|---|---|---|---|
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | |

3. There is coordination of care and/or support between the organizations in the network.

| Strongly Disagree | | | | | | | | Strongly Agree | Don't know |
|---|---|---|---|---|---|---|---|---|---|
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | |

4. Organizations in the network provide joint care and/or support together with other organizations.

| Strongly Disagree | | | | | | | | Strongly Agree | Don't know |
|---|---|---|---|---|---|---|---|---|---|
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | |

5. Which 3 organizations in the network do you collaborate with most intensively?

By this, we mean: which organizations do you most frequently carry out the activities listed in the table above?

Please type your answer in the field below.



**Part B: Value differentiation and integration**

When collaborating, you may consider different things to be important. For example, what you value in your work within your own organization, or what you consider important when collaborating with other organizations.

Below is a list of eighteen values ("what we consider important"). Please read the list carefully, and then click "Next."

Which 3 values do you consider most important in your own organization?
Which 3 values do you consider least important in your own organization?

| | |
|---|---|
| **Collaborative** | *Establishing and maintaining good (working) relationships between users, informal caregivers, professionals, and organizations—by working together across sectors, and in networks, teams, and communities.* |
| **Comprehensive** | *Users and informal caregivers are provided with a full range of care services and resources designed to meet their evolving needs and preferences.* |
| **Continuous** | *Services that are consistent, coherent, and connected, and that address users' needs across their life course.* |
| **Co-ordinated** | *Connection and alignment between users, informal caregivers, professionals, and organizations in the care chain, to reach a common focus matching the unique needs of the individual.* |
| **Co-produced** | *Engaging users, informal caregivers, and communities in the design, implementation, and improvement of services through partnerships, in collaboration with professionals and providers.* |
| **Effective** | *Ensuring that care is designed in such a way that outcomes serve health outcomes, costs, the user experience, and professionals' experience.* |
| **Efficient** | *Using resources as wisely as possible while avoiding duplication.* |
| **Empowering** | *Supporting people's ability and responsibility to build on their strengths, make their own decisions, and manage their own health, depending on their needs and capacities.* |
| **Flexible** | *Care that can change quickly and effectively, to respond to the unique, evolving needs of users and informal caregivers, in both professional teams and organizations.* |
| **Holistic** | *Putting users and informal caregivers at the center of a service that is "whole-person"-focused in terms of their physical, social, socioeconomical, biomedical, psychological, spiritual, and emotional needs.* |
| **Led by whole-systems thinking** | *Taking interrelatedness and interconnectedness into account, realizing changes in one part of the system can affect other parts.* |
| **Person-centered** | *Valuing people through establishing and maintaining personal contact and relationships, to ensure that services and communication are based on the unique situations of users and informal caregivers.* |
| **Preventive** | *Emphasizing the promotion of health and well-being and avoiding crises with timely detection and action, by and with users, informal caregivers, and communities.* |
| **Reciprocal** | *Care is based on interdependent relationships between users, informal caregivers, professionals, and providers, and it facilitates a cooperative, mutual exchange of knowledge, information and other resources.* |
| **Respectful** | *Treating people with respect and dignity, being aware of their experiences, feelings, perceptions, culture, and social circumstances.* |
| **Shared responsibility and accountability** | *The acknowledgment that multiple actors are responsible and accountable for the quality and outcomes of care, based on collective ownership of actions, goals and objectives, between users, informal caregivers, professionals, and providers.* |
| **Transparently shared** | *Transparently sharing of information, decisions, consequences, and results, between users, informal caregivers, professionals, providers, commissioners, funders, policymakers, and the public.* |
| **Trustful** | *Enabling mutual trust between users, informal caregivers, communities, professionals and organizations, in and across teams.* |

*Drag and drop the values into the boxes provided.*

## Part C: Experience of collaboration and goal achievement

We would also like to know how you experience the collaboration. Collaboration may run smoothly or less smoothly, and goals may sometimes be achieved and sometimes not.

For each of the following two statements, please indicate the extent to which you agree or disagree on a 9-point scale (1 = strongly disagree, 9 = strongly agree).

1. Collaboration among participants in the network works well.

| Strongly Disagree | | | | | | | | Strongly Agree | Don't know |
|---|---|---|---|---|---|---|---|---|---|
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | |

2. The network succeeds in achieving its shared goals.

| Strongly Disagree | | | | | | | | Strongly Agree | Don't know |
|---|---|---|---|---|---|---|---|---|---|
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | |

## Appendix 6.2: Interview guide key informants

*Part 1: Network characteristics: What are the characteristics of the included networks in terms of number of actors, governance form, and purpose (or task)?*

- What is the purpose or core task of the network?
- Which organizations participate in the network, how many are there, and how long have they been involved?
- How long has the network existed, and how has it developed over time?
- Can you describe your role or position within the network?

*Part 2: Differentiation: To what extent is there functional, structural, and normative differentiation among the actors in the included networks?*

Functional / structural:

- What roles and positions do the different organizations occupy within the network?
- What functions or activities do they perform?
- Are there differences between organizations in terms of their roles and positions, for example with regard to financial resources, size, or power?

Normative / values:

- Are you aware of what the different partner organizations consider important? If so, which values do you think guide the different partners at both the organizational level and the network level?
- Are there particular coalitions or groups of organizations that share similar views or values?

*Part 3: Integration: To what extent is there integration in the included networks, and how are collaboration among actors and the overall effectiveness of these networks assessed?*

Proxies related to questionnaire:

- Do the organizations in the network have regular contact with one another (e.g., face-to-face, email, meetings, etc.)?
- Do organizations know how to reach each other easily when referring patients or service users?
- Is there good coordination among the organizations in the network with regard to care delivery?
- Do organizations in the network regularly provide joint care and/or support together with other organizations?

Network effectiveness:

- How would you rate the collaboration among the actors within the care network?
- To what extent do you think the network succeeds in achieving its shared goal(s)?

*Part 4: Integration mechanisms: What activities are carried out to promote integration in the included networks?*

Functional / structural:

- How is the network organized?
- What coordination or meeting structures are in place?
- What type of governance model is used?
- How are decisions made?
- Who is responsible for what?

Normative / values:

- What is being done to support normative integration within the network?
- Has a collective network purpose been agreed upon? If so, what do you see as that network purpose?
- How are potential tensions or conflicts between values addressed?

About the network leader / broker:

- What activities does the network leader, coordinator or broker undertake to facilitate collaboration within the network?

# 7.

# Discussion

This dissertation adopted a relational and organization studies perspective on integrated care, understanding it as an organizational phenomenon shaped by interactions among interdependent actors. Despite a substantial body of work emphasizing the relational and collaborative nature of integrated care, it is commonly operationalized in instrumental terms, as project-based or policy-driven efforts to coordinate services. This research adopts a complementary premise: initiatives that pursue integrated care can be understood as collaborative relational endeavors unfolding within interorganizational networks. From this perspective, networks are not merely vehicles for implementing predefined interventions, but constellations in which actors, organizations, and individuals interact, negotiate, and collectively pursue purposes.

The central aim of this dissertation was to examine the role of values in such networks, and how values affect the effectiveness of integrated care. Rather than treating integrated care as a program, project, or method, this research foregrounded the actors, their values, and the relationships between them. The overall research question guiding this work was:

***What role do values play in care networks and how do they affect effectiveness in integrated care?***

Sub-questions were:

1. What values play a role in integrated care according to the existing literature?
2. What are the value orientations of actors in care networks, and how can similarities and differences in these orientations be explained?
3. How do individual values of actors and collective values at the network level manifest in care networks, what tensions arise, and how do actors address these tensions?
4. What combinations of conditions related to (value) differentiation and (value) integration are associated with network effectiveness?

As contemporary health and social care systems face mounting pressures, collaboration across organizational and sectoral boundaries is widely regarded as a necessary condition for more effective and sustainable care (Amelung et al., 2021; OECD/European Commission, 2024; World Health Organization, 2018, 2024). Yet despite decades of policy attention to collaboration and integration, most recently reaffirmed in the Integrated Care Agreement (IZA) in the Netherlands, many of these networks have so far struggled to deliver on their ambitious goals. While much emphasis is placed on processes and activities, and while new integration efforts

continue to be added, we still lack a clear understanding of the underlying relational and organizational mechanisms that explain why some networks succeed while others fail. This dissertation sought to address this gap by adopting values as an analytical lens to better understand interorganizational collaboration in integrated care.

To this end, the dissertation examined what values are considered relevant in both the literature and in practice; how values are expressed at the level of actors and networks; what tensions arise from value differentiation; and how such tensions are navigated. In addition, it explored how combinations of conditions relating to (value) differentiation, (value) integration, and governance modes, are associated with effective interorganizational networks in integrated care.

In the remainder of this Discussion chapter, I will first outline the main findings from the five studies conducted, as described in the preceding chapters. Second, I will discuss the implications of these findings, including how they address the main research question, how they relate to existing literature, and the theoretical contributions they offer. Third, I will provide recommendations for practitioners and policymakers. Subsequently, I will reflect on the methodology of this dissertation. This will be followed by a discussion of avenues for future research. I will conclude with a set of final remarks.



## 7.1 Main findings

The first study of this dissertation, a systematic review presented in Chapter 2, identified a cohesive set of 23 values relevant in integrated care, drawn from the existing literature. The international Delphi consensus study (Chapter 3), involving 33 integrated care experts from 13 countries, validated this set of values. The study consolidated the list from 23 to 18 values, each with descriptions and relevance scores corresponding to different levels of integration. These findings provided valuable insights into the multi-layered nature of integrated care as a concept. The set of values developed in Chapters 2 and 3 could serve as a normative basis of integrated care, representing a shared narrative about what the integrated care concept means, what it stands for, and what it should strive to achieve. Key values include 'holism,' 'co-production,' 'prevention,' and 'efficiency,' highlighting different aspects of integrated care.

In Chapter 4, an explorative cross-sectional study conducted across the WHO European region provided a quantitative analysis of value orientations among various actors in integrated care practice. While all 18 values were recognized as important by

the respondents, the study revealed significant differences in how actors prioritized and oriented themselves toward these values. In addition to the cohesive narrative highlighted in Chapters 2 and 3, Chapter 4 illuminated value differentiation among actors. Furthermore, the analysis identified two distinct clusters of values: one people-related and one governance- and organization-related. People-related values encompass principles such as 'empowerment', 'trust', and 'respect', while governance and organization-related values emphasize 'coordination', 'efficiency', and 'effectiveness'.

Building on this, Chapter 5 used an in-depth qualitative case study to examine how network-level values coexist with actor-level values, and how actor values may conflict with one another in practice. The study identified three specific value tensions among actors, gaining insight into value differentiation: (1) between the hospital and the primary care obstetrician practices, (2) between the primary care obstetrician practices and maternity care organizations, and (3) among the different primary care obstetrician practices. Additionally, it uncovered several coping strategies employed by the network broker (NAO) and the network actors themselves to address these tensions. Importantly, the study demonstrated that value differentiation also contributed to value creation for the end-users of the care network, in this case expecting and newly formed young families with a newborn. For example, clinical obstetricians (hospital) focus on pathology. Primary care emphasizes physiology and client relationships. Combined, these perspectives promote greater person-centeredness, a key network goal. While specifically joint births revealed value tensions between clinical (hospital) and primary care obstetricians, their values are also complementary. The findings indicate that value differentiation should not be considered solely as a source of tension; rather, it can also be understood as a critical condition contributing to the achievement of network objectives.

Lastly, Chapter 6 explores how actor-level values and network-level values manifest in practice, and what their interaction means for network effectiveness. It presents a configurational study using Crisp-set Qualitative Comparative Analysis (csQCA) based on data from 24 care networks pursuing integrated care. This study examined combinations of conditions related to differentiation and integration that are associated with network effectiveness. The findings revealed that achieving effectiveness in care networks requires a nuanced balance between differentiation and integration. In some cases, a functional balance between these dimensions is sufficient. However, in cases where value differentiation is pronounced, value integration at the network level, facilitated by a network broker, becomes essential.

## 7.2 Theoretical implications and contributions

This dissertation makes several theoretical contributions to the study of integrated care and interorganizational networks. Drawing on the organization studies perspective adopted throughout this dissertation, it develops a more nuanced understanding of how integration and differentiation function as interdependent dimensions in care networks, and positions values as a central analytical lens. In doing so, it goes beyond structural and functional perspectives on interorganizational networks, highlighting their normative and relational dimensions, particularly through the lens of values.

The findings demonstrate that actors involved in integrated care often prioritize values differently, with patterns that may relate to their professional, organizational, or educational backgrounds. Moreover, Chapter 3 shows that value differentiation is not limited to actors but also varies across levels of integration. While some values appeared consistently across personal, professional, managerial, and system levels, others were clearly level specific. Such value differentiation has profound implications for how connections are formed, how collaboration unfolds, and how actors relate to one another across levels, and ultimately how effectiveness is achieved within networks. This perspective highlights that values are not merely background assumptions or abstract ideals, but can shape problem framings, definitions of success, and the collaborative processes through which actors work together.



Taken together, the results of this dissertation contribute to theory in four ways that build on each other. First, they illuminate the significance of adopting a values perspective in the study of integrated care and interorganizational networks. Second, they challenge the dominance of integration, evident in practice, policy, and both integrated care and network literature, by highlighting the valuable role of differentiation. Third, enrich understanding of network effectiveness by demonstrating how both differentiation and integration of values, alongside functional and structural dimensions, influence its achievement and interpretation, highlighting the need for a configurational, multi-level approach. Fourth, they advance understanding of governance of interorganizational networks, with particular attention to brokerage and the role of the Network Administrative Organization (NAO). In the sections that follow, I examine each contribution in turn, starting with how a values perspective enhances our understanding of integrated care and interorganizational networks.

## A values perspective on integrated care and interorganizational networks

This dissertation set out to explore what values play a role in integrated care and how they manifest in interorganizational care networks. Values were defined as "*meaningful beliefs, principles or standards of behavior, referring to desirable goals that motivate action*" (Hitlin & Piliavin, 2004; Schwartz, 2012), and hence are understood here as normative and motivational constructs. By adopting this definition, the study approached values not as abstract ideals, but as elements that shape how actors think, what they care about, and how they act. Adopting an organization studies perspective, the dissertation focused on actors' value orientations and how these affect collaboration within interorganizational care networks.

The empirical findings of this dissertation show that actors from different organizations and professions bring their own value orientations into interorganizational networks. Chapters 2 and 3 identified a common set of values associated with integrated care, such as coordinated, efficient, and effective, as well as trustful, holistic, and respectful. This common set was used as an analytical lens in subsequent chapters. Chapter 4, based on a large quantitative cross-sectional study, revealed variation in value prioritization across professional roles and geographical backgrounds, and identified two distinct clusters of values: one people-related and one governance- and organization-related. Chapter 5 illustrated similar differences between various types of professionals, often coming from different organizations. Moreover, especially Chapters 5 and 6 show how these values affect collaboration in interorganizational networks: both by being different (through differentiation) and by enabling connection (through integration) between actors. Chapter 6 demonstrates that values thereby ultimately also affect network effectiveness. This positions values not just as background beliefs, but as an active and consequential dimension of collaboration in interorganizational networks.

When positioning these findings within the existing literature, I focus on three aspects: first, how the empirical results can be interpreted in light of the literature on values; second, how values are addressed in the existing literature on integrated care and the contributions of this dissertation to that field; and third, the specific implications of the findings for understanding interorganizational networks.

### *Interpreting empirical findings through values theory*

The first question concerns how the empirical findings of this study can be explained through existing literature on values. This stream of literature identifies a broad variety of sources from which values originate and also highlights their evolving and dynamic nature. Values may be shaped at (1) the individual level (through personal

experience and upbringing), (2) within professions (through training, codes of conduct, and shared norms), (3) within organizations (through mission, culture, and governance), and (4) within broader societal or cultural contexts. Furthermore, once formed, these values are not static but evolve through ongoing experiences, processes of professional and organizational socialization, and exposure to different institutional environments (Clark, 1997; Connor & Becker, 2003; Fung et al., 2016; Gibson et al., 2009; Kalleberg & Marsden, 2019; Moyo et al., 2016; Poorchangizi et al., 2019; Rokeach, 2008; Roth, 2025; Scholtens & Dam, 2007; Sellman, 2011; Wright et al., 2021; Yarbrough et al., 2017).

Because of their intangible nature, values are both conceptually and empirically challenging to study. They are often deeply embedded in context, not always directly observable, and sometimes taken for granted. In the care networks examined in Chapters 5 and 6, values operated both in the *background* (embedded in language, documents, and behavior) and *explicitly* (invoked in policy statements, mission documents, or moments of tension). Some values appeared relatively fixed or institutionalized, such as professional ethics, while others shifted across contexts and over time.



Defining values precisely and distinguishing them from related constructs such as interests, norms, or preferences is analytically challenging (March & Olsen, 2010; Rokeach, 2008; Schwartz, 2012). Empirical observations in this dissertation frequently revealed possible overlaps between normative commitments and strategic concerns. For example, when actors advocated for a specific value, it was not always completely clear whether this reflected a principled commitment, strategic positioning, or a combination of both. In some networks, actors were largely unaware of the normative foundations guiding their work, or took them for granted, so that values remained implicit and unspoken. Rather than being consciously articulated or critically examined, values operated unnoticed, unspoken, and unquestioned.

This dynamic nature of values is crucial for understanding their role in collaboration: actors in interorganizational networks bring layered and evolving value orientations shaped by their backgrounds and experiences. This was evident in the empirical work of this dissertation: Chapter 4 showed that stakeholder groups (users and informal carers, professionals, policymakers, researchers) prioritize values differently, while Chapter 5 illustrated similar differences among professional groups from different organizations, such as primary care obstetricians, clinical obstetricians, maternity nurses, and sonographers. Both Chapters 5 and 6 illustrated how these differences affected collaboration and ultimately network effectiveness. This suggests that

collaboration in interorganizational networks is shaped not only by formal roles or structural arrangements, but by the interplay of diverse and evolving value orientations of actors, which are enacted, confronted, and negotiated within ongoing interorganizational relationships.

***Values in integrated care theory: limited conceptual attention***

However, second, when looking at the integrated care literature, there is limited attention to values. Much of this work focuses primarily on structural and technical aspects of organizing integrated care, often emphasizing concrete aspects such as case management (Hudon et al., 2020; Stokes et al., 2015), payment models (Stokes et al., 2018; Tsiachristas, 2016), information technology (Cameron et al., 2014; Steele Gray, 2021), or implementation (Breton et al., 2019; González-Ortiz et al., 2018; Harnett et al., 2020; Wodchis et al., 2018).

While these elements are undeniably important, this focus tends to obscure the underlying values of actors that shape how integrated care is enacted in network practice. When values are mentioned in this stream of literature, they are often not elaborated with precision or are assumed to be inherently shared, as in the Rainbow Model of Integrated Care (RMIC), which refers to normative integration as *"coordination mechanisms based on shared values"* (Valentijn, 2015) without elaborating on how such sharedness emerges or is sustained in practice. In his article *"Taking integrated care forward: the need for shared values"*, Goodwin (2013a) similarly emphasizes the importance of shared values as a foundation for effective collaboration among diverse professionals and organizations. His perspective assumes that these values are or should be shared, particularly around ideals such as person-centeredness, equity, and mutual respect, as a prerequisite for successful integrated care (Goodwin, 2013a). These values were also identified in Chapters 2 and 3 of this dissertation. The findings presented in Chapters 4, 5, and 6 show that such values are not self-evidently shared, but rather differ (Chapter 4), and may clash as well as complement each other (Chapters 5 and 6).

This dissertation makes a theoretical contribution in this field by addressing the insufficient attention given to values as a critical yet underexplored dimension of integrated care. Viewed through a relational perspective, actors' value orientations become relevant to understanding how collaboration unfolds. Actors are not neutral vessels fulfilling predefined roles; they carry convictions, care about certain ideals or beliefs, and act accordingly. These values may influence not only individual behavior and interaction patterns, but also how networks as a whole function, adapt, and produce, or fail to produce, desired outcomes.

This perspective aligns with recent work by Van der Woerd (2024) and La Grouw et al. (2024), who examine how collaboration in networks is shaped through actors' everyday interactions and relationships. La Grouw et al. introduce the concept of *mundane dynamics* here. In this context, values may be continually enacted and re-enacted through everyday framing, positioning practices, and informal interactions: shaping how collaboration unfolds in practice. Values are not static principles but are constantly being negotiated in small-scale routines. Such everyday dynamics reveal how networks work. Not only because of formal agreements or shared ideals, but because of the subtle, ongoing practices through which values are lived and performed.

***Values in interorganizational networks: differentiation and integration***

Third, these insights into values have specific implications for analyzing interorganizational networks, as opposed to single organizations. A key question, then, is what distinguishes interorganizational networks from individual organizations when it comes to values. In single organizations, processes of socialization may align norms and values (Houle et al., 2025; Kraimer, 1997; Kristof-Brown & Guay, 2011). In interorganizational networks, however, this is not so straightforward because these networks consist of actors from different organizations who interact, often without a clear hierarchy.



Considerable research has examined how single organizations evolve into internally coherent, relatively homogeneous entities over time. Attraction–Selection–Attrition (ASA) theory, for example, explains how organizations reinforce internal value homogeneity while maintaining heterogeneity between organizations (Oh et al., 2018). Similarly, theories of normative isomorphism (DiMaggio & Powell, 1983) and homophily (Granovetter, 1973; McPherson et al., 2001) account for how shared educational and institutional experiences consolidate internal value orientations within organizations.

In interorganizational networks, however, these diverse organizational 'value DNAs' from different actors and from multiple organizations converge, adding an additional level of complexity beyond teams within single organizations. Rather than being problematic, this heterogeneity can become an asset if governed consciously, as also illustrated in Chapter 6. Research has shown that single organizations capable of managing both homogeneity and heterogeneity are better able to adapt and perform (McMillan-Capehart, 2006). Interorganizational networks bring together such diversity to address complex challenges that individual organizations alone cannot address.

At the same time, this dissertation shows that interorganizational networks are not only arenas of value differentiation, but also contexts in which values may become integrated at the network level. This raises the question of the extent to which values can be shaped, enacted, and reinforced at the interorganizational network level, in addition to sources such as personal experience, professional training, organizational cultures, or broader societal contexts.

The empirical findings indicate that such network-level value integration does indeed occur. Chapter 5, for example, identifies a range of coping strategies through which actors address value tensions at the organizational level. These strategies, which support value integration on the network level, operate both in interactions among individual actors and by the network administrative organization. Strategies include jointly developing a collective vision and mission, formulating network-wide policies, and deliberately facilitating dialogue about shared values. In addition, processes of network brokerage and orchestration play an important role in shaping and sustaining network-level value orientations across organizational boundaries, a topic that will be discussed more explicitly later in this chapter.

Together, these findings suggest that interorganizational networks can develop overarching value orientations that help coordinate action among diverse actors. Chapter 6 further highlights the essential role of network-level value integration for network effectiveness. Importantly, such integration does not imply full consensus or the elimination of value differences at the organizational or professional level. Rather, it provides a shared normative reference that enables collaboration in the presence of enduring value plurality. In this sense, interorganizational networks may exert a socializing effect, reinforcing or rearticulating values through ongoing interaction among actors.

Having explored how values manifest in care networks and how they are shaped at the network level, this dissertation has shown that interorganizational networks are not only settings where values from different organizations come together but also where shared value orientations can be shaped. The next section turns to value differentiation. It examines the diversity of values across organizations and explores why this diversity matters.

## From integration as ideal to differentiation as condition

This dissertation began by exploring values in interorganizational care networks. Chapter 2 identified values commonly associated with integrated care in the literature, such as continuity, person-centeredness, collaboration, and trust. Not

only as guiding principles but as normative building blocks of what integrated care aspires to be. The Delphi study in Chapter 3 resulted in international expert consensus on a core set of values. This conceptual foundation served as an analytical lens for the empirical studies presented in Chapters 4, 5, and 6.

As the research progressed, however, the perspective gradually shifted: from identifying a core set of values toward recognizing the presence and significance of value differentiation, the idea that different actors may prioritize different values. Chapter 4, based on a cross-sectional study involving 1,013 respondents across 42 countries in the WHO European Region, revealed significant variation in how different stakeholders prioritized values. Rather than confirming a universal set of values, the study highlighted value differentiation: the presence of plural value orientations across stakeholder groups.

Chapter 5 deepened this insight through an in-depth case study of a Dutch maternity care network. Here, value differentiation became even more visible, manifesting between professional groups and organizations. Crucially, the study found that this differentiation was not a problematic barrier to be overcome. While it created friction and tension, it also functioned as a generative force contributing to the realization of network goals and, ultimately, value creation.



Chapter 6 brought these threads together by examining 24 networks through a configurational analysis. This analysis revealed that network effectiveness is not driven by integration alone but results from an appropriate balance between integration and differentiation. Across the dissertation, the conceptual stance shifted from viewing integration as the normative ideal to understanding integration and differentiation as mutually constitutive processes that are both essential to interorganizational network functioning.

***The dominance of integration in integrated care and networks***

In policy, practice and research of integrated care, the dominant focus has long been on integration: the process of aligning and connecting professionals, services, and organizations. This emphasis is inherent in the term *integrated care*, which presupposes a goal of bringing parts together (Amelung et al., 2021). It is also reflected in influential frameworks such as the Rainbow Model of Integrated Care (Valentijn, 2015) which promotes integration across multiple levels: the clinical, professional, organizational, and system level.

Much of the existing integrated care literature examines how integration can be achieved. For example, by identifying facilitators and barriers (L. A. Nooteboom et al., 2021), or by analyzing how organizational culture or network structure facilitate integration (Tietschert et al., 2019; Van der Weert et al., 2022). Numerous models, frameworks, and implementation guides have been developed to support this integration process (R. Axelsson & Axelsson, 2006; Harnett et al., 2020; Minkman et al., 2025).

Similarly, in the literature on collaboration in interorganizational networks, numerous studies have investigated functional, structural and contextual factors enhancing integration (Bryson et al., 2015; Human & Provan, 2000; Nowell & Kenis, 2019; Raab et al., 2015; Shumate et al., 2023; Turrini et al., 2009). Specific examples are influential articles on integrative features such as central coordination, dense interconnections (Provan & Milward, 1995) and governance modes (Provan & Kenis, 2008). A recent review by Peeters et al. (2022) underscores this emphasis, by identifying 283 determinants of network effectiveness, most of which focus on integration.

The theoretical contribution of this dissertation lies in advancing both a shift in logic and a deeper understanding of how interorganizational networks function in the context of integrated care. Rather than viewing integration as the primary challenge, equal attention should be paid to differentiation. In doing so, this dissertation also contributes to a reconceptualization of integration: not as the normative end-state, but as a dynamic process that is influenced by differentiation. Differentiation and integration are mutually interdependent mechanisms, continuously influencing one another, and effective network functioning requires balancing the two. Differentiation should not be seen merely as a contextual starting point, but as a fundamental dimension of interorganizational networks.

This entails asking: *Which kinds of actors and perspectives are needed to address the specific issue at hand?* and *What types of expertise, knowledge, and values should be mobilized?* Differentiation, in this view, includes not only functional and structural diversity (e.g., roles and tasks), but also diverse ideas, perspectives, and values. By embracing such heterogeneity, networks are able to approach their objectives in novel ways, enabling more effective collaboration and problem-solving.

***Why differentiation matters***

Why is it important to take differentiation into account? Chapters 5 and 6 show that networks dealing with complex societal issues, such as youth care, require high

degrees of differentiation. These networks span sectors, professional domains, and organizational cultures. While this heterogeneity increases the difficulty of integration, it also expands the network's problem-solving capacity. To navigate this complexity, mechanisms such as network orchestration (Chapter 5) and brokerage through a Network Administrative Organization (NAO) (Chapter 6) become vital. The central challenge, then, is not achieving maximal integration, but balancing differentiation and integration in relation to the network's goals and context.

Importantly, Chapter 6 demonstrates that networks with insufficient differentiation may struggle to be effective, for example not being able to generate novel approaches or outcomes. Excessive homogeneity may stifle innovation, limit interpretive flexibility, and reinforce status-quo thinking (McMillan-Capehart, 2006; McPherson et al., 2001; Oh et al., 2018). Thus, rather than viewing a maximum degree of integration as the ultimate aim, interorganizational networks should start from the complexity of the problem and build the necessary heterogeneity to address it. Integration mechanisms should then follow to ensure alignment without suppressing pluralism.

These findings resonate with and extend insights from organization studies. Classic work by Lawrence and Lorsch (1967) emphasized that differentiation and integration are interdependent processes within organizations. More recently, scholars such as Puranam (2018) and Raab and Kenis (2020) have applied similar reasoning to interorganizational settings. These studies argue that interorganizational networks, like organizations, must differentiate to accommodate diverse roles, expertise, and perspectives, while simultaneously integrating to ensure coordination and coherence (Kenis & Raab, 2020; Lawrence & Lorsch, 1967; Puranam, 2018; Puranam et al., 2014). In network management literature this is mentioned as enhancing *"substantive variety substantive variety to broaden the space within which solutions are sought"* (Klijn & Koppenjan, 2015, p. 102).



***Value differentiation: an additional condition***

In addition to emphasizing the importance of differentiation in general, this dissertation makes a specific theoretical contribution by further developing and integrating the concept of value differentiation into the existing literature. By adding a values-based perspective, it shows how value differentiation, beyond structural or functional differentiation, affects effective collaboration. In this dissertation, I define value differentiation as *"Different value orientations of actors within a network"*. Rather than being mere background assumptions or abstract ideals, values form an active layer of differentiation that shapes how actors frame problems, define success, and engage in collaboration. While prior studies have focused on differentiation in

terms of tasks, goals, or knowledge domains, this research highlights values as a distinct and underexplored source of both complexity and productive potential in interorganizational networks.

This insight resonates with literature that acknowledges value differentiation. Jones (2022) argues that to fulfill the collaborative aims of health systems, policy evaluation must begin with a values inquiry: identifying what matters to diverse stakeholders, including policymakers, practitioners, patients, and communities. Oldenhof et al. (2025) contend that complexity in healthcare is fundamentally normative. They suggest that value differentiation should not be suppressed but constructively engaged through reflexive management and governance. Recent research by Kuitert et al. (2024) also emphasizes this "wickedness" of combined value systems in organizations. Complementing these perspectives. Roth, Vakkuri, and Johanson (2024) provide empirical evidence from a social and healthcare innovation ecosystem, demonstrating how actors navigate value diversity through mixing, compromising, and legitimizing mechanisms. These processes illustrate how value differentiation can be productively managed: values are combined, conflicts are reconciled, and legitimacy is maintained, reinforcing the idea that normative plurality, when actively engaged, is a strategic resource rather than a liability. Collectively, these studies underscore the complexity of different values in organizing and highlight the potential benefits of consciously attending to value diversity.

Recent work on organizational culture heterogeneity argues that variation in normative orientations, rather than consensus alone, can contribute to positive outcomes. For example, Tietschert et al. (2024) demonstrate that cultural heterogeneity within healthcare teams is positively associated with perceived care quality and employee retention, up to a point. Their findings reveal a curvilinear relationship, where moderate levels of internal diversity can be beneficial, while excessive divergence may lead to fragmentation. Although studied in one autonomous organization, such insights reinforce the idea that normative plurality, when consciously addressed, can also be a productive resource rather than a liability.

Nooteboom et al. (2007) similarly argue that “cognitive distance” between collaborating actors should be neither too small nor too large: moderate differences optimize absorptive capacity and innovation, while excessive distance hampers coordination. Similarly, value differentiation in interorganizational networks may enhance creativity and responsiveness, but only if paired with mechanisms to address this normative diversity. This underscores the need for a balance between differentiation and integration, not only in knowledge and roles but also in values.

This resonates with Van Duijn's (2022) argument that "integration needs differentiation," and that tensions can be productive. However, such productivity requires that actors at multiple levels continuously "tinker with tensions", negotiating rather than eliminating tensions (Van Duijn, 2022). Differentiation enables interorganizational networks to mobilize specialized knowledge, local capacities, different values and viewpoints. Without it, networks risk reducing complex problems to overly simplified solutions. Yet, differentiation without integration can result in fragmentation: a loosely connected assembly of actors with limited collective capacity. This balance is especially critical when addressing nowadays complex issues which inherently require multiple forms of knowledge, legitimacy, and problem framings.

These insights from different streams of literature raise the question of how functional differentiation (the division and allocation of tasks) relates to value differentiation (the differing value orientations of actors within a network). Drawing on the discussions above, it becomes apparent that values are shaped within professional, organizational, and broader societal contexts. From this perspective, functional differentiation may reinforce value differentiation: as tasks are divided and allocated across actors embedded in distinct organizational or professional contexts, their differing value orientations may be amplified. Conversely, value differentiation may also influence functional differentiation, as networks could strategically assign tasks to actors whose value orientations align with specific functions or goals. Theories such as normative isomorphism normative isomorphism (DiMaggio & Powell, 1983) and homophily (Granovetter, 1973; McPherson et al., 2001) suggest mechanisms through which these processes might unfold, emphasizing the role of socialization, institutional pressures, and network ties in shaping both values and task allocation. Taken together, these reflections highlight a potentially dynamic and bidirectional interplay between functional and value differentiation, with important implications for how interorganizational network effectiveness is understood.



## Network effectiveness as a configurational outcome of integration and differentiation

Building on the insight that differentiation and integration are dynamically intertwined, this dissertation has not only examined how values manifest in interorganizational care networks, but also how differentiation and integration of values relate to network effectiveness. This raises important conceptual questions about how network effectiveness should be understood and theorized when multiple value orientations coexist. At the same time, it raises a societally relevant question, as care networks are increasingly expected to address complex public problems

(Ministerie van Volksgezondheid, Welzijn en Sport, 2022; R. Peeters, 2025; Van der Weert, 2024; Van der Woerd, 2024).

In studying network effectiveness in Chapter 6, a configurational approach was adopted, examining combinations of conditions that jointly lead to an outcome. The analysis revealed two pathways towards network effectiveness. The first pathway consisted of the combination of functional differentiation and functional integration, in the absence of value differentiation or value integration, leading to network effectiveness. This suggests that achieving effectiveness requires a balance between functional differentiation and functional integration: functional integration without functional differentiation would be ineffective, as complementarity is necessary to achieve network goals. Conversely, functional differentiation without integration would risk fragmentation. This first pathway represents interorganizational networks in which actors performed different tasks requiring coordination, but where no value differentiation was observed.

The second pathway incorporated a values perspective. It was primarily composed of networks with more pronounced value differences among the actors, and consisted of a combination of functional differentiation, functional integration, value differentiation, value integration at the network level, and the presence of a Network Administrative Organization (NAO). This can be seen as an extension of the first pathway: in addition to the combination of functional differentiation and functional integration, values also played a role in the form of value differentiation and value integration. The results demonstrate that value differentiation can be an important factor in achieving network effectiveness, provided that it is accompanied by value integration and supported by network brokerage, in this case, in the form of an NAO. These findings suggest that understanding network effectiveness requires looking at both integration and differentiation, and considering not only functional and structural dimensions but also value dimensions.

***Actor-level differentiation and network-level integration***

In this dissertation, I have examined value differentiation primarily at the actor level, reflecting differences in value orientations among individual actors, organizations, or professional groups. By contrast, value integration occurs at the network level, enabling coordinated action and shared purpose. Chapters 5 and 6 illustrate how these mechanisms interact across levels: actor-level differentiation can coexist with network-level integration, and this coexistence can even be productive. For example, professionals from primary, secondary, and social care may hold different perspectives or priorities about delivering care (actor-level value differentiation).

These differences do not necessarily hinder collaboration; they can be productive when the network simultaneously maintains commonly accepted standards of behavior and collective beliefs about desirable outcomes (network-level value integration). Recognizing these multi-level dynamics is essential for understanding how interorganizational networks achieve effectiveness in practice, as it highlights that a configurational approach must account for how conditions operate and interact across multiple levels to produce effective outcomes.

***Network effectiveness: a configurational perspective***

Rather than treating values as background conditions, this dissertation conceptualizes value differentiation and value integration as integral elements within configurations that produce network effectiveness. The concept of network effectiveness has been well examined in the interorganizational network literature, with influential contributions by Provan and Milward (1995, 2001), Turrini et al. (2009), and Kenis and Provan (2009). These works conceptualize effectiveness at multiple levels: community, network, and participant, and across multiple dimensions, such as goal achievement, sustainability, and legitimacy. Other contributions have broadened the field by including process-oriented and contextual factors such as system stability, resource munificence, and learning (Kenis & Provan, 2009; Li & Zhang, 2025; Provan & Milward, 1995; Raab et al., 2015; Shumate et al., 2023; Turrini et al., 2009).



However, the dominant analytical focus in this literature remains on structural and process determinants of effectiveness, such as governance mode, network density, size, age, and network management (Bryson et al., 2015; Koppenjan & Klijn, 2004; Li & Zhang, 2025; R. Peeters et al., 2022; Provan & Kenis, 2008; Turrini et al., 2009). Some of these works acknowledge cognitive and normative aspects indirectly, for example through constructs such as goal consensus or shared vision. Few studies explicitly examine the role of values as independent conditions for network effectiveness. As a result, the capacity of networks to navigate normative diversity remains under-theorized in much of the effectiveness literature.

This dissertation contributes to the theory of network effectiveness in two ways. First, it explicitly positions values as integral to the conditions that affect effectiveness. Rather than assuming that shared values are always beneficial (Ansell & Gash, 2008), the findings demonstrate that value differentiation can enhance effectiveness when it is balanced with value integration and supported by appropriate governance.

Second, it confirms that network effectiveness is contextually contingent and emergent: what constitutes effectiveness, and how it is achieved, depends on the

interplay of contextual, structural, functional, relational, and value conditions. This challenges linear assumptions that more integration automatically leads to higher effectiveness and aligns with complexity-oriented perspectives that view collaborative performance as the product of adaptive balancing between integration and differentiation. It also responds to calls for more configurational approaches to network evaluation (R. Peeters et al., 2022). Approaches that look at combinations of conditions rather than linear effects. In doing so, we join a growing stream of empirical studies that aim to unpack what works, for whom, and under what conditions (Fiss, 2011; Li & Zhang, 2025; Raab et al., 2015; Ragin, 2014; Shumate et al., 2023; Verweij et al., 2013).

***Conceptual challenges in theorizing network effectiveness***

In Chapter 6, while studying network effectiveness, I encountered several conceptual challenges that shaped our understanding of how effectiveness is experienced and assessed in interorganizational care networks. A key challenge in conceptualizing network effectiveness lies in its interpretive nature. Given the complexity of integrated care networks (Michgelsen et al., 2023; Wankah et al., 2020), assessments of effectiveness often rely on participants' perceptions of progress toward jointly formulated goals. While such self-reports offer valuable insight into how network outcomes are experienced internally, they also raise important theoretical questions: To what extent should perceived effectiveness be taken at face value, and to what extent does it reflect strategic optimism, social desirability, or "window dressing"?

Interestingly, despite prior evidence suggesting that executive assessments of network performance are prone to bias (Khodyakov et al., 2021), our findings in Chapter 6 revealed limited evidence of overly positive self-evaluation. Many respondents candidly reported that their networks were not yet effective, indicating a degree of critical self-awareness that strengthens the credibility of these assessments. This underscores a key theoretical point: perceived effectiveness can be a meaningful indicator, but only when interpreted in relation to goal specificity, ambition, and the developmental stage of the network (R. Peeters et al., 2022; Turrini et al., 2009).

A further theoretical nuance concerns the dynamic and incremental nature of network development (Van der Woerd, 2024). Networks vary widely in the ambition and scope of their goals: some focus on modest, tangible outcomes, while others pursue long-term, transformative objectives. Effectiveness, therefore, may not always be an absolute condition but sometimes also a judgment, contingent on what a network sets out to achieve and how progress is understood in context.

Finally, our analysis highlights the frequent conflation of process quality with substantive goal attainment. Participants often equated improved collaboration, smoother communication, growing trust, or better meetings, with network success. In Chapter 6, we distinguished process satisfaction from tangible outcomes, operationalizing effectiveness as visible, practice-level change aligned with the network's stated goals, rather than merely positive interpersonal experiences. This distinction has theoretical significance: it challenges the literature's tendency to use integration or processual quality as proxies for effectiveness and emphasizes that collaborative performance must be assessed through both relational and outcome-oriented lenses (R. Peeters et al., 2022).

Together, these reflections suggest that network effectiveness is inherently context-dependent, interpretive, and multidimensional. Conceptualizing requires attention not only to structural and relational conditions but also to how goals are defined, perceived, and enacted in practice, providing a more nuanced theoretical understanding of what constitutes effective interorganizational collaboration in integrated care networks. These insights raise a further question: if effectiveness emerges from balancing differentiation and integration, and value orientations actively shape network dynamics, how can governance support this balancing act in practice?



## Governance of networks: enabling value differentiation and integration through brokerage

Building on the insight that network effectiveness emerges from balancing differentiation and integration, including value differentiation, this raises a practical and theoretical question: how can governance in interorganizational networks support the productive navigation of these tensions?

This dissertation shows that network brokerage is a central factor in mediating the balance between value differentiation and value integration. Findings from Chapter 6 indicate that interorganizational networks characterized by value differentiation are more likely to be effective when value integration is actively supported, in combination with a Network Administrative Organization (NAO). The NAO thus functions not only as a coordinating entity but also as a mechanism that facilitates value integration across the network, while not erasing value differentiation. The qualitative case study in Chapter 5 provided in-depth insights into how a network orchestrator within an independent NAO actively navigated and balanced value differentiation and value integration in practice, shaping interactions, decision-making, and collaborative processes. Taken together, these findings underscore

the central role of network brokerage in enabling value differentiation and value integration to combine productively.

***Why the NAO is effective in addressing value differentiation***

Let me now turn to what these findings imply for our understanding of the governance of interorganizational networks, and for the role of the NAO in networks where value differentiation is present. In this dissertation, I have approached governance as

> *"the use of institutions and structures of authority and collaboration to allocate resources and to coordinate and control joint action across the network as a whole"* (Provan & Kenis, 2008, p. 231)

Provan and Kenis (2008) distinguish three modes of network governance, based on two key dimensions. The first concerns whether network governance is brokered or not. At one end of the spectrum, governance is fully self-managed through the interactions among the organizations in the network, resulting in a highly decentralized form of governance. This is referred to as *shared governance*. At the other end, governance is highly brokered, with a centralized broker assuming control. In such arrangements, apart from day-to-day operational interactions, organizations have little direct contact with each other, and governance responsibilities are vested in a single organization.

The second dimension concerns whether governance is carried out by internal participants or by an external entity. When the participating organizations collectively govern the network, this again constitutes *shared governance*. Alternatively, a single participating organization may assume a leading role in governing the network, creating a *lead organization governed network*. Finally, governance may be externalized to a *Network Administrative Organization* (NAO), which can be established by the participating organizations themselves. The authors note that an NAO could also consist of only of a single person, that could be referred to as a network facilitator or broker.

Furthermore, Provan and Kenis (2008) propose a contingency model to guide such decisions. In their framework, the choice of a suitable governance mode depends on four contingency factors: trust, number of participants, goal consensus, and the need for network-level competencies. They argue that as trust becomes less evenly distributed, the number of participants increases, goal consensus declines, and the need for network-level competencies grows, more centralized forms of governance,

such as NAOs, and to a lesser extent lead organizations, become more effective than highly decentralized shared governance.

Findings from this dissertation indicate that, in contexts where value differentiation is pronounced, the NAO is particularly effective. This raises an important question: why does the NAO work so well under these conditions? The answer may lie precisely in these two governance dimensions described by Provan and Kenis (2008).

First, the NAO functions as a broker within the network, positioned between the participating organizations. While interactions between organizations continue to focus on the primary proces—in this case, the delivery of care and support services—the NAO is fully dedicated to governing the network, concentrating a range of network-level competencies within its role. This central position enables the NAO to mediate effectively between organizations that exhibit differentiated value orientations.

Second, the external and independent nature of NAO governance may also be advantageous because, unlike the lead organization model, it avoids the possible dominance of one participating organization and its pre-existing values. In the lead organization model, there could be a risk that the leading organization will assert its values in a dominant manner, potentially resulting in normative isomorphism (DiMaggio & Powell, 1983) or homophily (McPherson et al., 2001) within the network. These dynamics are also reflected in Attraction–Selection–Attrition (ASA) theory (Oh et al., 2018).



Through its centralized, external broker position, the NAO appears particularly well-suited to preserve space for value differentiation while simultaneously facilitating value integration. Acting as an independent intermediary with network-level competencies, an NAO may help mediate potential value tensions that could arise in shared governance arrangements, while also avoiding the imposition of a dominant value framework, as can occur in lead organization-governed networks.

This dissertation contributes to theory by demonstrating that governance can play a decisive role in enabling value differentiation while facilitating value integration in interorganizational networks. More specifically, it suggests that, in the presence of value differentiation, an NAO is the more appropriate governance choice. In doing so, this study extends the contingency framework of Provan and Kenis (2008) by identifying value differentiation as an additional contingency factor.

***Key brokerage competencies for value differentiation***

Having established why the NAO emerges as the most suitable governance mode in the presence of value differentiation, chapters 5 and 6 of this dissertation also offer insights into how NAOs operate in practice particularly in relation to values, and how network-level competencies are being used to work with values. The empirical findings show that the NAO is not merely a coordinating entity. Returning to Provan and Kenis's (2008, p. 231) definition of governance as *"the use of institutions and structures of authority and collaboration to allocate resources and to coordinate and control joint action across the network as a whole,"* the evidence presented here suggests that an NAO also functions as a space in which a broker with network-level competencies actively balances value differentiation and value integration.

Chapters 5 and 6 illustrate how this works in practice: a network broker operating within an NAO. As one network broker explained (Chapter 5):

> *"It is mainly about being in connection, in listening, in taking it along, in picking it up again and showing each other's perspectives.…I think that's my role. Show each other the vision and perspective of the other in the conversations.…So yes, a chameleon."*

And a network broker in Chapter 6:

> *"For me it is mainly about connecting, listening, taking things along, picking them up again and showing each other's perspectives."*

These accounts highlight the relational and adaptive network-level competencies required to enact the broker role effectively.

These findings resonate with broader insights from the collaboration literature. For example, O'Leary et al. (2012) emphasize the importance of individual relational attributes in collaborative settings. Their work underscores that collaboration is sustained through the interpersonal skills of 'effective collaborators'. Such skills can be particularly salient within an NAO. In this dissertation, these attributes were particularly relevant for dealing with value differentiation and integration, as network brokers needed to listen actively, reframe issues, and translate perspectives between actors with different value priorities.

Other studies have explored the notion of *orchestrational work*, which further clarifies the behavioral competencies of the network broker role. Bartelings et al. (2017),

for example, define orchestrational work as the deliberate integration and fine-tuning of activities carried out by professionals across organizations to deliver joint results. In the findings of Chapter 5 and 6, this orchestration often involved bridging different value frames, stabilizing relationships in moments of tension, and creating alignment without erasing value differentiation. This confirms that the NAO does not merely serve as a coordinating body; rather, as seen in Chapters 5 and 6, it provides the space for orchestrational work competencies that enables both network stability and responsiveness to values. This also resonates with a recent study on network orchestration. Network goals do not simply emerge from structure, but are the result of deliberate, relationally skilled orchestration that connects actors across institutional boundaries (Cremers et al., 2024).

These findings further align with recent empirical work by Roest et al. (2025), who examined how network coordinators in Dutch healthcare improvement networks maintain commitment over time. Their observation that sustained engagement requires ongoing goal reassessment, expectation management, and investment in trust parallels the work of brokers in NAOs in this dissertation, who continuously reconnected diverse value priorities with the network.



## 7.3 Recommendations for practice and policy

The findings of this dissertation yield concrete implications for both the practice and policy of interorganizational networks in integrated care settings. First, I address practitioners: network leaders, facilitators, and professionals who are directly engaged in shaping the day-to-day functioning of networks. These recommendations focus on how to work productively with diversity, balance integration and differentiation, and strengthen relational capacities. Second, I address policy and decision makers from governments and funders, whose frameworks, incentives, and regulatory approaches can either enable or constrain such practices.

### Practice recommendations

The findings of this study carry important implications for practice. These recommendations emphasize the need to work with, rather than against, the inherent (value) differentiation and complexity of interorganizational networks in integrated care.

First, practitioners should acknowledge, embrace, and leverage differentiation, or in other words: diversity. While 'being on the same page' is often regarded as

hallmarks of successful collaboration (for example the Dutch motto: "all noses in the same direction"), this dissertation demonstrates that room for differentiation, and specifically of perspectives, professional backgrounds, institutional logics, and value systems, is equally vital. Differentiation enables networks to mobilize specialized knowledge, draw on local capacities, and engage with multiple perspectives on a given issue. It can serve as a resource for creativity, critical reflection, and adaptive capacity. However, these benefits only materialize when diversity is recognized and actively engaged with, rather than treated as an obstacle to be overcome.

In practice, this calls for the deliberate creation of spaces and opportunities in which differences can be articulated, explored, and reflected upon without the pressure of immediate resolution or homogenization. It also requires ongoing reflexivity regarding inclusion: who is currently involved, whose voices are absent, and which perspectives are (still) needed. This dissertation therefore offers a different working method: differentiation should not be treated as a contextual challenge to be "managed away," but as a crucial design dimension.

Practitioners can begin by asking: *What perspectives, functions, expertise, knowledge, and values are needed to achieve the purpose of this network?* From there, the network can be intentionally organized, with appropriate integration mechanisms and governance arrangements tailored to that purpose. Moreover, practitioners should recognize that the broader ecosystem surrounding a particular issue is often complex, diffuse, and difficult to oversee. Mapping this ecosystem—identifying which actors are involved, what value orientations die have, what initiatives already exist, how responsibilities and interests are distributed, and how these elements relate to the network's articulated purpose—can provide essential guidance for determining an appropriate form of differentiation. Such ecosystem-oriented inquiry helps clarify which perspectives, functions, and value orientations are genuinely needed, and which may be peripheral or duplicative. By making these contextual dynamics explicit, practitioners can more intentionally configure the network's composition, ensuring that differentiation aligns with the network's purpose rather than emerging by default or historical accident.

Subsequently, practitioners should actively balance this differentiation with integration. Differentiation, while valuable, also requires coordination to move diverse actors towards a shared purpose. This demands integration mechanisms and governance arrangements that align with the type of diversity present. In relatively straightforward networks, where differentiation is primarily functional (e.g., in roles or expertise), functional integration, such as clear agreements on roles, responsibilities,

and workflows, may suffice. In more value-plural networks, however, integration efforts must also address values, such as facilitating dialogue on network-level values.

A third practical recommendation is to invest in brokerage roles and relational network-level competencies. Leveraging value differentiation within networks requires brokerage that is attentive to both structural and normative aspects of collaboration. Brokers play a crucial role in navigating tensions, facilitating dialogue, and fostering value alignment without erasing differences. Effective brokerage involves not only technical coordination but also relational competencies: the ability to translate between perspectives and support ongoing exchange. Sustaining such roles requires explicit investment in both the capacity of individual brokers and the organizational infrastructure that enables them to operate effectively, such as NAOs.

Taken together, these practice recommendations call for a shift from viewing (values) differentiation as a problem to be solved, towards recognizing it as a resource to be cultivated.

### Policy recommendations



The findings of this research also have significant implications for policy. These implications challenge linear, instrumental views on interorganizational networks as vehicles to address contemporary challenges in health and social care and instead foreground their relational nature.

First, interorganizational networks should not be conceived as time-bound projects to 'solve' contemporary problems in health and social care, but as enduring relational realities. Collaboration in interorganizational networks is not merely the execution of a technical blueprint but the ongoing interaction between people representing different organizations, each of whom brings their own values, priorities, and organizational logics. These values are neither static nor fully negotiable at the outset; rather, they can evolve over time as actors interact and as contexts shift. From a policy perspective, this means that networks cannot be "built" to full maturity within a predefined period, nor can they be "completed" in the sense of reaching a final state. Instead, they require ongoing cultivation, maintenance, and adaptation. For policymakers, this implies the need to: (1) adopt longer-term and more adaptive funding horizons that allow networks to develop and mature over time; (2) avoid treating networks as technical or blueprint-like interventions that can be completed within fixed project cycles; and (3) create flexibility in regulatory and accountability frameworks to support ongoing relational work and adaptation.

Second, policy should avoid one-size-fits-all integration models. The evidence from this study demonstrates that integration is not synonymous with effectiveness. In fact, effectiveness emerges from a nuanced configuration of integration, differentiation, and an appropriate governance form. Excessive emphasis on integration risks overlooking the important role of differentiation in enabling diverse contributions. Policymakers should therefore resist the temptation to impose standardized integration models. Instead, they should look at the specific purpose, context, resources, knowledge bases, tasks, and value constellations of a given network. Effectiveness is more likely when these elements are aligned in ways that are locally meaningful rather than centrally prescribed. For policymakers, this implies the need to: (1) refrain from mandating standardized integration templates; (2) support context-sensitive approaches that align with the specific purpose, tasks, knowledge bases, and value constellations of a given network; and (3) enable local actors to configure their own balances of integration and differentiation through flexible policy instruments, without prescribing preferred organizational models.

Third, policy should avoid the top-down imposition of 'closed' networks. While governments and health insurers nowadays often define networks by geographical or administrative boundaries, following the IZA (Ministerie van Volksgezondheid, Welzijn en Sport, 2022) this study shows that such pre-defined closure can limit their capacity to address complex problems effectively. Over the past years, many networks have emerged organically, initiated bottom-up by actors who share a specific purpose, history of collaboration, or problem focus. These existing networks often embody valuable relational capital, trust, and accumulated knowledge. Policies that rigidly define network membership or boundaries risk not only constraining resources and excluding relevant actors, but also unintentionally undermining or displacing these already-functioning collaborations. Effective policy should therefore begin with a careful understanding of what networks, relationships, and initiatives are already in place, and how new policy ambitions can align with, build upon, or strengthen them rather than overwrite them. For policymakers, this implies the need to: (1) avoid prescribing fixed boundaries or mandatory membership structures; (2) systematically map and acknowledge existing networks and collaborations before introducing new arrangements; and (3) create structural space for networks to grow and reconfigure around emerging issues, ensuring that bottom-up initiatives and existing ecosystems are strengthened rather than displaced.

Taken together, these recommendations point to the need for policies that treat interorganizational networks as adaptive, context-sensitive, relational constellations rather than as fixed organizational instruments.

## 7.4 Methodological reflections

This dissertation contributes to our understanding of the role of values in inter-organizational networks pursuing integrated care. At the same time, it is important to critically reflect upon the methodological choices that underpin these contributions and their implications for the interpretation of findings. This dissertation contributes to our understanding of the role of values in inter-organizational networks pursuing integrated care. At the same time, it is important to critically reflect upon the methodological choices that underpin these contributions and their implications for the interpretation of findings. I first reflect on the overall approach of this dissertation, after which I address broader issues related to studying its core concepts, namely values and network effectiveness.

### Overall methodological approach and research design

First, the use of multiple methods across the dissertation enabled a wide variety of perspectives on the research topic. I was able to combine broad, international insights with detailed, context-specific understanding. For instance, Chapters 2, 3, and 4 incorporated a highly international scope: the Delphi study in Chapter 3 included experts from 13 countries, and the survey in Chapter 4 reached respondents across 42 European countries, in collaboration with the World Health Organization (WHO). This international scope is particularly valuable, as the challenges and practices of shaping integrated care networks are relevant across diverse national contexts. Simultaneously, these studies were complemented by more micro-level, in-depth perspectives. Chapter 5, for example, involved an intensive case study of a single interorganizational network in the Netherlands, where every participating organization was represented by at least one respondent. This in-depth exploration enriched and contextualized the prior studies, providing complementary insights. Finally, Chapter 6 examined 24 networks, combining multiple data sources, including documents, surveys, and in-depth interviews with key informants, allowing both cross-case comparisons and more deep, nuanced understanding. In sum, the combination of methods enabled examination from multiple vantage points: from micro-level, day-to-day practices within a single network to broader, cross-national patterns across Europe.

Second, this dissertation began with a systematic review and a Delphi study (Chapters 2 and 3). This decision may be questioned, given the relational, practice-oriented focus on networks: should we not have first observed what actually occurs in empirical practice, rather than initially consulting the literature? While this was indeed a consideration, it was deemed essential to first gain a clear understanding

of values as a concept, and specifically of integrated care values, thereby establishing a strong and robust theoretical foundation. This foundation subsequently served as both an analytical lens and a shared vocabulary for empirical observation. For instance, the values set developed in Chapters 2 and 3 was directly applied in the surveys reported in Chapters 4 and 6 to examine value priorities, as well as value differentiation and integration.

Third, throughout this dissertation, values have been examined at multiple levels, with subgroup distinctions varying across chapters. In Chapter 2, the focus was on overarching values at a conceptual level, while Chapter 3 explored individual expert opinions on these conceptual values. Chapter 4 analyzed the professional value orientations of service users and informal carers, professionals, policy and decision makers, and researchers from various countries, highlighting differences between professional groups and EU regions. In Chapter 5, data were collected at the professional level, from individuals with diverse backgrounds, and at the network level, represented by directors and network orchestrators. The analysis focused specifically on differences among professional backgrounds, including gynecology, ultrasonography, clinical midwifery, primary care midwifery, and maternity care. Finally, Chapter 6 incorporated both the network and actor levels, represented by organizations, with data from one representative per organization and an informant per network. Taken together, these studies underscore an important methodological point: by examining values at multiple levels across the dissertation, we were able to capture variation both within and between actor groups and organizational contexts, which may otherwise have been overlooked. At the same time, the specific levels and subgroup distinctions varied across chapters, reflecting the different research foci and methods, which may be considered a methodological limitation in terms of consistency.

Fourth, while the empirical observations of values, interorganizational networks, governance, and effectiveness were captured at single points in time across the various chapters, the dissertation acknowledges that these constructs are inherently dynamic. Network composition can change as actors enter or exit, governance may evolve (Mitterlechner, 2018), and the prioritization of values among participants may evolve over time. Such temporal dynamics could theoretically influence patterns of value differentiation and integration, representing a potential limitation of point-in-time measurement. Nonetheless, this study mitigates this concern in several ways. The examination of 24 diverse care networks in Chapter 6 encompassed a wide range of configurations, contexts, target populations, and objectives, providing a rich and varied empirical palette. Furthermore, the in-depth case study in Chapter 5 explicitly probed respondents' reflections on longer-term experiences, capturing temporal

evolution and providing a more nuanced understanding of how values and value dynamics unfold within networks over time.

Taken together, these methodological choices shaped how values, interorganizational networks, governance, and effectiveness could be empirically observed and analyzed across different contexts, levels, and points in time. At the same time, they foreground specific challenges related to the operationalization and interpretation of the dissertation's core concepts, particularly values and network effectiveness, which are addressed in the next subsection.

### Methodological challenges in studying core concepts

The core concepts examined in this dissertation also posed methodological challenges and limitations. First, the empirical analysis highlighted the complexity of studying values, especially within interorganizational care networks with multiple actors. Values are often implicit, embedded in practices, and difficult to distinguish from related constructs such as interests or norms. This ambiguity complicated data collection and interpretation, as the same value claim could reflect deeply held beliefs, strategic positioning, or a combination of both. To address this complexity, multiple methods were employed. Beyond the literature review and Delphi consensus study in Chapters 2 and 3, values were examined empirically through a cross-sectional survey (Chapter 4), a qualitative case study with in-depth interviews (Chapter 5), and a qualitative comparative analysis integrating documents, survey data, and interviews (Chapter 6). Throughout, interpretive caution was applied to avoid over- or under-attributing normative meaning to actors' statements. Taken together, it is important to emphasize that values were approached and studied empirically. In this dissertation, values were investigated based on observation rather than theory. It was not the aim to further deconstruct the concept of values theoretically, but rather to observe them empirically and examine their role within interorganizational networks.



Second, network effectiveness was studied in Chapter 6 primarily through self-reported measures. Such measures offer the advantage of capturing insider perspectives on network progress, including aspects of performance that may not be visible through external evaluation. However, they also present interpretive challenges, as perceptions can be influenced by strategic optimism, social desirability, or selective recall, and may conflate collaboration process quality with substantive outcomes (Khodyakov et al., 2021). Notably, respondents demonstrated critical self-awareness, with many explicitly acknowledging that their network had not yet achieved effectiveness; nevertheless, the potential for bias cannot be excluded.

A further methodological limitation related to network effectiveness concerns the variability of network goals. Network effectiveness judgments are inherently relative to what a network seeks to achieve, and differences in goal ambition or specificity complicate cross-case comparability. Modest, tangible objectives may be attained relatively quickly, whereas more ambitious goals require longer time horizons. This underscores the need for caution in interpreting perceived effectiveness and suggests that future research should combine perceptual data with external indicators while explicitly accounting for variation in goal-setting.

These methodological considerations and limitations are important for interpreting the findings presented in this dissertation: rather than treating values or network effectiveness as fixed or universally comparable attributes, the results should be read as context-dependent and relational, shaped by actors' interpretations, interactions, and goal orientations within specific network configurations.

## 7.5 Future research agenda

The organization studies and relational perspective adopted in this dissertation, coupled with the use of values as an analytical lens, has generated a number of valuable insights, while simultaneously raising new questions. In this section, I outline three promising avenues for future research.

The first avenue concerns a more fine-grained investigation of values in everyday network practice. This dissertation has shown that actors' values play a pivotal role in collaboration within interorganizational networks and affect their effectiveness. We examined this at the network level through the concepts of value differentiation and value integration. Yet, many questions remain regarding the ways in which values manifest, how they develop over time, how they may influence behavior, and the processes through which they shape collaborative dynamics. Deeper insights into these processes would be highly valuable. Longitudinal, qualitative, practice-based studies, potentially employing ethnographic methods, could provide richer, multilayered understandings of how values emerge, evolve, and affect network effectiveness over time.

Specifically, it would be valuable to investigate whether certain combinations or configurations of values are inherently incompatible, despite the focus of this dissertation on the "value of different values," which emphasizes that value differentiation can serve as a productive condition. This question also connects

to the empirical findings of Chapter 4, where factor analysis revealed two distinct clusters of values: 'people-related' values and 'governance and organization' values. These clusters illustrate that values tend to cohere in patterned configurations rather than existing in isolation, and that their productive potential depends on how they are balanced rather than fully aligned. In this dissertation, these clusters appeared to function as complementary orientations rather than as mutually exclusive ones. Future research could explore whether other value configurations are less compatible and under what conditions such combinations become difficult to sustain in practice.

At the same time, this dissertation necessarily worked with a bounded set of values. The empirical analyses were based on the values identified in Chapter 2 (the 23 values from the systematic review) and Chapter 3 (the 18 values refined through the Delphi study), which were operationalized and contextualized for integrated care settings. However, alternative values could have been considered, and it is plausible that some value configurations may be inherently difficult or even impossible. This phenomenon is observed, for instance, in political processes where certain normative positions cannot easily coexist or work together. Future research could explore which values are most likely to conflict, under what conditions attempting to integrate them may be counterproductive, and how far apart values can be before they impede effective collaboration. Such investigations would offer important insights into the possible limits of productive value differentiation in interorganizational networks.



The second avenue involves further exploration of differentiation as a central dimension in interorganizational networks. In both the integrated care literature and broader network studies, integration has traditionally received predominant attention, while differentiation remains relatively understudied. Differentiation concerns the composition of the network: who participates and who does not, and which actors are essential for achieving the network's purpose. The inclusion of actors with diverse backgrounds is particularly important, as heterogeneity and diversity represent key strengths of networks, a finding corroborated by this dissertation. Organizations may differ in multiple ways, such as knowledge, resources, roles, scale, or sector (public or private). This dissertation has extended this discussion by specifically highlighting value differentiation. Future research could investigate additional forms of differentiation, explore their interrelations with other types of differentiation, and examine how these patterns interact with forms of integration to shape network functioning.

The third avenue concerns brokerage. This dissertation demonstrates that brokerage functions as a central mechanism mediating the balance between value differentiation

and value integration. It further shows that a Network Administrative Organization (NAO) constitutes an appropriate governance form in networks characterized by value differentiation, and highlights the network-level competencies within the NAO that are critical in such contexts. Future research could examine in greater detail how brokers within NAOs manage value differentiation and integration, what skills and competencies they use, what forms of support they require from the NAO, and how these dynamics compare to other governance modes. Such research would provide further insight into the mechanisms through which network-level governance structures and broker competencies jointly shape collaborative outcomes.

## 7.6 Concluding remarks

This dissertation has approached integrated care not as a policy, project, program, method, or set of technical interventions, as is often done in health services research. Instead, it has been conceptualized from an organization studies, and in particular relational, perspective, understanding integrated care as a constellation of actors linked through interactions and relationships, often organized into purpose-oriented networks that are actively governed.

By focusing on values as a dimension of differentiation and integration, this research demonstrates how actors' value priorities and perspectives shape collaboration in interorganizational networks and influence their effectiveness. The findings highlight the importance of recognizing the values held by different actors in a network, and of understanding how these values can be aligned or leveraged to support collaboration and collective goals.

Despite the dominant emphasis on integration in much of the literature, the findings highlight that differences, particularly differences in values, are not inherently problematic. On the contrary, when appropriately balanced with integrative mechanisms and brokered governance, such diversity can be a valuable resource. This dissertation therefore advocates for the recognition of heterogeneity in interorganizational networks. It is precisely this diversity that constitutes the strength and adaptive capacity of networks as an organizational form.

# 7

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## Summary

Collaboration between autonomous organizations is widely regarded as a key response to the challenges facing healthcare systems. Such collaboration is often conceptualized as the integration of differentiated groups of actors and has led to the proliferation of interorganizational networks and partnerships. In the healthcare literature this is generally referred to as 'integrated care'. Despite high performance expectations, outcomes often remain unclear or disappointing: collaborations slow down, stall, or fail to achieve their intended impact. This raises the question of what extent such initiatives truly address the underlying causes and challenges in integrated care, or whether new integration and collaboration efforts are repeatedly initiated without sufficient understanding of the factors that shape their success or failure.

To better understand this issue, a perspective is needed that adequately captures the relational and organizational complexity of integrated care. This dissertation therefore approaches integrated care from an organization studies perspective, specifically adopting a relational lens. Integrated care is not viewed as a technical intervention or policy instrument, but as a constellation of interacting actors within interorganizational care networks.

Two conceptual lenses are central to this dissertation. First, it builds on insights from organization studies that networks are shaped by the interplay between integration and differentiation. Research on integrated care typically focuses on integration: connecting, aligning, and coordinating actors. It pays less attention to differentiation, which refers to differences in expertise, roles, and capacities between organizations. This one-sided focus may limit the ability to fully leverage diversity, even though such diversity is precisely what makes interorganizational networks valuable. At the same time, differentiation may also introduce tensions and coordination challenges. This dissertation therefore adopts an approach in which integration and differentiation are studied in conjunction.

Second, the dissertation examines how these processes of integration and differentiation manifest in terms of values: what actors within a network consider important. Existing research primarily focuses on structural and functional aspects of collaboration, such as roles, tasks, and positions. However, differences within networks may also arise from less tangible dimensions, such as professional subcultures and their associated values. At the same time, integration is often pursued through the promotion of shared values. This points to a fundamental

tension: while diversity in values may foster complementarity and innovation, it may also hinder collaboration. Conversely, a certain degree of shared values may be necessary for effective collaboration. Values thus function both as a source of friction and as a source of cohesion. This dissertation examines the role of values within interorganizational care networks.

The study begins with a systematic literature review on values in integrated care, presented in **Chapter 2**. Drawing on values theory, the dissertation clarifies how *values* are defined and how they differ from related concepts such as "*value*." The review results in a set of 23 values underlying integrated care, each accompanied by a definition. The most frequently identified values are 'collaborative', 'coordinated', and 'transparent'. The findings show that values may be interrelated, that actors may assign different levels of importance to them, and that their meaning may vary across contexts and levels. This set thus provides an analytical vocabulary for the remainder of the dissertation.

In **Chapter 3**, this set of values is empirically tested and refined through a Delphi study involving 33 international experts from 13 countries. The results lead to a consolidated set of 18 values, including an assessment of their relevance at different levels of integration (personal, professional, managerial, and system levels). Sixteen values originate from the initial set, while two new values ('effective' and 'efficient') are added. The identified values are primarily instrumental (behavior-oriented) and together form an international normative basis for integrated care, as well as a shared language for making values explicit.

**Chapter 4** examines whether different actor groups – service users and informal carers, professionals, policy and decision makers, and researchers – differ in their value orientations. Based on a survey of 1,013 respondents from 42 European countries, both the absolute (rated on a 9-point scale) and relative (selection of the three most important values) importance of the 18 values are analyzed. Absolute differences are limited, indicating broad support for integrated care as a concept. At the same time, significant differences emerge in the relative importance assigned to values by different actor groups. This indicates value differentiation: although actors support the same concept, they do so from different normative perspectives. Factor analysis further reveals two clusters of values: 'people-centered' values, related to the relationship between care users and professionals, and 'governance and organizational' values, related to the organization and objectives of the healthcare system.

To better understand the role of values in practice, **Chapter 5** presents a case study of a Dutch pregnancy and childbirth network. Based on interviews, the study examines which values actors consider important, which tensions arise from them, and how these tensions are addressed. The study distinguishes between values that actors consider important from their own role and values they consider important for the network as a whole. Furthermore, the study identifies three value tensions between actors: between midwifery practices (homogeneous actors), between clinical and primary care obstetricians, and between maternity care organizations and primary care obstetricians (both heterogeneous actors). The findings show that this value differentiation can hinder collaboration, but that it is also necessary to achieve network goals. Eight strategies are identified through which actors deal with these tensions. These are employed by the Network Administrative Organization (NAO) and the professionals themselves, and are both functional-structural and cognitive-cultural in nature. The findings show that value differentiation in networks should not only be seen as a problem, but also as an important building block for achieving network goals.

**Chapter 6** presents a configurational study using crisp-set Qualitative Comparative Analysis (csQCA) of 24 care networks with different types of target groups and actors. The analysis focuses on combinations of conditions related to functional and value integration and differentiation in relation to network effectiveness. Data are collected through surveys, interviews with key informants, and document analysis. The analysis identifies two configurations associated with effective networks. The first is characterized by a combination of functional differentiation and integration. This refers to networks in which actors need to align different tasks, but where no value differences have been identified. The second configuration additionally includes value differentiation, value integration, and the presence of a separate network broker, in the form of a Network Administrative Organization (NAO). These networks, for example, focus on more complex issues, involving many actors from different domains and a broader range of perspectives and interpretations. A key finding is the role of the network broker, who actively facilitates value integration at the network level. The network broker's overarching perspective and independent positioning may explain its importance. Overall, the findings demonstrate that achieving effectiveness in interorganizational care networks requires a nuanced balance between integration and differentiation. While functional alignment may suffice in some cases, value integration becomes essential in contexts characterized by strong value differentiation.

**Chapter 7** integrates the findings and outlines their theoretical and practical implications. The dissertation makes four main contributions. First, it underscores the importance of adopting a values perspective in the study of integrated care and interorganizational networks. Second, it critically challenges the dominant emphasis on integration by highlighting the crucial role of differentiation. Third, it advances the understanding of network effectiveness by demonstrating how both functional and value-based dimensions jointly shape the realization and interpretation of effectiveness, thereby underscoring the need for a configurational and multi-level approach. Fourth, it contributes to the literature on network governance, with particular attention to the role of network brokers and Network Administrative Organizations.

Taken together, the findings suggest that diversity, such as differences in values, perspectives, and expertise, should not primarily be viewed as a problem, but as a key source of value creation. It enables the integration of specialized knowledge and provides multiple perspectives on complex issues. This calls for creating space for dialogue and reflection, where consensus and uniformity are not necessarily the primary objectives. Differentiation should not be treated as something to be "resolved," but rather as a deliberate design choice in network composition: which forms of knowledge, values, and expertise are required to achieve network goals? Such differentiation must then be aligned with appropriate integration mechanisms. While these may take functional forms, such as coordination and workflows, networks characterized by high levels of value differentiation also require value integration: an ongoing dialogue about shared values at the network level. The findings further emphasize the importance of investing in network broker roles and competencies, particularly in contexts marked by diverse values and perspectives, where connection is needed without homogenization.

For policymakers, these findings imply a shift from linear and instrumental approaches toward a more relational perspective on interorganizational networks. Networks should not be treated as temporary projects or interventions, but as enduring forms of collaboration that evolve over time. This requires longer-term funding horizons, reduced reliance on project-based approaches, and more flexible supervisory and accountability frameworks. Moreover, the findings caution against the use of standardized integration models and top-down implementation strategies. Effective networks require context-sensitive design, room for local dynamics, and alignment with existing relationships. Policymakers should therefore identify and build upon existing networks, allow space for bottom-up development, and impose flexible rather than rigid membership structures.

In sum, this dissertation approaches integrated care from an organization studies and relational perspective, with a particular focus on values as a dimension of differentiation and integration. It demonstrates how actors' values shape collaboration and affect the effectiveness of interorganizational networks. The findings highlight the importance of recognizing and mobilizing these values in support of shared goals. Despite the dominant emphasis on integration in practice, policy, and research, the dissertation shows that differences in values are not inherently problematic. On the contrary, when combined with appropriate integration mechanisms and governance arrangements, such diversity can become a valuable resource for achieving collective outcomes. The dissertation therefore advocates recognizing heterogeneity as a defining strength of interorganizational care networks.

## Samenvatting

Samenwerking tussen zelfstandige organisaties wordt breed gezien als een antwoord op de uitdagingen in de zorg. Deze samenwerking wordt vaak opgevat als de integratie van verschillende actoren en heeft geleid tot een toename van netwerken en samenwerkingsverbanden. In de zorgliteratuur wordt dit veelal aangeduid als 'integrale zorg' ('integrated care'). Ondanks hoge verwachtingen blijven de resultaten echter vaak onduidelijk of teleurstellend: samenwerkingen vertragen, verzanden of halen niet het beoogde effect. Dit roept de vraag op in hoeverre deze initiatieven daadwerkelijk inspelen op de onderliggende oorzaken van de uitdagingen in integrale zorg, of dat vooral nieuwe integratie- en samenwerkingspogingen worden geïnitieerd zonder voldoende inzicht in de factoren die hun succes of falen bepalen.

Om dit vraagstuk beter te begrijpen, is een perspectief nodig dat recht doet aan de relationele en organisatorische complexiteit van integrale zorg. Dit proefschrift benadert integrale zorg daarom vanuit een organisatie studies en specifiek vanuit een relationeel perspectief. Het bekijkt integrale zorg niet als een technische interventie of beleidsinstrument, maar als een geheel van samenwerkende actoren binnen interorganisationele zorgnetwerken.

Centraal in dit proefschrift staan twee conceptuele lenzen. Ten eerste wordt voortgebouwd op het inzicht uit de organisatiewetenschappelijke literatuur dat netwerken worden gevormd door de wisselwerking tussen integratie en differentiatie. Onderzoek naar integrale zorg richt zich doorgaans primair op integratie: het verbinden, afstemmen en coördineren van actoren. Differentiatie, dat verwijst naar verschillen in expertise, rollen en capaciteiten tussen organisaties, krijgt daarentegen minder aandacht. Deze eenzijdige focus kan ertoe leiden dat de meerwaarde van diversiteit onvoldoende wordt benut, terwijl juist deze diversiteit interorganisationele netwerken waardevol maakt. Tegelijkertijd kan differentiatie ook spanningen en coördinatieproblemen met zich meebrengen. Dit proefschrift hanteert daarom een benadering waarin integratie en differentiatie in samenhang worden bestudeerd.

Ten tweede wordt onderzocht hoe deze processen van integratie en differentiatie tot uiting komen in termen van waarden: datgene wat actoren binnen een netwerk belangrijk vinden. Bestaande kennis richt zich voornamelijk op structurele en functionele aspecten van samenwerking, zoals rollen, taken en posities. In netwerken kunnen verschillen echter ook voortkomen uit minder tastbare dimensies, zoals professionele subculturen en bijbehorende waarden. Tegelijkertijd

wordt integratie vaak nagestreefd via het benadrukken van gedeelde waarden. Dit wijst op een fundamentele spanning: waar diversiteit in waarden kan bijdragen aan complementariteit en innovatie, kan zij ook samenwerking bemoeilijken. Omgekeerd kan een zekere mate van gedeelde waarden noodzakelijk zijn voor effectieve samenwerking. Waarden fungeren daarmee zowel als bron van frictie als van verbinding. Dit proefschrift onderzoekt welke rol waarden vervullen binnen interorganisationele zorgnetwerken.

Het onderzoek begint met een systematische literatuurstudie naar waarden in integrale zorg, gepresenteerd in **Hoofdstuk 2**. Aan de hand van waardentheorie wordt verduidelijkt hoe in dit proefschrift waarden worden gedefinieerd en hoe *waarden* zich onderscheiden van verwante concepten zoals *waarde*. De studie resulteert in een set van 23 waarden die ten grondslag liggen aan integrale zorg, elk voorzien van een nadere omschrijving. De meest frequent geïdentificeerde waarden zijn 'samen', 'gecoördineerd' en 'transparant'. De bevindingen laten zien dat waarden onderling kunnen samenhangen, dat actoren er verschillend belang aan kunnen hechten, en dat zij context- en niveauspecifiek kunnen worden ingevuld. Deze set vormt daarmee een analytisch vocabulaire voor de verdere studies in dit proefschrift.

In **Hoofdstuk 3** wordt deze waardenset empirisch getoetst en aangescherpt via een Delphi-studie onder 33 internationale experts uit 13 landen. De resultaten leiden tot een geconsolideerde set van 18 waarden, inclusief een beoordeling van hun relevantie op verschillende integratieniveaus (persoonlijk, professioneel, management- en systeemniveau). Zestien waarden zijn afkomstig uit de oorspronkelijke set, terwijl twee nieuwe waarden ('effectief' en 'efficiënt') worden toegevoegd. De geïdentificeerde waarden betreffen voornamelijk instrumentele waarden (gedragsoriëntaties) en vormen gezamenlijk een internationale normatieve basis voor integrale zorg, evenals een gedeelde taal om waarden expliciet te maken.

**Hoofdstuk 4** onderzoekt vervolgens in hoeverre verschillende actorgroepen – zorggebruikers en mantelzorgers, professionals, beleidsmakers en beslissers, en onderzoekers – verschillen in hun waardenoriëntaties. Op basis van een survey onder 1.013 respondenten uit 42 Europese landen wordt zowel het absolute (beoordeeld op een 9-puntsschaal per waarde) als het relatieve (selectie van de drie belangrijkste waarden) belang van de 18 waarden geanalyseerd. De absolute verschillen blijken beperkt, wat wijst op een breed gedragen steun voor integrale zorg als concept. Tegelijkertijd worden significante verschillen zichtbaar in het relatieve belang dat actorgroepen aan waarden toekennen. Dit duidt op waardendifferentiatie: hoewel actoren hetzelfde concept ondersteunen, doen zij dit vanuit verschillende normatieve

perspectieven. Factoranalyse laat bovendien twee clusters van waarden zien: 'mensgerichte' waarden, gericht op de relatie tussen zorggebruikers en professionals, en 'governance- en organisatiewaarden', gericht op de inrichting en doelen van het zorgsysteem.

Om de rol van waarden in de praktijk beter te begrijpen, presenteert **Hoofdstuk 5** een casestudie van een Nederlands geboortezorgnetwerk. Op basis van interviews wordt onderzocht welke waarden actoren belangrijk vinden, welke spanningen hieruit voortkomen en hoe hiermee wordt omgegaan. De studie maakt onderscheid tussen waarden die de actoren vanuit hun eigen rol belangrijk vinden en waarden die ze belangrijk vinden voor het netwerk als geheel. Verder identificeert de studie een drietal waardenspanningen tussen actoren: tussen verloskundige praktijken (homogene actoren), tussen klinisch en eerstelijnsverloskundigen, en tussen de kraamzorg en eerstelijnsverloskundigen (beide heterogene actoren). De bevindingen laten zien dat deze waardendifferentiatie de samenwerking kan bemoeilijken, maar dat ze ook nodig is om netwerkdoelen te bereiken. Er worden acht strategieën geïdentificeerd waarmee actoren omgaan met deze spanningen. Deze worden gehanteerd door de netwerk administratieve organisatie (NAO) en de professionals zelf, en zijn zowel functioneel-structureel als cognitief-cultureel van aard. De bevindingen laten zien dat waardendifferentiatie in netwerken niet alleen als een probleem moet worden gezien, maar ook als een belangrijke bouwsteen voor het bereiken van netwerkdoelen.

**Hoofdstuk 6** presenteert een configuratiestudie aan de hand van Crisp-set Qualitative Comparative Analysis (csQCA) van 24 zorgnetwerken met uiteenlopende soorten doelgroepen en actoren. De analyse richt zich op combinaties van condities met betrekking tot functionele en waarden integratie en differentiatie in relatie tot netwerkeffectiviteit. Dit gebeurt aan de hand van vragenlijsten met actoren, interviews met sleutelpersonen en documentanalyse. Uit de analyse blijkt dat twee configuraties worden geassocieerd met effectieve netwerken. De eerste wordt gekenmerkt door een combinatie van functionele differentiatie en integratie. Dit gaat om netwerken waarin actoren verschillende taken op elkaar moeten afstemmen, maar waar geen waardenverschillen zijn vastgesteld. De tweede configuratie omvat daarnaast waardendifferentiatie, waardenintegratie en de aanwezigheid van een afzonderlijke netwerkmakelaar, in de vorm van een netwerk administratieve organisatie (NAO). Deze netwerken richten zich bijvoorbeeld op thema's die complexer zijn, met veel actoren uit verschillende domeinen en een breder scala aan perspectieven en interpretaties. Opvallend in dit tweede pad is de rol van de afzonderlijke netwerkmakelaar, waarbij de data laat zien dat deze actief betrokken is

bij waardenintegratie op netwerkniveau, om het netwerk effectief te laten zijn. Het helikopterperspectief en onafhankelijke positionering van de netwerkmakelaar zou een verklaring kunnen zijn voor het belang van deze rol. De bevindingen van deze studie laten zien dat het bereiken van effectiviteit in zorgnetwerken een genuanceerd evenwicht vereist tussen differentiatie en integratie. In sommige gevallen is een functioneel evenwicht tussen deze dimensies voldoende. In situaties waarin waardendifferentiatie sterk aanwezig is, wordt waardenintegratie op netwerkniveau echter essentieel, gefaciliteerd door een afzonderlijke netwerkmakelaar.

**Hoofdstuk 7** integreert de bevindingen uit de verschillende hoofdstukken en formuleert de theoretische en praktische implicaties. Het proefschrift levert vier bijdragen. Ten eerste wordt het belang van een waardenperspectief in de studie naar integrale zorg en netwerken onderstreept. Ten tweede wordt de dominante focus op integratie kritisch bevraagd door het belang van differentiatie te benadrukken. Ten derde wordt het begrip netwerkeffectiviteit verdiept door te laten zien hoe zowel differentiatie als integratie van waarden, naast functionele en structurele dimensies, van invloed zijn op het realiseren en interpreteren van effectiviteit, en daarmee de noodzaak van een configuratieve en multi-niveau benadering te onderstrepen. Ten vierde draagt het proefschrift bij aan inzichten in governance van netwerken, met specifieke aandacht voor de rol van netwerkmakelaars en netwerk administratieve organisaties.

Samen impliceren de bevindingen dat diversiteit, bijvoorbeeld in waarden, perspectieven, en expertise, niet als probleem moet worden gezien, maar als essentiële bron van waardecreatie. Het maakt gespecialiseerde kennis mogelijk en biedt meerdere perspectieven op vraagstukken. Dit vraagt om ruimte voor dialoog en reflectie, waarbij consensus en uniformiteit niet het directe streven moet zijn. Differentiatie moet niet worden gezien als iets dat 'opgelost' moet worden, maar als bewuste ontwerpkeuze ten aanzien van netwerksamenstelling: welke kennis, waarden en expertise zijn nodig om het netwerkdoel te realiseren? Deze differentiatie moet vervolgens worden verbonden aan passende integratiemechanismen. Dit kan functioneel, zoals coördinatie en werkprocessen, maar in netwerken met een hoge waardendifferentiatie is ook waardenintegratie nodig: een dialoog over gezamenlijke waarden op netwerkniveau. Dit proefschrift laat ook zien dat het van belang is om te investeren in netwerkmakelaarsrollen en -competenties. Zeker in netwerken waar waarden en perspectieven relatief divers zijn, is het van belang om deze te verbinden zonder deze te homogeniseren.

Voor beleidsmakers betekent dit dat er een verschuiving nodig is van lineaire, instrumentele benaderingen van interorganisationele netwerken, naar een meer relationeel perspectief. Ten eerste impliceert dit dat netwerken niet moeten worden gezien als tijdelijke projecten of interventies, maar als duurzame samenwerkingsverbanden die zich ontwikkelen in de tijd. Dit vraagt om langere financieringshorizonten, minder projectmatige aanpakken, en flexibelere toezichts- en verantwoordingskaders. Ten tweede betekent dit dat blauwdrukken als integratiemodellen moeten worden vermeden. Een focus op integratie betekent niet automatisch dat netwerken effectief zullen zijn. Dit hangt namelijk af van een delicate balans tussen integratie en differentiatie, en passende governance. Dit pleit voor het vermijden van standaardmodellen, het centraal stellen van de context en meer lokale ruimte voor netwerkontwikkeling. Ten derde bekritiseert dit top-down implementatie van netwerksamenwerking. Beleidsmakers kunnen beter eerst bestaande netwerken in kaart brengen zodat daarbij kan worden aangesloten, meer ruimte laten voor bottom-up netwerkvorming en -ontwikkeling, en ten slotte kiezen voor flexibele in plaats van rigide netwerklidmaatschapsstructuren.

Dit proefschrift benadert integrale zorg vanuit een organisatiewetenschappelijk en relationeel perspectief, en focust specifiek op waarden als dimensie van differentiatie en integratie. Hiermee laat het zien hoe de waarden van actoren een rol spelen in de samenwerking in interorganisationele netwerken en hun effectiviteit. De bevindingen benadrukken het belang van het herkennen van de waarden van de verschillende actoren binnen een netwerk, en deze te benutten om de gezamenlijke doelen te ondersteunen. Ondanks de nadruk op integratie in praktijk, beleid en literatuur, laat het proefschrift zien dat waardenverschillen niet inherent problematisch zijn. Integendeel, wanneer deze worden gecombineerd met passende integratiemechanismen en governance, kan deze diversiteit juist een waardevolle bron zijn om gezamenlijke doelen te bereiken. Dit proefschrift pleit daarom voor de erkenning van heterogeniteit in interorganisationele zorgnetwerken, wat juist de kracht vormt van netwerken als organisatievorm.

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# Publications

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## Peer-reviewed publications

1. Michgelsen, J., **Zonneveld, N.**, Miller, R., Stein, V., Longpré, C., Jubinville, M., Goodwin, N., & Minkman, M. (2025). Navigating a Decade of Integrated Care Research in the International Journal of Integrated Care: How Far Have We Come? *International Journal of Integrated Care*, *25*(3), 25.
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1. **Zonneveld, N.**, Glimmerveen, L., & Minkman, M. (2025). Values in Integrated Care. In V. Amelung, V. Stein, E. Suter, N. Goodwin, E. Nolte, & R. Balicer (Red.), *Handbook Integrated Care* (pp. 53-66). Springer International Publishing.
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1. **Zonneveld, N.**, Kenis, P., Raab, J. (2025). *Samen Brede Welvaart realiseren in de praktijk. Whitepaper themalijn Netwerk Governance.* Academische Werkplaats (Be) sturen op Brede Welvaart, Tilburg University.
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## About the author

Nick Zonneveld (1989) is currently a Senior Researcher at Vilans, the Centre of Expertise for Care and Support. He also serves as Theme Manager of the Network Governance line within the Academic Collaborative Center for Governance and Management for Broad Prosperity at Tilburg University.

Nick's research focuses on interorganizational networks and collaboration in the public sector, particularly in healthcare, social care, and social services. He is fascinated by how individuals and organizations with diverse backgrounds, motivations, and capabilities work together towards a common goal. To study this, he employs a variety of methods, ranging from qualitative to quantitative approaches.

Nick has conducted research for a wide range of commissioners and funding bodies, including the *World Health Organization*, the *European Commission*, the *Dutch House of Representatives (Tweede Kamer)*, the *Ministry of Health, Welfare and Sport*, and *ZonMw*. During his time at Vilans and Tilburg University, he has published in scientific journals such as *Health Expectations*, *Leadership in Health Services*, *International Journal of Integrated Care*, *BMC Health Services Research*, *Public Policy and Administration*, *Journal of Clinical Medicine*, *Bestuurskunde*, and *Management & Organisatie*.

He conducted his PhD research at the Department of Organization Studies, School of Social and Behavioral Sciences at Tilburg University, under the supervision of Prof. Mirella Minkman, Prof. Patrick Kenis, and Prof. Jörg Raab. Before starting his PhD, Nick obtained a Master's degree in Public Administration from Erasmus University Rotterdam in 2011.

Driven by a strong commitment to making scientific knowledge accessible, Nick aims to translate research insights into formats that are understandable and useful for practice. This motivation is reflected in his work at Vilans and the Academic Collaborative Center, where he contributes to knowledge products such as white papers, webinars, roadmaps, and interactive formats like games and case-based learning tools.