Scientific Note

Institutionalization of Integrated Youth Care

What are the barriers and how to move forward?

Ingeborg Veldkamp & Nick Zonneveld

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Abstract

Youth care is increasingly organized in an integrated manner. In integrated health care, the services are provided over several professionals, organizations, and sectors. However, integration is a complex process. In order to integrate care, actors involved must institutionalize integrated working and thinking methods. This study examines the institutionalization process of integrated youth care and what barriers could be identified. A qualitative case study was done on a local youth care network in the Netherlands. 17 semi-structured interviews were conducted with various actors from the case study. In addition, a document analysis was done. We identified several regulative, normative, and cognitive barriers, that show that integration does not always take place. Our study reveals differences in whether those involved say that they consider integration important, or whether they actually think and act in an integrated manner. We therefore concluded that cognitive institutionalization is still insufficient.

Evidence for Practice

- Integrated care should be approached as a complex, non-linear and long-term process of system change, and not as a project.
- More attention needs to be paid to cultural embedding within the organizations themselves.
- Regulative facilitators are important to structure the integrated provision of care and needs to be aligned.

Keywords: Integrated care, institutionalization, local youth care network, barriers

Introduction

A challenge in youth care is to provide care for children and their families with complex issues across multiple life domains (Van Leeuwen, 2018). These issues are connected in such a way that often the expertise of professionals with different backgrounds is required. To organize this, multiple types of care and support services need to be integrated (WHO, 2015; Valentijn, 2015). Although integration of care and support services is widely seen as a promising strategy, the provision of youth care is still often fragmented. This leads to coordination problems in the provision of care. The often-heard reproach in youth care is that there are sometimes fifteen different care providers providing services to one family. These care providers do not always know about each other's existence (Van Leeuwen, 2018). Therefore, a shift towards integrated health care is needed.

A shift towards integrated healthcare could be seen as a social change. To understand this process, it is relevant to investigate whether actors in youth care adhere to integrated care working and thinking in practice, and if they actively contribute to the establishment of integrated care (Lawerence & Suddaby, 2006; Hardy & Maguire, 2017). This study looks at this integration process from an institutional theory perspective. Institutional theory assumes that integrated care needs to be institutionalized. Institutionalization is a process in which new systems of cultural and structural elements become embedded in existing ways of working and thinking and, in laymen's terms, begin to be 'taken for granted' (Tolbert & Zucker, 1996; Scott, 2014; Klijn & Koppenjan, 2014; Greenwood et al, 2017). A new institution of integrated care would imply that all actors involved look beyond the boundaries of their own disciplines, organization, and sector.

In the existing literature, many studies highlight facilitators, barriers, and interventions (De Bruin et al., 2020; Ling et al., 2012; Minkman, 2012; Nooteboom, 2021; Valentijn, 2015). Integration of services is, however, a complex and non-linear process, in which the entire healthcare system must adopt integrated ways of working and thinking. More insight is therefore needed about the process and which factors can hinder the integration of care (Goodwin, 2019). Therefore, the research question of this study is: what barriers could be identified in the institutionalization of integrated (youth) care? Additionally, we provide insight in what phase of institutionalization which barriers are most common.

Theory

Looking from an institutional theory approach, a change of the leading institutions in youth care is needed to achieve integration. Applying institutional theory offers insight on how institutional ideas, which are embedded in rules, cultures, and patterns of behaviour, influence the actions of individuals. Institutional theory focusses on systems of cultural elements, with which people give meaning to their daily activities (Rao, Monin & Durand, 2003). Institutions can be defined as "cognitive, normative, and regulatory structures that stabilize social behaviour. Institutions are transported by different carriers- cultures, structures, and routines – and they operate at multiple levels of jurisdiction" (Scott, 1995, 2014; Koppenjan & Klijn, 2014).

Table 1: Pillars of institutionalization

The regulatory pillar	Includes the ability to set rules and if necessary, the possibility of sanctions and rewards to prevent future behavior (Koppenjan & Klijn, 2014). In the field of integrated health care, this refers to the formal regulation of integrated partnership care, such as E-Health or financing.
The normative pillar	Refers to the coherent norms, values and objectives that shape the institution. Social coercion is a regulator of behavior (Koppenjan & Klijn, 2014). All actors involved share and believe in integrated care norms such as collaboration or holism (Zonneveld et al., 2018, 2020).
The cognitive pillar	Means that there is a shared framework of mental models or shared perceptions, that groups of individuals possess, that characterize social reality, and gives meaning to daily activities (Scott, 2014; Petracca & Gallanger, 2020). The cognitive institution within integrated care can be expressed, for example, in the underlying ideas about how the integral care is organized.

Institutional change

Institutionalization, or institutional change, occurs when new ideas, such as cross-border collaboration in youth care, become embedded in the existing structures or patterns of behaviour, or replaces existing structures (Tolbert & Zucker, 1996; Greenwood et al., 2017). There is much debate about whether institutions are subject to change, and what the role of human action is within this. After all, one of the characteristic aspects of institutions is that they are relatively stable and structure patterns of behaviour (Rao, Monin & Durand, 2003). At the same time institutions are socially constructed by people to understand their social reality (Berger & Luckmann, 1967). From this point of view, it can be argued that institutions are changeable and that individual actions can play a role (Lawrence & Suddaby, 2006; Hardy & Maguire, 2017). This contradiction is also known as the structure-agency debate. The question therefore is, how a change in the leading institutions within healthcare is possible.

According to structural theorists most organizations belong to an organizational field (Dimaggio & Powell, 1983). An organizational field can be defined as a set of organizations that are materially or immaterially linked to each other (Tolbert & Zucker, 1983). This perspective is important because the organizations within integrated care are also linked to each other within an organizational field. The behaviour of the organizations within the field arises from mutual interaction with each other (Greenwood et al., 2002). It can be argued that leading institutions can change, if the mutual interaction changes, a process that's called isomorphism. According to Tolbert & Zucker (1996) institutionalization within organizational fields develops in three stages.

1. The pre-industrialization phase starts when the established order is destabilized. This can be caused by changes within policy and legislation, market forces or technological changes. The organizations will respond to these external changes by making new agreements and innovating internally. Gradually, this results in new formal rules, policies, and procedures. In this phase, especially regulative institutions are created.

2. In the semi-industrialization phase the new structural order is moving to a more permanent status. Tolbert and Zucker (1996) refer within this phase to 'objectification' which means that social consensus develops among the organizational decision-makers about the value of the new structural order. To reach consensus, evidence can be gathered to ensure the new structure is potentially successful. In this phase there is normative acceptance of the new structures, so mainly the normative pillar is defined. However, acceptance is not optimally completed, because adopters still tend to stay informed and monitor the success or failure of the change.

3. The full-institutionalization phase means the new institution is fully disseminated and accepted across the members of the organizational field. It relies on the historical continuity, and above all on the permanence of the new institution's existence, which will survive generations of organizational field members. Full institutionalization occurs when there is cognitive legitimacy and the ideas are taken for granted (Petracca & Gallanger, 2020). This phase is therefore strongly related to the cognitive pillar (Scott, 1994; Tolbert & Zucker, 1996; Klijn & Koppenjan, 2014).

However, institutional change is often not as linear as described above. While some organizations may adapt to an organizational field, others may deviate from these norms. Isomorphism thus falls short in explaining organizational differences, or institutional complexity, and the role of individuals within institutional change, a common criticism from the agency-side of the debate (Greenwood et al., 2017; Lawrence & Suddaby, 2006; Hardy & Lawrence, 2004; Hardy & Maguire, 2017). Institutional complexity occurs when the different organizations have differentiated or incompatible ways of working and thinking (Greenwood et al., 2010). In this article, we refer to institutional complexity as 'barriers'. Integrated care may especially deal with this complexity since organizations with different cultures and frames of reference work together. This could make the transformation to integration of care services more difficult. In this study, we therefore look barriers within the institutionalization process.

Methods

To gain deeper insight into the institutionalization process of integrated youth care, we conducted a qualitative case study. A local youth care partnership in the Netherlands was used as a case study. This youth care partnership has the ambition to deliver integrated care and support to children and their families. In this partnership, 14 municipalities and 11 health care organizations are involved. To maintain its anonymity, we refer to it as "the youth care partnership".

Table 2: Respondents

Respondent	Role	Organization
R1	Policy officer	Municipality A
R2	Policy officer	Municipality B
R3	Team manager	Healthcare organization A
R4	Healthcare manager	Healthcare organization B
R5	Alderman	Municipality C
R6	Healthcare manager	Healthcare organization C
R7	Policy officer	Municipality D
R8	Care line manager	Healthcare organization D
R9	Nurse specialist	Healthcare organization E
R10	Remedial educationalist	Healthcare organization F
R11	Project supporter	The youth care partnership
R12	Behavioural scientist/manager	Healthcare organization C
R13	Policy officer	Municipality A
R14	Policy officer	Municipality B
R15	Behavioural scientist	Healthcare organization G
R16	Psychologist	Healthcare organization H
R17	Psychologist	Healthcare organization I

To investigate the institutionalization process of the case study, semi-structured interviews were held with 17 respondents. The respondents were selected based on a stratified purposive sampling. The youth care partnership is divided in three different teams with a different scope or specialty. Various organizations are involved in these teams. The aim was to speak to a respondent of each of the organizations involved in one team of the youth care partnership. This means that respondents with different roles were involved in the study (table 2).

The study also includes a document-analysis. The sampling of the documents was purposive. All policy documents of one team of the youth care partnership were used. The policy documents were analyzed searching for different facilitators that should organize the integral collaboration.

The qualitative data were analyzed using an inductive approach, which is mainly explorative and explanatory in nature. A qualitative and inductive research strategy is appropriate because institutional theory is based on social constructivism, a process in which beliefs, norms and values are constructed and shared through a process of social construction, and this strategy makes it possible to examine these underlying beliefs, norms, and values. The interviews and documents were analyzed by using coding in MAXQDA. Three rounds of coding (open, axial, and selecting) were done and a second researcher supervised the coding process. During the coding process, we focused on whether respondents have or share integrated norms, values, beliefs, and working-methods, and if there are barriers within the regulatory, normative, and cognitive pillars.

Results

Our analysis identified barriers experienced by the respondents.

Barriers within the regulative pillar

A lack of interorganizational governance: most respondents (N=11) recognize that having a joint governance structure promotes integration. The youth care partnership is divided into three teams, in these 'teams' various relevant organizations are associated. These teams have different project teams and different administrative structures. Above these development teams, there are five managerial leaders. Most respondents believe that the division into teams with project leaders is the interorganizational governance of the partnership. Because they have started a joint project and speak to each other through this project on daily basis or weekly basis.

However, respondents (n=11) acknowledge that this inter-organizational governance is only centered on the people who have a role in the governance structures as described above and that the organizational change itself has not yet started. The changes that are discussed in the development teams do not yet happen consistently in daily tasks

of health care professionals. The respondents indicate that the current interorganizational governance has not yet been able to implement integrated working methods in all organizations. Working methods such as integrated financing, joint diagnosis structures or professional collaboration and mutual dependence in the provision of care.

Financial barriers: the financing structure of youth care must be adapted to integrated cooperation. Some respondents (N=4) therefore believe that financing should be arranged per patient and not per organization, this makes it easier to treat one patient with multiple organizations. R9: "(…) Then we work with one child, one care program with one financing plan. And this way, the care remains manageable. And we can all achieve that of we work together more closely". However, the respondents (N=15) mentioned that the current financing is impeding the integrated collaboration, due to the way in which care is financed per patient, R4: "It is complicated there, because the funding is not designed for integrated youth care, the funding is organized according to specialism". First, the financing of care organizations per specialism, encourages competition between the various organizations. Because when the care organizations are financed per patient, the incentive to refer a patient to another organizations disappears. R16: "If you no longer have to compete within tenders, this will benefit the cooperation and vision of the region". Secondly, to allow clients with multiple problems to be treated by different specialisms, forms of 'under contract' are arranged between the care organizations. Many healthcare providers see this as a barrier.

Inequality in the degree of interdependence: the care providers involved, differ in expertise, specialism, and regional/national range. It is important to show the differences between the organizations because some respondents (N=8) have insisted that there is a difference in dependence on the integrated network. While some organizations greatly depend on the existence of the network, others are less. First, care organizations who provide supra-regional or national work, depend less on the network than the providers who are only regionally located. Second, some smaller organizations are more dependent on municipal funding than the larger healthcare organizations, R7: "the organizations who really depend on municipal funding, are more willing to change. And the one who is less, is more likely to say I don't want to change, because I have other sources to provide care". At last, respondents (N=5) also indicate that there is a difference between the municipalities in the degree of dependence. Smaller municipalities with a greater demand for youth care, seems to need the network more, than larger municipalities.

Barriers within the normative pillar

Clashing or competing norms and values: within the normative pillar, respondents mention barriers that impede collaboration, such as clashing or competing norms and values and a lack of trust. Although all respondents (N=17) prioritized collaboration as the most important value, in practice there still seem to be clashes between other values. R10: "Time and money, that's the clash. In the partnership you want to be complete and extensive, you don't want to skip anyone, you want to collaborate. But as a healthcare organization, you want to have effective results as soon as possible". The clash between care provision and affordable care, and between collaboration and efficiency are recognized by most respondents (N=8). The high pressure on youth care, due to long waiting lists, financial and labour shortages, ensures that organizations also put their own organizational and client's interests ahead of the network's interest. This puts the value of "cooperation" under pressure, R4: "If you are a specialist and you must treat suicidal children, then you are busy stabilizing the child. And then it is quite complicated to stay oriented towards collaboration"

Due to the competition and the financing structure, not all organizations completely trust each other, this was recognized as a barrier in the collaboration. R14: "Really trusting? I don't know. I think organizations within the partnership are also afraid of losing their market position, through collaboration you can lose your clients, thus revenue.

Barriers within the cognitive pillar

The cognitive pillar refers to the cultural embedding of integrated care. This means that the provision of integrated care is taken for granted by the involved professionals and organizations. Respondents believe that the partnership has taken serious steps to create some cultural understanding of collaboration in the provision of care. However, it is not enough to transform the healthcare service in the partnership, because integrated working methods have not yet been fully implemented within the organizations and organizational cultures themselves. R2: "If your

goal is to connect and collaborate, then it goes well, but if you want to transform the healthcare, then it goes very small steps".

Within the cognitive pillar, the institutionalizing of the integrated care principles has not happened yet. Especially because organizations can still provide good care, without having to work together exclusively for it. In addition, it seems more efficient to organize care as an organization itself than together, due to the many care requests within youth care, few health care personnel and financial shortages. Here is no sense of interdependence yet, so youth care organizations are prioritizing their own organizations, and don't think integrally yet. R14: "and we can't wait, because waiting lists are of course huge, and outflow is difficult. That something prove care with their own organizations is faster than provide the care integral".

Most often, respondents (N=9) recognized that the institutionalization of integrated care principles in the youth care partnership has not been optimally completed, since the facilitators and changes towards the provision of integrated care have not yet been implemented or culturally embedded within the organizations themselves. There is a difference between the policy and management ideas, and the implementation of care itself within the organizations. R9: "What I see, is that some people of the organizations commit themselves to the partnership. But in the meantime, it is left to the people who have signed up for the pilot, and it will therefore not be widespread within the organization".

Figure 1: Institutional barriers

Institutional barriers		
Regulatory pillar	***Normative pillar***	***Cognitive pillar***
• Lack of interorganizational governance • Financial barriers • Inequality in the degree of interdependency	• Clashing or competing norms and values • Lack of trust	• Lack of integral thinking and acting • Lack of cultural embedding of integral principles within the organizations themselves

Discussion

In our study, we have investigated the integration of youth care services by looking through the lens of institutional theory. In this way, we approached integration of youth care as an institutionalization process. We have identified several barriers within this process. In the regulatory pillar we identified a lack of interorganizational governance and finance, and a lack of dependency between actors. The importance of suiting governance arrangements (Minkman, 2017; Provan & Kenis, 2008) and funding (Struijs et al., 2015; Tsiachristas, 2016) are frequently mentioned in the literature. In the normative pillar, the results demonstrated clashing norms and values, and a lack of trust, which importance is also often stressed in the literature (Goodwin, 2013; Zonneveld et al., 2022).

Integration of services is still often seen as an instrument, intervention, or project to improve youth care. By applying institutional theory our study has demonstrated that integration is a complex non-linear process. In which the change towards integrated care is an interaction between regulatory system changes, and the way in which individual organizations or professionals respond to these changes. Integrated care could be seen as a system change, in which an entire healthcare system must start working and thinking from integrated care principles. That's why we believe that in addition to the attention for regulatory and normative aspects, attention should also be paid to the cognitive embedding of integrated care.

The barriers identified in this study can be placed in the institutionalization phases by Tolbert and Zucker (1996). The pre-industrialization phase is usually triggered by pressure from external factors. In this case, the triggering factor was the decentralization of youth care in 2015. This was followed by a period of destabilization, in which new structures were devised by policymakers. Within the first phase of the collaboration, various policymakers developed new plans. During the interviews explicit questions were asked about how the youth care partnership is organized, how cooperation with various actors works and what the partnership does to integrate. However, several regulative barriers occurred that impede the integral collaboration within the partnership. These barriers can be placed in the regulatory

pillar of institutionalization (Scott, 1994; Koppenjan and Klijn, 2014).

The semi-industrialization phase is characterized by the normative acceptance of the new structures (Tolbert & Zucker, 1996). The study findings show that the partnership paid attention to normative integration. Almost all respondents indicated that cooperation was one of the most important values. But that due to a lack of trust and a lack of integral regulative patterns, norms and values could clash within the youth care partnership.

The full-institutionalization phase can be characterized by the cognitive legitimacy of the new structural order (Tolbert & Zucker, 1996). In this case this would mean that care integration is taken for granted by the professionals involved. It should be self-evident that partners need each other in care delivery, to refer patients to partners, and to think and act beyond organizational boundaries. The respondents were asked if the partnership is already optimally integrated. Most respondents indicated that this was not yet the case and that still many barriers that stood in the way. Most respondents mention that they do not always automatically refer patients to other organizations in the partnership, and that organizing care within their own organization is often faster.

To conclude, this study demonstrated a strong focus on the regulatory facilitators to integrated youth care. This means that mainly the working methods are integrated, but that not all actors think from integrated principles yet, or that all actors have 'shared mental models' (Im et al., 2022). Future research could focus more on the cultural embedding of integrated care principles and on how organizations internally deal with the transformation towards integrated health care.

Conclusion

This study analyses the process of integrating youth care services, by applying institutional theory. Several barriers in this process have been identified. The barriers identified in this study can be distinguished within the regulatory, normative, and cognitive pillar of institutionalization. Within the regulatory pillar, we have seen 1) a lack of interorganizational governance, 2) financial barriers and 3) a difference in the degree of dependency. Within the normative pillar, we have seen 1) clashing or competing norms and values and, 2) a lack of trust. Within the cognitive pillar, we have seen 1) a lack of integral thinking and acting and, 2) a lack of cultural embedding of integral principles within the organizations themselves.

By using institutional theory, this study demonstrates that integration of youth care services includes more than the implementation of an intervention or working method. Integration of youth care services can be seen as an institutionalization process and system change, which also includes new ways of working and thinking. In other words: a system change. This insight is relevant for policy and decision makers pursuing integration of youth care services. It can be concluded that the youth care partnership is still in development, in which traditional ways of working and thinking impede the transformation process towards integration. More facilitators or strategies from the organizations themselves are therefore needed to achieve integrated care.

A note from the authors

Ingeborg Veldkamp is a lecturer and researcher in public administration at the Thorbecke Academy of NHL Stenden. Ingeborg studied history (University of Groningen) and public administration (Erasmus University Rotterdam). Ingeborg is currently involved in the Vital Governance research group, where research is conducted into political-administrative challenges in the Northern parts of the Netherlands.

Nick Zonneveld is a health services/health system researcher with a Master's in Public Administration from Erasmus University (2011). Nick currently is a PhD candidate at Tilburg University and works at Vilans, Centre of Excellence in Long Term and Social Care in the Netherlands. Nick is involved in several international and national research projects on governance and organization of integrated health care and social care.

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