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Pilot Population Management Wesselerbrink

A qualitative case study of social innovation in healthcare

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Abstract

In the neighborhood Wesselerbrink in the city of Enschede in the Netherlands, an experimental Pilot in the domain of capitation financed healthcare was conducted with the aim of improving the health and the individual experience of care for the given population while simultaneously trying to reduce the associated healthcare costs per capita. This thesis intends to present a qualitative case study of the Pilot in order to establish why the innovation process facilitated the failure of successfully developing a social innovation. Future attempts to embark on the journey of social innovation in the domain of healthcare provision might benefit from the lessons drawn in this study.

Keywords: Failed Social Innovation; Population Management Wesselerbrink

Table of contents

1. Introduction

As indicated in the abstract, this thesis constitutes a qualitative analysis of a social experiment that was intended to lead to the development of a social innovation. Bekkers (2016, p.12) uses the following definition of social innovation as formulated by Voorberg et al (2014): "…the creation of long lasting outcomes that aim to address societal needs by fundamentally changing the relationships, positions, and rules between the involved stakeholders, through a process of participation and collaboration".

Much literature has been written about social innovation and how it constitutes a solution to a variety of social problems like the ageing of the population and the associated rising costs of healthcare. However, very little literature is available on the failure of social innovation, which is by itself rather curious, as it is by no means an easy task to successfully realize a social innovation. Seeing as the social problems of modern-day society are very difficult to solve, such as the rising costs in healthcare due to the ageing of the population, social innovation seems to be regarded more often as a possible solution to these problems. Thus, this thesis will evaluate how the innovation process during the realization of the Pilot failed to facilitate the development of a social innovation. Consequently, by reading this thesis, organizations that attempt to realize a social innovation will know what approach to take and which pitfalls to avoid.

1.1. Background

Healthcare provision in the Netherlands is rapidly changing due to the fact that it starts to become too expensive. The CPB Netherlands Bureau for Economic Policy Analysis (CPB) calculated that about 8% of the Dutch gross domestic product (GDP) was spend on healthcare in the year 1972 (Van der Horst et al, 2011). In 2010, this percentage stood at 13.2%, but in 2040, depending partly on the choices made by future Dutch governments, the percentage could increase to anywhere between 22% and 31% of GDP. For decades, the costs of healthcare in the Netherlands have been increasing more rapidly than the economic growth. This is to be blamed partly on the proportional rise in the ageing population, who tend to make more use of the healthcare services, and partly on the development of new but costly treatments. To ensure healthcare does not become unaffordable, the healthcare provision is rapidly changing. In the case of preventive, curative and long-term care, the government reserves less money for the provision of healthcare and support of its citizens, while simultaneously focusing on prevention and the citizen's ability to live independently with the help of his or her own

network in order to set-up an integral, holistic plan of treatment aimed at making the citizen healthy again.

An example of the Dutch government's efforts to cut down on healthcare costs is the adoption of the law "Wet maatschappelijke ondersteuning 2015" (Wmo 2015), which, translated in English, means as much as the "Social Support Act 2015". This law came into force on 1 January 2015 and it determines the transfer of caring responsibilities in the domain of extramural healthcare from the central government to the municipalities (Gevolgen invoering WMO, 2014). Caring responsibilities like the provision of daytime activities and healthcare attendance of the independently living elderly, chronically ill and handicapped people are now the responsibility of the municipalities. At the same time, this law ensures citizens are no longer offered long-term healthcare attendance that is paid for by the municipality without first checking if there are any people within their own network capable of offering healthcare attendance (for free). Consequently, every citizen will receive an interview of admission that determines exactly what kind of healthcare attendance their own network can provide before the municipality will fund any additional help. This a measure that is intended to cut down on healthcare costs for the municipality, seeing as the transfer of healthcare responsibilities by the central government was accompanied by a lower financial budget on the presumption that municipalities are standing in closer relation to their citizens than the central government and should thus be able to deliver healthcare cheaper and more efficiently.

Seeing as municipalities are now required to provide healthcare services while doing it on a cheaper basis than the central government used to, there exists a dire need for the development of new, innovative approaches in healthcare provision. The Dutch municipality Enschede has chosen to experiment with capitation financed healthcare in the neighborhood Wesselerbrink. This project has been given several, slightly different names during its development, one of which is "Pilot Populatiemanagement Wesselerbrink Enschede". Throughout this thesis, it will always be referred to as the Pilot.

In Wesselerbrink, the objective of the Pilot was to strive for the realization of at least one of three separate goals referred to as the Triple Aim by Berwick et al (2008), namely: to improve the individual experience of care, to improve the health of the population, and to reduce the healthcare costs per capita for the given population (Projectgroep Populatiemanagement, 2015, p.7). To realize the objectives of the Pilot, new and innovative healthcare arrangements for the clients in Wesselerbrink were supposed to be developed (Projectgroep Populatiemanagement, 2015, p.17). However, the focus of the Pilot is limited to the provision of healthcare arrangements and their subsequent costs regarding

extramural healthcare under the domain of the Wmo 2015, "Wlz" and "Zvw" (Projectgroep Populatiemanagement, 2015, p.9). This statement requires a slightly further explanation:

In the Netherlands, extramural healthcare, meaning care that is provided to the client at home and not in for instance a hospital, is provided under the domain of various acts including the earlier mentioned Wmo 2015, the Wet langdurige zorg (Wlz) and the Zorgverzekeringswet (Zvw) (Ministerie van Volksgezondheid, Welzijn en Sport, 2016). Translated in English, these laws respectively stand for the "Social Support Act 2015", "Long-term Care Act", and "Health Insurance Act". A citizen who feels he or she requires extramural healthcare can officially apply for it after which an employee of the municipality will have a personal conversation with the citizen in order to determine whether extramural care provided by a healthcare organization is required. If so, a healthcare arrangement is offered to the citizen that falls under a certain act, for instance under the Wmo 2015. When, for instance, someone had an accident and is therefore not able to clean their house for an extended period of time and there is no one in his or her personal network able/willing to help, a healthcare arrangement that entails domestic help might be issued under the Wmo 2015 seeing as it falls under the domain of this specific act. The innovative healthcare arrangements offered in the Pilot are supposed to be able to potentially fall under the combined domains of the Wmo 2015, Wlz and Zvw, which is normally not allowed. This encourages the development of healthcare arrangements completely new to the domain of extramural healthcare. For instance, when a healthcare professional feels it will be beneficial to the health of a client to arrange for an excursion to an amusement park, then this can be arranged and will be paid for by the health insurance company (de Vries, 2017). Simply put, the realization of the objectives of the Pilot require social innovation, which constitutes the background upon which this thesis is written.

The Pilot was supposed to take place in three neighborhoods in Enschede, namely in Wesselerbrink, Glanerbrug and Pathmos-Stevenfenne/Stadsveld (Projectgroep Populatiemanagement, 2015, p.6). The idea was for the municipality Enschede, referred to as "Enschede" from now on, to cooperate together with the health insurance company Menzis, which is the one with the largest amount of clients in Enschede, and nine healthcare organizations that are also active in Enschede. These organizations are: Ariëns Zorgpalet, Aveleijn, Bruggerbosch, de Posten, Livio, Zorggroep Manna, Mediant, RIBW GO and TSN. Together, these organizations are referred to as the "Consortium" and they carried the responsibility of establishing the objectives of the Pilot and making sure these got carried out and concluded.

Not all healthcare organizations were supposed to be present in every neighborhood, but rather, every neighborhood was assigned a certain number of healthcare organizations, who were intended to cooperate with each other. The division was the following:

- Wesselerbrink: Aveleijn, de Posten, Livio, RIBW GO and Zorggroep Manna
- Glanerbrug: Ariëns Zorgpalet, Bruggerbosch, Livio and Zorggroep Manna
- Pathmos-Stevenfenne/Stadsveld: TSN, Zorggroep Manna and other to be determined parties.

On 12 June 2014, the Consortium came together to sign a declaration of intention in which they sketched the outlines of their intended collaboration in these three neighborhoods (Projectgroep Populatiemanagement, 2015, p.6). Each neighborhood would have their own lay-out, agreements and planning lumped together under the common denominator of the Pilot. Subsequently, the first neighborhood in which the Pilot would commence was in Wesselerbrink on 1 January 2016 (Projectgroep Populatiemanagement, 2015, p.7) and once the Consortium deemed the Pilot to be successful in Wesselerbrink, plans would be made for the Pilot to start in the other two neighborhoods. The Pilot was supposed to be concluded on 31 December 2017. However, on 8 May 2017, the decision was made to terminate the Pilot prematurely after which it was de facto concluded around 19 May 2017 when all the pending issues were dealt with (de Vries, 2017). In addition, the Pilot was only ever conducted in Wesselerbrink, which had been the result of an insufficient progress towards the realization of the objectives of the Pilot.

In July 2017, a proposal for a new Pilot will be submitted to the Pilot's steering committee and as soon as it is agreed upon, the new Pilot is supposed to commence somewhere in the fall of 2017, but a precise starting date could not be provided yet (de Vries, 2017).

1.2. Research questions

As mentioned in the previous section, the realization of the objectives of the Pilot required the development of new, innovative healthcare arrangements, which can be regarded as an intent to develop a social innovation. However, the social innovation failed and in order to establish why this happened, the main research question constitutes the following:

To what extent did the innovation process facilitate the failure to successfully develop a social innovation in the Pilot?

In order to answer the main research question, it is necessary to provide an analysis of the time during which the Pilot was conducted. However, there are various ways to conduct this analysis and to that extent, it is important to first determine which specific factors the analysis will focus at in terms of the development process of the Pilot. Therefore, the first sub-question constitutes the following:

Which factors are important to the development of the Pilot?

The innovation process behind the development of a social innovation can be analyzed in many different ways. In this thesis, the decision was made to base the analysis on the environment in which the Pilot took place and six different factors that function as drivers or barriers that enhance or impede the successful development of a social innovation. These factors are: the learning process factor; the leadership factor; the administrative culture factor; the internal procedures, routines and systems factor; the resource slack factor and the citizens factor. The decision behind analyzing the innovation process of the Pilot in this particular way was inspired by previous research conducted in the research project LIPSE on social innovation in the public sector. LIPSE, which stands for Learning from Innovation in Public Sector Environments, was conducted between 2013 and 2016 and it studied the drivers and barriers behind the innovation process that determined the success of a social innovation (*Lipse – home*, 2017). Thus, it formed an excellent source of inspiration behind determining the approach upon which the innovation process behind the Pilot should be analyzed. The second sub-question is:

Which lessons can be extracted from the outcome of the Pilot?

The reasons for formulating this additional sub-question were twofold. First, the Pilot is not the only experiment in regards to the provision of alternative kinds of extramural healthcare. Bekkers (2014) described that many of such experiments are conducted in municipalities all over the Netherlands ever since the adoption of the Wmo 2015. As mentioned earlier, the municipalities did not only become responsible for the provision of extramural healthcare for its citizens due to this law, but this healthcare is supposed to be provided with a smaller financial budget at the same time. This forms the reason behind all of these experiments regarding healthcare provision and they are still being conducted at the time during and after this thesis was written, at least for a couple of more years. Therefore, the analysis of the innovation process behind the Pilot is also providing a general insight in how one should approach the development of what is supposed to become a social innovation. Second, the Pilot was terminated prematurely but a follow-up Pilot is supposed to be conducted in the fall of 2017 (de Vries, 2017). To ensure the new Pilot will manage to realize the Triple Aim objectives, in comparison to the old one, the analysis of the innovation process will not only describe what could have gone better, but it will also provide recommendations as to what could be improved the next time. Consequently, this thesis fills a research gap by extracting lessons from the outcome of the Pilot to the benefit of not only its successor, but also to future experiments with healthcare provision that are to be conducted in other municipalities.

2. Theoretical framework

This chapter describes the factors that are important for the analysis of the innovation process behind the Pilot. It starts with a conceptualization of social innovation after which the consecutive sections will provide a detailed description of the environment and the six other factors that are essential to examine in detail seeing as they influence the innovation process by functioning either as a driver or a barrier in its development.

2.1. Conceptualizing social innovation

Social innovation is a rather vague concept that requires a very precise definition. Pollitt and Hupe (2011) defined it as one of the "magic concepts", a so-called pervasively used key-term among academics and practitioners. It has a broad scope, great flexibility, is regarded very positively and will provide a solution for the most tenacious social problems in the domain of public policy that modern societies face. Mulgan (2010), for instance, mentions the ageing of the population and the subsequent rising costs of healthcare, budgetary crises in every possible domain, to improve the quality of the educational system and to reinvigorate socially and economically deprived cities and regions. In academic discourse, these problems are often referred to as "wicked problems", which are essentially problems that are very difficult or sometimes even impossible to solve, due to the incapacity of one organization to understand its scope as well as prevailing disagreement about its causes and the best way to tackle them (Conklin, 2006). When bringing up the "magic concept" of social innovation to address these wicked problems, one stimulates the development of various new frameworks, paradigms and approaches by the actors who are presupposed to solve them. On the one hand, this can be regarded as a positive development, but on the other hand the variety in newly developed practices impedes the analysis of a pragmatic and evidence-based view of the potential of these new practices. As a result, social innovation lacks a proper conceptualization in policy-oriented literature such as that of Mulgan (2010), Mair (2010), Cels et al (2012), and Bates (2012). This type of literature contains a lot of advice and "to-do lists" that tries to facilitate social innovation without offering a proper conceptualization that can be used in dealing with all kinds of wicked problems instead of only a specific one.

Taking the aforementioned into consideration, it is necessary for the purpose of this thesis to first conceptualize the definition of social innovation. Bekkers et al (2013) identified four recurring factors in the literature on social innovation:

First, social innovation requires that the outcome of a production is need-oriented for society or a societal group of people. In its essence, a social innovation should constitute an innovative activity or a service with the desire to fulfill a societal need by creating a social or public good that benefits society. This societal need constitutes more than the mere fulfillment of an economic necessity such as an improvement in the efficiency and effectiveness of a public service. Instead, one might also think of improving access to a public service or improving citizen participation, as indicated by Mulgan (2007) and Cels et al (2012). Thus, social innovation revolves around the creation of added societal and public value.

Second, social innovations are required to fulfill societal needs and therefore cannot be realized without the involvement and participation of relevant stakeholders in the development, implementation, monitoring and adoption. In its essence, social innovation is a process of open co-creation, as described by Bason (2014) and Lee et al (2012). Gloor (2005), Bommert (2010) and Sørensen & Torfing (2011) are referring to social innovation as a process of collaborative innovation. An example would be the actual subject of this thesis in which the public sector, the municipality in this case, cooperates with the private sector, which are the healthcare insurance company and healthcare organizations, in order to fulfill the societal need of improving the state of health of the citizens, improving the quality of healthcare and reducing its costs.

Third, the public sector has a history of being supply-driven instead of need-driven. With the development of more need-driven public services through the process of social innovation, new social relationships as well as new types of collaboration come to exist between the various involved actors. Additionally, this will lead to the development of new types of coordination and communication (Bason, 2014). These new kinds of social relationships, collaboration, coordination and communication can be constituted as game changers, because they have the potential to fundamentally alter the way in which the services that deal with collective challenges are produced and organized. That way, the usual rules one applies to solving societal problems are altered as well. Bates (2012) describes how this creates the opportunity to develop new arrangements, which constitutes a discontinuity with the past, as mentioned by Osborne & Brown (2005). To illustrate, one might look at the example of the collaboration between citizens who make use of solar energy as their main source of energy. By producing solar energy by themselves through solar panels and subsequently sharing the generated electricity among them or with the energy producers, they are no longer dependent on local energy producers, who often have a monopoly position as well. These energy co-operations have completely changed the existing way of energy production and distribution business models, which resulted in the process of institutional conversion as mentioned by Thelen (2006).

Fourth, social innovation specifically emphasizes that the new outcomes it is supposed to generate are not necessarily innovations driven by science and technology. Instead, Howaldt & Schwarz (2010) mention how a social innovation often constitutes changes in behavior, attitudes, relationships and interaction patterns. An example of this can be found in dealing with the societal need of reducing obesity. In general, to reduce obesity, one requires a change in behavior rather than a scientific or technological innovation. Thus, an emphasis should be put on procuring behavioral insights.

Taking these four recurring factors in the literature on social innovation into consideration, Bekkers (2016, p.12) uses the following definition of social innovation as formulated by Voorberg et al (2014): "…the creation of long lasting outcomes that aim to address societal needs by fundamentally changing the relationships, positions, and rules between the involved stakeholders, through a process of participation and collaboration".

2.2. The environment of the social innovation

The environment in which the social innovation takes places usually contains a number of challenges, hence it is seen as an important source for public sector innovation. Osborne & Brown (2005) mention how it is precisely these challenges that trigger the decision to develop a social innovation. Often, these challenges stand in relation to a perceived performance deficit, which has to do with shortcomings in both the efficiency and the effectiveness of the operations within the organization.

De Vries et al (2015), who together made an analysis on the basis of empirical literature in regards to public sector innovation, have established that pressure from the environment can be considered as an important driver for successful public sector innovation. This environmental pressure constitutes public and political demands in combination with media attention, which can subsequently trigger the development of a social innovation.

Additionally, Van Acker et al (2015) mention how this pressure from the environment can be regarded as an actual incentive by public sector organizations to recognize the need for a social innovation and to start developing it. Thus, Van Acker et al (2015) state in a more general sense that external accountability, for instance to the government or the population in general, which is apparent from the fulfillment of imposed regulatory norms, actually functions as an incentive to innovate. This is actually an interesting observation, seeing as further research conducted by Albareda et al (2014) and Voorberg et al (2015) is also showing that the development of new regulatory frameworks and regulations in general by the government actually function as an inducement leading to the development of new innovative solutions or the taking over of an approach of one organization by

the other. The general assumption is that regulations are working as an impediment or barrier to innovation seeing as these regulations are looked upon as a distortion, but the literature on the environment in which a social innovation is conducted disprove this. Rather, the regulations are functioning as guarantees to ensure a minimum service quality thereby enhancing the safety. As a matter of fact, without the presence of these regulatory frameworks, one would actually really be confronted with a barrier, seeing as a lack of a minimum quality of a service would pose a risk that impedes the ability of organizations to develop and adopt new innovations. This has been confirmed through research conducted by Flemig et al (2015) and Nasi et al (2015). In sum, regulations are actually constituting a driver that cultivates the process of innovation.

The extent to which external demands on organizations, for instance by the imposing of regulations, as mentioned earlier, influence the innovation process has been more closely examined by Albareda et al (2014). They looked at the innovative capacity of metropolitan areas and governments in cities like Rotterdam, Barcelona and Copenhagen and the relation between the respective characteristics of the environments they have to operate in. They found that external factors, such as changes in demography, unemployment, healthcare and economic growth, stand in relation to external demands, such as pressure employed by the media, the national government or an economic crisis, as well as to political factors, like citizen engagement and elections, and finally to internal factors, like internal reorganization, the strategic plans of an organization and a change in internal procedures. In European countries, they concluded that social innovation practices are a result of co-evolution, as mentioned earlier, of various developments in different environments, both internally and externally, determined on the basis of the applicable context thereby making it contingent. Often, the demands that come from various environments are mixed together in the discussion about the development of a social innovation. If one regards these external demands coming from the environment as challenges for the development of an innovation, then the process of innovation is linked to an agenda-setting process as well, which creates a specific policy window. At the same time, it is then required to have leadership, for instance in the form of a so-called policy entrepreneur, who is responsible for combining all the developments in the innovation process in a sense-making and coherent way. The importance of leadership in the innovation process will be discussed later in section 2.4. regarding the leadership factor.

Furthermore, research by Albareda et al (2014) has shown the existence of a discrepancy between the way a municipality rates its own innovativeness and the way its innovativeness is perceived in that same municipality in its external networks, which the representatives of the municipality participate in. This observation has led to two implications. First, if one wishes to improve the innovative

capabilities of a public organization, one can decide to systematically explore the existing external perception of the innovativeness of the public organization to allow for an improvement of the innovative capacity. This can be achieved for instance by ensuring the affected community is involved in defining the challenges the social innovation is supposed to solve. Deciding to set up a system that allows for self-assessing by the municipality to monitor the extent of their responsiveness in regards to meeting external needs and challenges would help in that regard. The second implication has to do with a human resource aspect. Research conducted by Albareda et al (2014) has shown the existence of a positive correlation between the self-rated innovativeness of a municipality and its external communication, which indicates that the people within an organization that uphold contact with people from the outside, meaning the population or citizens, are also holding the innovativeness of the organization in a higher esteem, while simultaneously having a more positive work orientation. Therefore, one can conclude that this way of work orientation is also constituting a driver for successful innovation.

Seeing as the process of social innovation in the public sector is dependent on the cooperation between a large variety of actors such as citizens, other public organizations, companies and social groups, the environment also functions as a reservoir of social capital. This means that the cooperation of an organization with various professional and social networks is also forming a driver for social innovation. After all, the cooperation with social and professional networks grants an organization access to new knowledge, information, ideas, expertise and support in general that is beneficial to the social innovation. An added benefit of this cooperation constitutes the organization's ability to be more in touch with the changing needs and developments in their direct environment, increasing their responsiveness to it. Thus, the role of both social capital and informal networks can be regarded as a driver for innovation.

Additionally, Albareda et al (2014) emphasized how there exists a relation between the structure of the informal network and the administrative structure of an organization. This means that a formal administrative structure that deals mainly with external-oriented tasks is also bringing about an external informal network, which increases the organization's social capital. However, there is one remark to be made in regards to this observation, namely that an organization can only fully exploit their environmental resources with the help of innovation intermediaries and boundary spanning. Innovation intermediaries, also referred to as bridgers, brokers, or change agents, are the individuals, firms or agencies facilitating innovation by bringing together all the necessary knowledge and stakeholders that allow for a successful innovation. Boundary spanning specifically refers to the individuals in the innovation process that link together the internal networks of an organization with

external sources of information. However, the success of innovation intermediaries and the process of boundary spanning requires a certain type of leadership, which will again be discussed in section 2.4. regarding the leadership factor.

Finally, one has to take into consideration the extent to which a country is ready to innovate, which also constitutes a part of the innovation environment. This has partly do with the administrative culture of a country, which will be discussed in section 2.5. However, Nasi et al (2015), who have conducted research regarding the drivers and barriers of adoption, diffusion and upscaling of social innovation in the public sector driven by changes in the ICT department, put emphasis on the technological, demographic and socioeconomic characteristics of a country. When discussing the adoption of social innovation driven by ICT changes, they mentioned how the quality of the ICT infrastructure of a country and the possible digital divide, meaning the ICT infrastructure is not equally developed everywhere, can also constitute a driver or barrier for social innovation. This could mean that in order to stimulate the innovation readiness of a country to allow for innovation in the public sector to take place, initial investments might be required to improve the innovation climate.

2.3. The learning process factor

Osborne & Brown (2009) referred to the process of innovation as the development, adoption and implementation of a new service that has to be discontinuing with the way in which the service was provided in the past. Van Acker et al (2015) and Flemig et al (2015) emphasized how the process of development, adoption and implementation of a new service should be analyzed in detail. They found that this process constitutes an actual process of learning from which they drew the conclusion that innovation processes are equal to a learning process between and in organizations. To improve the debate on public sector innovation, one should use the insights gained from research into policy, social -and organizational learning.

This process of learning is very much akin to processes of trial and error and experimentation, and in the case of policy diffusion and the adoption of an innovation, to imitating existing social innovations. Flemig et al (2015) have also found that risk perceptions and definitions are of an influence to the learning process. An innovation is supposed to solve a number of specific problems or challenges, although the solutions are bringing along possible risks as well. These can come from different risk definitions in various public service domains, such as the risks posed to service users, service staff, to the organization itself or even the wider community. Therefore, one should precisely determine the appropriate level of risk to reach a certain benefit during the process of social innovation. Of course,

this is also related to the nature of the problem as well as the nature of the innovation. To solve a simple problem, one might only require a technical approach, whereas solving a more complicated problem would require a more sophisticated approach to risk governance and the engagement of the stakeholders. Obviously, when there are more organizations and stakeholders involved in the innovation process, there is also a higher risk. Thus, one should very precisely define the acceptable level of risk during the innovation process and make sure it is regarded as a strategic issue instead of an issue that is used to blame people whenever mistakes are made. This does require a culture within the organization that does not teach the employees to avoid taking risks and does not seek to blame them once mistakes are made. Risks should instead be brought up and discussed with the informal networks, the community and the users of the public service the organization provides.

Additionally, research by Nasi et al (2015) has shown that innovation as a process of learning does not stop once an innovation is discussed and implemented. Rather, they continue in the form of feedback loops, making sure one keeps learning from the innovation in order to constantly improve it. Kattel et al (2015) described the importance of these feedback loops. They indicated that when a social innovation is studied, emphasis is usually put on the first years after the implementation of the social innovation. However, they emphasized the need to look further than the first few years and to focus on the actual normalization process of the innovation, seeing as much feedback can be gained from that as well. To determine how durable a public sector innovation is, one should look at the organization of the provision of feedback and the accountability processes in order to comprehend which dynamics generate them. One should ask oneself whether the innovation still exists or if it was terminated, the rate of its adoption and whether it had been altered or if it perhaps even stimulated the creation of new innovations. Answering these questions will help in the analysis of the learning process behind the innovation and understanding the innovation capacity of organizations and their capacity to adopt change, as it forces organizations to evaluate their innovations and innovation capacities. To illustrate this, Voorberg et al (2015) showed that a lack of financial support formed a barrier in certain terminated innovations that closely involved citizens. The outcome of evaluating such innovations is that if enough financial support had been present, or a more sustainable business model was developed, these innovations might not have to be terminated. Research done by Van Acker et al (2015) has also shown that award winning innovations, in comparison to those that did not win an award, are scoring higher in terms of the way feedback, accountability and learning was executed.

2.4. The leadership factor

Leadership is an important factor in the process of social innovation. In the literature on leadership in the innovation process, leadership is usually referred to as "transformative leadership", which means that the one who leads the innovation process should have a vision in regards to the direction the social innovation should take. Nasi et al (2015) describe how the leader's vision should concern either a problem that has to be solved, a new way of working within the organization or already a new solution which should support the success of the innovation. Leadership, in the form of support from politicians in the legislative and executive bodies of the country, is especially regarded to be important for the adoption and implementation of newly developed concepts and ways of working. To gather the support of these politicians, a stable and consistent political vision should be shaped, emphasizing it as a policy priority.

Other types of leadership are also present in the literature. Albareda et al (2014) put attention to the role leadership plays in the innovation capacity. In their research, they looked at the characteristics of the type of leadership employed in social innovations in the municipalities of Copenhagen (Denmark), Rotterdam (Netherlands), Barcelona (Spain), and West Lothian (Scotland). The leaders of the social innovation projects in these municipalities exhibited a specific combination of skills concerning motivation, collaboration and risk taking. They named this type of leadership the motivator-risk-taker-type and it entails having the quality to motivate people, managing to connect them, as well as not being scared to take risks and to tolerate the mistakes made by the employees. People employing this type of leadership have no trouble following the bureaucratic structure of the innovation process, embracing the procedures and emphasizing the need of hierarchy allowing for the creation of an environment in which the employees feel safe to take risks and the leader motivates them to work better and harder. In order to achieve this goal, they focus less on hierarchical control and more on providing freedom for the individual employees and groups of employees to initiate their own ideas. They are also able to carefully define and emphasize the borders between the organizational structure and the role played by the informal networks. These leaders emphasize the role of the individual and how to motivate them. If an employee requires support, they are the ones to go to.

Voorberg et al (2015) also put an emphasis on leadership in their research on the role citizens play in regards to co-creation of the social innovation. They put attention to leadership from the perspective of "linking leadership", which refers to the type of leadership that allows for the mobilization of social capital in a professional welfare organization, municipality (on the political and administrative level),

and in a local community. Linking leadership also entails connecting the people involved with the social innovation in these three mentioned domains. Essentially, linking leadership refers to the ability to bond and bridge between people and organizations. Leaders are supposed to act as innovation intermediaries, otherwise referred to as brokers, engaging in boundary spanning and linking together the various sources of information and people.

Worth mentioning is one specific kind of leadership touched upon by Nasi et al (2015) and Voorberg et al (2015). It is called "political leadership", which is leadership expressed by, for example, a minister, mayor or alderman. This type of leadership provides legitimacy to the necessity of change in terms of vision being explored and it helps creating a safer innovation environment, because it allows for the provision of mental and material support to the innovation process. Political leadership functions also as an innovation intermediary by linking people and organizations together for the innovation process. Kattel et al (2015) also emphasized the necessity of political leadership by critically regarding the outcomes of a social innovation by for example emphasizing the need to develop and implement evaluative frameworks that address both efficiency gains and links the social innovation's outcomes to trust and legitimacy.

2.5. The administrative culture factor

In the literature on social innovation, the administrative culture is also constituting an important factor in public sector innovation and is usually analyzed in relation to the leadership factor. The administrative culture of an organization is not a very precisely defined concept, but at least it entails the dominant norms and values of an organization as well as its various grown and established practices that form the rules which the members of the organization should follow. Additionally, it entails the communication patterns of the organization and in the previous sections 2.3. and 2.4., it was already brought forward that within the organization's administrative culture it is important to have room for trial and error and open dialogue. In line of that, one must also make sure that no one is seeking to blame staff members, service users and external service partners during the innovation process when it is not developing as smoothly as predicted.

Voorberg et al (2015) have done research about the willingness administrative and professional organizations displayed to get involved in the process of co-creation with societal groups and citizens, in which a special emphasis was put on the importance of the organization's culture. In the part of their research that compared co-creation practices in urban and welfare renewal, they found that the degree of willingness to get involved with the co-creation process stood in relation to the risk-

averseness of the organization's administrative culture. One country might have a more inviting administrative culture than the other, because the other might regard citizen participation to be risky. This stands in relation to the openness public officials display to get involved with the innovation process. Usually, politicians and public managers with a leadership role are more willing to take the risk of involving citizens, whereas frontline workers, meaning bureaucrats that work at the "streets" like social workers, teachers and police officers, are less willing to. In the event one chooses to co-create with the citizens, it are the frontline workers who are required to change their way of working, although they are often rather sceptic and do not trust the competences of the citizens they are supposed to work with. When this skepticism prevails, it is important for an organization to develop an incentive structure that stimulates the co-creation with the citizens and other stakeholders. An example can be found in the research of Nasi et al (2015) in their analysis of the drivers and barriers behind the diffusion of e-procurement. They found that skepticism prevailed at the employee level and they made the same observation in regards to the adoption of telework, which means working at home. To deal with this skepticism, they recommended that the spontaneous emergences of grassroots initiatives, which entailed the experimentation with various forms of telework among the employees, could work as an agent of change to take away the skepticism. However, it is vital that the top management protects and allows for these initiatives to occur.

It is also important to comprehend why one organization's culture is more prone to risk-taking while another is more risk-avoidant. Voorberg et al (2015) and Nasi et al (2015) identified a link to this aspect of the organization's culture and the role of the state and tradition of governance. Both of the conducted research arrived to the conclusion that state and governance traditions matter to this, because both of these traditions embrace certain values and norms and role conceptions, which can function as either a driver or a barrier during the innovation process in the public sector. Voorberg et al (2015) found that countries that employ a centralized state structure are usually lacking a tradition of citizen participation. The same can be said of countries that have a strong administrative law culture dominating the public sector. In such countries, innovation is regarded as very risky as it could lead to negative political repercussions, which in turn contributes to the existence of an administrative culture where blame is avoided. Also, citizens are not looked upon as active and involved in these countries, but as mere subjects intended to just obey the law. Countries that do contain a tradition of citizen participation are often having a civil society with associations and various kinds of grassroots initiatives that play a vital role in the implementation and shaping of public services. This also means that the successful transfer of best practices to other countries depends in large part on the respective state and governance traditions.

2.6. The internal procedures, routines and systems factor

The grown practices of an organization are also constituting an important factor in developing, adopting and implementing a public sector social innovation. The grown practices determine the various informal and formal rules of an organization, which in turn leads to the development of various kinds of habits that play an ambiguous role. As mentioned earlier, a social innovation has to constitute a discontinuity with the past and thus also with the pre-existing patterns within an organization, which means these grown practices are possibly at odds with the innovation process.

The literature seems to confirm this to a certain extent. For instance, Voorberg et al (2015) mention that the co-creation between an organization, citizens and other relevant stakeholders are at odds with an organization's grown practices. The fact to the matter is that co-creation brings about a number of incompatibilities, such as different budget cycles, budgeting and financial application procedures, performance management systems, reporting and accreditation regimes. These barriers to the innovation initiative can only be overcome by the willingness of the organization and its administrative, legal and financial professionals to use their discretionary powers that allow for derivations to the standard grown practices to occur. This involves risk taking, as referred to earlier, and brings about the question previously touched upon to which extent the administrative culture of the organization is risk avoidant and which type of leadership is necessary to be present in order to protect the people who seek to act beyond the pre-existing routines and procedures.

Albareda et al (2014) bring about another perspective in their research on innovation capacity. They found that both internal and external informal networks are positively influencing the innovation capacity, seeing as they function as a reservoir for expertise, information, knowledge and ideas. In addition, the formal structure of an organization, consisting of a division of responsibilities, tasks and competences with the support of various kinds of routines and procedures, allows for the emergence of informal networks. Thus, the shape of the informal networks is determined by the formal structure of the organization. This has the advantage that the lack of speed in which the formal and hierarchical structures are noticing changes in the environment is compensated for by the nature of the informal networks, which are more dynamic and flexible and can also be used as a reservoir for expertise, information, knowledge and ideas to the benefit of the innovation.

Next to that, Albareda et al (2014) have also found that a certain kind of stability and predictability that contributes to the creation of a safe environment to undertake risks in and in which those who are involved with the innovation process are motivated, is provided by the existence of procedures,

rules, routines and a hierarchy. This means that the innovation capacity of an organization requires a certain extent of rule-following, although the freedom for groups and individuals to propose new ideas should not be suppressed. In addition, Flemig et al (2015) have found that larger organizations that contain even more procedures, routines and systems are better capable of managing the innovation risks, seeing as they were capable to develop a system of risk governance that is more sophisticated. In comparison, a smaller organization lacks this kind of sophisticated system of risk governance and is required to deal with the innovation risk on an ad hoc basis. The development of this system requires a lot of expertise, which is unfortunately to be found usually in a larger organization only. Also, it helps if an organization has a clear line of hierarchy as this clear chain of command can be of great help in developing these sophisticated models of risk governance.

The stability of an organization is not merely provided by the existence of procedures and routines, but by all sorts of systems such as for instance their ICT infrastructure. This can also function as a barrier to the process of innovation, seeing as for instance an innovation that relies heavily on ICT may be hindered during the development of new ideas and practices in the innovation process due to a lack of the quantity and quality of the ICT infrastructure. Therefore, an organization must always take stock of the systems that determine its stability.

2.7. The resource slack factor

During the process of innovation, an organization needs to explore, develop and implement new ideas, which requires the re-allocation of people, attention, energy and time. The pre-existing routines of working require a change or will simply be terminated while simultaneously new working routines need to be developed or introduced. Thus, the success of a social innovation requires resource slack, which entails the relative abundance of resources. In several cases, the resource slack should not merely be used to develop and implement new ideas, but also to do some necessary investments. Nasi et al (2015) describes for instance how investments in the ICT infrastructure and the ICT skills of the employees in an organization are required to stimulate the adoption of innovations driven by ICT.

At the same time, one requires investments for the development of various kinds of training and consulting activities related to the professional or technical aspects of the innovation process. This could in turn lead to the development of new supporting organizations as well. If a social innovation is also relying on volunteers to function properly, then a problem might occur if they have a relative lack of experience related to the tasks they are ought to carry out. In this scenario, the need for training

is even larger, as indicated in the research done by Flemig et al (2015) relating to risk management and the research done by Voorberg et al (2015) on co-creation with citizens.

An important issue to take into consideration when talking about the importance of resource slack is the role that funding plays in the innovation process or more precisely: the access to funding and its timing. Flemig et al (2015), when discussing risk management during the development of a social innovation, indicate that the access to funding for organizations or groups that seek to innovate is a lot easier in one sector than the other. For instance, access to funding regarding innovations in the area of sustainability seems to constitute a large funding driver. From this research outcome, one can conclude that social innovation is more likely to occur in one kind of area or theme than the other, even though the need for innovation might just be as urgent in areas that lack an access to funding. The timing of funding, as in, the time at which funding becomes accessible, is also an aspect to take into consideration. Research done by Flemig et al (2015) shows funding tends to become available during the first stage of a social innovation, when it is still regarded as new. This has far-reaching consequences in regards to the financial sustainability of the innovation. Voorberg et al (2015) indicated this as well in their research on co-creation, while simultaneously mentioning that it is vital in the case of citizens initiating a social innovation, that funding stays available for a longer period of time during the innovation process, especially when attention for the innovation is fading away. This is recommended due to the fact that citizens usually do not possess financial resources to the same extent as professional organizations do.

2.8. The citizens factor

Essential to social innovation is that end users, the ones who are supposed to use the social innovation, are involved with its development, more specifically, with the development of new products and services or with the re-design of pre-existing services and products. In regards to the subject of this thesis, the end users are the citizens who should be involved with the development of the Pilot and to function as co-designers. Therefore, it is necessary to also take a look at the factors that explain why citizens would choose to participate in social innovation practices in the public sector. Voorberg et al (2015) have done research about the co-creation of citizens in innovation in both welfare services and urban renewal. Several drivers and barriers have been put forward in their research concerning the success of co-creation with citizens of which three factors are the most important to take into consideration:

The first factor in the co-creation process constitutes the willingness of the citizens. However, citizens are never a homogenous group, so their willingness tends to be very unbalanced. Groups of prosperous, privileged and well-educated citizens, based upon their education, socioeconomic status and cultural and demographic background, tend to show a lot more willingness than more deprived groups of citizens. Of course, this influences the kind of problems one can define to be solved and the approach to take towards them within the social innovation project.

The second factor constitutes the fact that the willingness of the citizens is also related to the problem or challenge that requires solving. Citizens need to feel a sense of ownership in regards to the challenge or problem that has to be solved, which will lead to an increase in the willingness citizens display to participate in the co-creation process. Essentially, the citizens need to be intrinsically motivated. They should also be able to give expression to their sense of ownership by providing them with the opportunity to take responsibility. The ability to take responsibility should be granted by, for instance, the government and the professional organizations involved with the innovation process by means of letting the citizens know they are doing a good job and giving them credit for their actions.

The third factor is about allowing citizens to use their social capital. When they choose to participate in the co-creation process, it requires a lot of effort, not only in regards to time and energy, but access to information, knowledge and expertise that a single citizen most probably does not have is also required. Thus, a division of labor is essential, which means the group of involved citizens should be willing enough. To mobilize this group of citizens, they are required to trust and know each other, and they should know they are able to make use of the existing association and grassroots initiatives and use them for support. In addition, it should be made clear who the innovation intermediaries are, which are those whom are able to link the people as well as their ideas and knowledge, leading to a mobilization of different groups of people. Essentially, citizens should be able to mobilize their social capital by the effective use of boundary spanning by the innovation intermediaries.

Finally, one should take notice that cooperation during the social innovation process does not only entail cooperation with the citizens, but also with the other stakeholders like, in the case of the subject of this thesis, healthcare organizations. The employees of these stakeholders should also be willing to cooperate with and support each other. After all, initiatives posed by the citizens might form an impediment to the existing programs and cooperation arrangements of the welfare organizations. These organizations might thus regard these citizen initiatives as a threat to their existing programs. This is why Flemig et al (2015) have emphasized the importance of the relevant stakeholders in the innovation process to seek support and organize cooperation with each other.

2.9. Conclusion

This chapter described the factors that are important to take into consideration in order to analyze the innovation process behind the Pilot. As a result, it is now possible for the actual analysis to be made and to see whether the innovation process really managed to facilitate the development of a social innovation. During the analysis, it will be indispensable to always take into consideration the extent to which the environment and the six factors indeed contributed to the development of a social innovation.

3. Methodology

This research will provide a comprehensive analysis of the innovation process behind the Pilot. It will present a qualitative case study based on an explorative research design. This choice was made in order to gain insights and familiarity with the way in which experiments in the provision of extramural healthcare are conducted in the Netherlands. The most commonly used research method was a documentary analysis on the basis of secondary data namely evaluations and general press releases of the Pilot written by the project group. Another research method entailed an interview that was held on 30 June 2017 with the leader of the project group of the Pilot called Tjalling de Vries in which he discussed the reasons behind the early termination of the Pilot and the plans regarding the establishment of the new one.

Section 1.1. started by providing the focus and the general background to the topic of the thesis. It indicated how healthcare costs are rising in the Netherlands and how the Dutch government intended to reform extramural healthcare in order to reduce these costs. Subsequently, it described the objectives the Pilot was supposed to realize, how the Pilot was intended to be conducted and how the provision of extramural healthcare is generally organized in the Netherlands. This should have provided the reader with a general idea of the reasons why and how the Pilot was supposed to be conducted in the wider framework of extramural healthcare. Next, section 1.2. introduced the research questions that the thesis is supposed to provide an answer to by means of carefully formulating the significance of these specific questions in regards to conducting a proper analysis of the innovation process behind the Pilot. Furthermore, this section also explained the relevance of this thesis by mentioning which research gap it filled.

The second chapter constituted the theoretical framework and it described the factors that were important for the analysis of the innovation process behind the Pilot. First, a conceptualization of the rather vague term “social innovation” was provided to the reader, so that it became clear why the development of the Pilot could be regarded as an attempt to introduce a social innovation. Subsequently, the factors that were important for the analysis of the Pilot’s development were provided on the basis of existing literature regarding public sector innovation by describing how these factors are able to function either as drivers or barriers that enhance or impede the successful development of a social innovation.

The fourth chapter introduced the actual analysis based on these factors. For instance, when discussing the factor regarding the role of leadership, a determination was made to what extent there were leaders present during the innovation process and whether they showed the ability to actually

express leadership skills. Subsequently, a conclusion could be drawn whether the role of leadership functioned as a driver or a barrier to the innovation process. In case it functioned as a barrier, a recommendation was made in regards to how it could function as a driver, for instance by the appointment of different leaders that exhibited more necessary qualities.

The fifth chapter formed the conclusion by summarizing which lessons were drawn from the innovation process and by providing answers to the research questions. Furthermore, section 5.1. briefly discussed the limitations of the conducted analysis and made a suggestion for further research.

4. Analysis

This chapter will provide an analysis of the Pilot based on the factors mentioned in the theoretical framework. Each factor will describe what went well during the innovation process and where there exists room for improvement. Whenever it is possible, a recommendation will also be provided in terms of how this improvement could take shape.

4.1. The role of the environment

To start with, one should have a look at the extent to which the environment contributed to the innovation process. Osborne & Brown (2005) mention how challenges in society might trigger the decision to develop a social innovation. These challenges stand in relation to a perceived performance deficit, which has to do with shortcomings in both the efficiency and the effectiveness of operations within an organization. Thus, a closer look should be taken at which challenge Dutch society is facing and to what extent it triggered the decision to develop the Pilot.

The supposed challenge Dutch society is facing are the rising costs of healthcare. To that extent, the Dutch government has delegated the provision of extramural healthcare to the municipalities through the adoption of the Wmo 2015, as mentioned in the introduction of the thesis. At the same time, the municipalities received less money for the actual provision of healthcare to its citizens, which is a potentially problematic situation, especially for a municipality like Enschede that has been facing enormous cutbacks in spending since 2015 and is required to cutback an additional 14.5 million euro in spending on healthcare for next year ("Pact tegen bezuinigingen op zorg in Enschede", 2017). Thus, it makes sense for the Pilot to be conducted in order to explore alternative ways of healthcare provision to reduce costs while simultaneously trying to improve it. In addition, it is important to realize that Enschede is not the only municipality experimenting with alternative ways of healthcare provision as there are hundreds of municipalities in the Netherlands attempting the same (Bekkers, 2014). Most probably, this also strengthened the resolve for the development of the Pilot and shows how the challenge in Dutch society, to keep providing good healthcare despite rising costs and a probable cutback in spending, triggered the decision for the development of the Pilot.

The next issue in regards to the environment, is what determined the suitability of Wesselerbrink for the realization of the Pilot. Wesselerbrink, a neighborhood in the south of Enschede, contains a population with a predominantly low, social-economic status who consume a relatively large amount of healthcare. To illustrate, in 2013 in Wesselerbrink, 33% of all households are making use of at

least five healthcare arrangements (Projectgroep Populatiemanagement, 2015, p.6). In comparison, in other neighborhoods in Enschede like Stroinkslanden and Helmerhoek this percentage stands only at 16% and 17% respectively. Additionally, social cohesion in Wesselerbrink is low, the amount of immigrants from non-Western countries is high, as well as the amount of families with only one parent. The amount of people looking for a job while being unemployed is 15.9%, in comparison to an average of 8.8% in Enschede in 2013 (Projectgroep Populatiemanagement, 2015, p.7). In other words, Wesselerbrink is a perfect breeding ground for an attempted social innovation like the Pilot.

Furthermore, the literature on the environment is also talking about how imposed regulatory norms, the so-called boundaries within which the Pilot is supposed to be conducted, are the necessary key parameters benefiting the development of a social innovation (Van Acker et al, 2015). They constitute a driver behind the innovation process, seeing as they take away the risks that might prevent an organization from developing or adapting an innovation. In order to expand on the regulatory norms defined in the Pilot, it is important to first provide an outline of the Pilot's governing structure.

The governing structure of the Pilot consists of four groups in a descending hierarchical order, namely: the Consortium, the steering committee, the project group and the Team (Gemeente Enschede, 2015, p.5). First, there is the Consortium that consists of the directors of the involved organizations in the Pilot, namely Enschede, Menzis and nine healthcare organizations, as mentioned in section 1.1. Second, there is the steering committee consisting of representatives of the healthcare organizations, managers of Menzis and a representative of the official in Enschede responsible for the department of healthcare in the day-to-day management of the city council, the so-called alderman or "wethouder" in Dutch, as the term does not translate well in English. Third, there is the project group, which is directed by the steering committee, consisting of managers and policy advisors of the healthcare organizations, Menzis and Enschede with Enschede delivering the head of the project group. Within the project group, there are also several working groups that are each responsible for a different aspect of the Pilot like communication, finances, or monitoring. Fourth, there is the Team, which is directed by the project group, that carries the responsibility for the daily realization of the Pilot. It consists of employees of all members of the Consortium, except for those of Menzis, and they are organizing and monitoring the provided healthcare in Wesselerbrink with each of them representing the organization they work for. A crucial factor here is that the employees of the healthcare organizations and Enschede are developing truly innovative healthcare arrangements. Finally, apart from these four groups forming the governing structure of the Pilot, there is also a separate working group formed internally that works for Enschede and contains a jurist, financial expert, district manager and a representative of the healthcare meeting place in Wesselerbrink where people can ask questions about and request healthcare.

As might have become apparent in the preceding paragraph, the Team carries the responsibility for the development of innovative healthcare arrangements. Regarding imposed regulations, the Team's room for experimenting with the realization of their tasks and their internal and external collaboration is limited (Projectgroep Populatiemanagement, 2015, p.21). The clients may not be discomforted in their healthcare provision when participating in the Pilot. For instance, if the clients would require multiple conversations instead of only one before they will be assigned a healthcare arrangement, then this might cause them discomfort, which is to be avoided at all times. Additionally, the freedom of choice of the client in choosing between the various healthcare organizations for their healthcare provision is to be respected. If the Team disagrees internally and is unable to find a solution for their problems, they are to attend to the project group in order to help them solve their problems. Naturally, the realization of the Pilot should always be in accordance with the law as stipulated in the Wmo 2015. To conclude, the necessary key parameters required to foster the innovation process were clearly present.

Subsequently, Albareda et al (2014) mention the existence of a discrepancy between the way a municipality rates its own innovativeness and the way its innovativeness is perceived in that same municipality in its external networks, which the representatives of the municipality participate in. Thus, Enschede might enhance its innovative capacity by exploring the external perception of its innovativeness by setting up a system of self-assessment involving the citizens of Enschede. In regards to the realization of the objectives of the Pilot, an enormous obstacle was the amount of clients attracted to participate in the Pilot. About 80 to 100 clients were required in order to conduct a proper social research, which is what the Pilot in the end was supposed to be (Projectgroep Populatiemanagement, 2015, p.38). However, after one year since the start of the Pilot there were only about 30 clients (Werkagenda Menzis, gemeenten en regio's, 2017, p.1). The lack of clients had partly to do with the fact that potential clients did not see the need of "innovative healthcare arrangements", because their existing healthcare arrangements suited them well enough already or an alternatively proposed healthcare arrangement was no longer required (Projectgroep Populatiemanagement, 2016a, p.4). The idea of developing innovative healthcare arrangements originally came from Enschede. Thus, a proper assessment of the innovativeness of Enschede might have improved the innovative capacity of Enschede to the extent that a more appealing idea to reform the provision of extramural healthcare would have been presented to the potential clients.

Seeing as the process of social innovation in the public sector is dependent on the cooperation between a large variety of actors such as citizens, other public organizations, companies and social groups, the environment also functions as a reservoir of social capital. This means that the cooperation of an

organization with various professional and social networks is also forming a driver for social innovation (De Vries et al, 2015). The Pilot was based upon the collaboration of various actors seeing as employees of Enschede, Menzis and nine healthcare organizations were supposed to realize the objectives together. In addition, members of the Team were supposed to cooperate with all kinds of executive authorities, such as the "Wmo-loket", the already present "social neighborhood team" in Wesselerbrink and general practitioners (Projectgroep Populatiemanagement, 2015, p.21). The Wmo-loket is a local office to which citizens can go in order to receive information, advice and support regarding the provision of healthcare under the Wmo 2015. The social neighborhood team fulfills the same role, but regarding healthcare in general and not just the Wmo 2015. Thus, one can safely conclude that adequate use was made of the available social capital and informal networks, which benefitted the innovation process.

To conclude, the rising costs of healthcare in the Netherlands successfully triggered the decision for the development of the Pilot. The imposed regulatory norms within which the Pilot was supposed to be conducted were carefully defined thereby contributing to the innovation process. Unfortunately, Enschede failed to properly assess its innovative capacity, which probably contributed to the development of a Pilot that did not properly suit the needs of its citizens. However, the Pilot did manage to fully utilize the available social capital and to cooperate with various actors in extensive informal networks.

4.2. The role of the learning process

The process of innovation, in regards to the Pilot, constitutes the development, adoption and implementation of new services (Osborne & Brown, 2009). Essentially, innovation processes constitute a learning process in and between organizations, which can be considered as processes of trial and error and experimentation. Seeing as these processes of trial and error also bring about potential risks, it is important to determine to what extent the project group determined which risks were acceptable to take during the innovation process of the Pilot in order to realize its objectives.

Unfortunately, the Pilot had a big shortcoming regarding this aspect seeing as there were no risk definitions established that benefitted the daily affairs of the Team. De Vries (2017) indicated that the healthcare arrangements offered to the clients by the Team were just not innovative enough, as in, they were not radically different in comparison to the past. This constitutes one of the reasons behind the failure of realizing the objectives of the Pilot. De Vries (2017) emphasized that the Team was cooperating and not in any way opposed towards the idea of developing innovative healthcare arrangements. They just employed a certain, non-innovative method of working as a result of which

there might be an allocation of an external professional in the new Pilot who should encourage and support the Team to really think outside the box and develop a different method of working. However, there might be an underlying problem behind a lack of the development of innovative healthcare arrangements which does not have anything to do with the "incompetence" of the Team. The Team had a lot of freedom in determining what kind of healthcare arrangements they wanted to offer to the clients, but, in addition to improving the state of health of the population and the individual experience of care, the costs of healthcare were supposed to be reduced as well. Seeing as there were no established risk definitions in relation to what these innovative healthcare arrangements might cost, it might have been difficult for the Team to really make adequate use of their freedom in experimenting with them. In addition, these innovative healthcare arrangements are potentially radically different from ordinary healthcare arrangements and it is also very hard to precisely determine the extent to which a client's health might benefit from a new healthcare arrangement. These facts, combined with a lack of risk definitions, might explain the lack of the development of innovative healthcare arrangements by the Team.

Furthermore, as Nasi et al (2015) indicated, the process of learning is not supposed to stop once the social innovation has been discussed and implemented, but rather, it is supposed to continue in the form of feedback loops to ensure everyone keeps learning from the innovation in order to improve it constantly. In order to determine the durability of a social innovation, one should look at the organization of the provision of feedback and the accountability processes and to comprehend which dynamics generate them. In regards to the Pilot, one can safely assume that the innovation process was constantly monitored. The Team met each other every month to share experiences, knowledge and details regarding the work process (Projectgroep Populatiemanagement, 2015, p.28). The project group met on a biweekly basis to discuss the work process of the Team, affairs relating to internal and external communication, the monitoring of the results of the Pilot and its costs. The steering committee met on a quarterly basis to discuss the progress of the Pilot and the advice provided by the project group regarding the direction the Pilot should take. Finally, the Consortium met every six months also to discuss the progress of the Pilot and to see whether or not the Pilot should expand to other neighborhoods, which unfortunately never happened. Thus, one could state that the progress of the Pilot was regularly evaluated meaning there existed a feedback loop that supported the innovation process.

4.3. The role of leadership

Leadership is essential to the development of a social innovation seeing as without proper leadership, whatever objectives one might set will be nearly impossible to realize. In regards to the Pilot, the

question rises which kinds of leadership were required during the innovation process and to what extent was such leadership present. The literature mentioned three essential types of leadership, namely transformative leadership, political leadership and linking leadership. Thus, a closer look should be taken at the presence of these types of leadership.

To start with, transformative leadership entails the provision of a vision by a leader that stimulates the direction the innovation should take. In other words, the innovation process would have benefitted from a leader who showed transformative leadership that steered the Team towards the development of the innovative healthcare arrangements. In the beginning of December 2015, just before the Pilot commenced, the members of the Team first met each other (Projectgroep Populatiemanagement, 2016a, p.2). During or slightly after this meeting, the decision was made to make the Team self-organizing, which entails the absence of a leader. The result of this decision was that the Team did not operate as quickly and effectively as was intended, which resulted in the appointment of a team coach around February/March 2016 who was supposed to foster the development of cooperation and creative thinking within the Team (Projectgroep Populatiemanagement, 2016a, p.2). However, it can essentially still be asserted that there was an absence of a leader in the Team and no transformative leadership was shown. This assertion can be made, because the team coach did manage to foster the cooperation between the members of the Team, but merely stimulating creative thinking does not equal the propagation of a vision towards the development of innovative healthcare arrangements. The Team might have profited from the appointment of a leader who actively directed the Team towards the development of innovative healthcare arrangements by, for instance, providing examples of activities that can be conducted with the clients to the benefit of their health. The leader of the Team might consult scientific literature regarding the provision of extramural healthcare that is not employed in the Netherlands, or, in other words, to research how other countries are organizing their extramural healthcare and to determine if there are any existing practices that should be adopted. The self-organizing nature of the Team and the inability of the team coach to assert transformative leadership probably contributed to the inability of the Team to develop innovative healthcare arrangements as well. This can at the same also be regarded as a lack of propagation of transformative leadership on behalf of the project group. Seeing as the project group directs the Team and meets on a biweekly basis to discuss the work process of the Team, the project group might have insisted on the appointment of a leader to direct the Team's daily affairs.

Next, the literature mentioned the need of political leadership, which means that politicians were supposed to support the Pilot within executive and legislative bodies. In addition, the need of political commitment was emphasized, which, in the case of the Pilot, means that Enschede should be committed to the development and successful realization of the objectives of the Pilot. The initiative

to conduct the Pilot came from Enschede and its employees were also actively involved with the execution of the Pilot. Additionally, Enschede also approved of the realization of the new Pilot in the fall of 2017 after the termination of the old one (de Vries, 2017). To that extent, political leadership has definitely been present during the realization of the Pilot, which the innovation process benefitted from.

Lastly, the literature talked about linking leadership, which entails the ability of a leader to mobilize social capital in the local community, municipality or professional welfare organization. The leader is also required to connect different people together in order to persuade them to collaborate. As has been discussed previously, the Pilot involved the collaboration of various employees from the municipality, healthcare organizations and a health insurance company. In the evaluation of the year 2016, which entails the first year of the Pilot, it was mentioned how at first the Team struggled to collaborate effectively (Projectgroep Populatiemanagement, 2016a, p.2). Fortunately, this problem was eventually solved, which led to smooth collaboration within the Team (Projectgroep Populatiemanagement, 2016a, p.3). Thus, one can safely assert that linking leadership was present during the innovation process seeing as collaboration between the Team had been effectively improved and no further reports were made of difficulties relating to collaboration between the various involved actors.

4.4. The role of the administrative culture

The administrative culture of an organization entails the dominant norms and values as well as the various grown and established practices that form the rules which the members of the organization should follow. In order to function as a driver to the innovation process, it is important that the administrative culture, or in other words the organizational culture of an organization, provides room for dialogue and trial and error. Thus, it is essential to closely examine the administrative culture of the Team seeing as the Team carried the responsibility for the daily realization of the Pilot.

Section 4.2. on the learning process had already discussed the necessity of providing room for trial and error while section 4.3. on the role of leadership essentially discussed how leaders should function as brokers during the innovation process by facilitating collaboration between the various involved actors. The administrative culture of organizations is closely related to the learning process and the role of leadership. The lack of risk definitions and the absence of a leader for the Team had already been mentioned as factors that hampered the ability of the Team to develop innovative healthcare arrangements. When de Vries (2017) was subsequently asked whether a lack of room for trial and error for the Team formed one of the reasons for the failure to realize the Pilot's objectives, he

indicated that this was not the case. The evaluation of the Pilot for the year 2016 also indicated that collaboration between the members of the Team was going smoothly (Projectgroep Populatiemanagement, 2016a, p.2).

However, smooth collaboration does not constitute the only important aspect of the openness of the administrative culture. The commitment of the organizations involved with the realization of the Pilot is also constituting an important aspect. In the beginning of 2016, the project group indicated that it was hard to estimate how much time should be allocated per member of the Team towards the Team's activities. The decision was made to allocate four hours per week per person, but in practice the individual members of the Team required different amounts of time to dedicate towards the Pilot and they had difficulties to combine the work for the healthcare organizations they represented with the work for the Team (Projectgroep Populatiemanagement, 2016a, p.3). Thus, the issue regarding a lack of time required attention from the healthcare organizations and also flexibility on their behalf. Although the healthcare organizations showed the willingness to be flexible, the evaluation of the year 2016 indicated that in practice this willingness was hard to be found (Projectgroep Populatiemanagement, 2016a, p.3). Thus, it seems that the involved healthcare organizations were not dedicated towards the realization of the Pilot's objectives to the extent that was required. Voorberg et al (2015) indicate how the willingness of an organization to get involved with the process of co-creation stands in relation to the risk-averseness of the organization's administrative culture. It seems as if the involved healthcare organizations were averse to the risk of their employees not being able to fulfill their regular activities outside of the Pilot, which led to the lack of flexibility towards allotting more time to their employees for participating in the Pilot. In order to understand this fact, one should realize that even though the healthcare organizations participated in the Pilot on a voluntary basis, they were still expected to pay the salaries of the employees that were assigned to the Pilot (Projectgroep Populatiemanagement, 2015, p.11). There had not been a reservation of a financial budget for the man hours dedicated towards the activities of the Team. Although it would make the new Pilot, which is supposed to be conducted in the fall of 2017, a lot more expensive, the innovation process behind the Pilot would surely benefit if a financial budget were to be reserved for the amount of man-hours to be dedicated towards the activities of the Team. Simultaneously, periodical assessments should be made in case the amount of clients participating in the new Pilot would increase, thereby requiring more man-hours for the Team and thus a reservation of a larger financial budget.

4.5. The role of the internal procedures, routines and systems

Internal procedures, routines and systems can also be characterized as grown practices. The grown practices of organizations might constitute an impediment to the innovation process seeing as a social innovation is supposed to constitute a discontinuity with the past. During the realization of Pilot, it has indeed become apparent that grown practices impeded the innovation process. In section 4.2. on the learning process, it had already been mentioned that the healthcare arrangements offered to the clients of the Pilot were just not innovative enough. De Vries (2017) attributed this to a non-innovative method of working of the Team despite their willingness to develop new healthcare arrangements. This is an example of a grown practice that impeded the innovation process. In section 4.3. regarding the role of leadership, the recommendation had already been put forward to allocate a team leader who should actively direct the Team in their development of innovative healthcare arrangements.

Furthermore, Voorberg et al (2015) indicated how co-creation between various organizations are at odds with the existing grown practices. Incompatibilities like different budget cycles, financial application procedures, ICT systems and accreditation regimes between the organizations can also form an impediment towards the innovation process. In order to solve these incompatibilities, willingness of the involved organizations is required in addition to risk-taking and appropriate leadership, which are two factors already touched upon earlier.

During the realization of the Pilot, there existed two pressing incompatibilities that required solving, namely the availability of an ICT system for the Team in order to share data regarding the clients of the Pilot and an efficient way to declare the healthcare costs associated with the healthcare arrangements offered by the Team (Projectgroep Populatiemanagement, 2016a, p.3). Fortunately, these incompatibilities have largely been solved before and during the realization of the Pilot. It took a long time to make an ICT system available for the Team, but eventually the healthcare organization Livio offered the use of the ICT system Omaha by reserving a certain part of the system specifically for the use of the Team (de Vries, 2017).

However, it was a lot more difficult to deal with a proper way of declaring the expenses of the healthcare arrangements. Normally, when a citizen requires a healthcare arrangement concerning extramural healthcare, the expenses can be declared in, for instance, the framework of the Wmo 2015, Wlz or Zvw. Seeing as the goal of the Pilot was to develop healthcare arrangements that might combine elements of all of these three separate acts, which would normally not be allowed, a solution to this incompatibility was required. Therefore, the agreement was made to issue a special order under which the healthcare expenses falling under the Wmo 2015 could be claimed (Projectgroep

Populatiemanagement, 2016b, p.3). This special order was issued in writing in order to have an accountant deal with Enschede, so that any healthcare costs which under normal rules will not be covered by the health insurance company, will still be covered. However, in practice this whole process consumed a lot of time because it took quite a while for the special order to be drawn up and to be agreed upon as well, which in turn slowed down the process of developing innovative healthcare arrangements. As a result, during the course of the Pilot in 2016, the project group submitted the proposal of skipping this special order altogether in order to solve this problem (Projectgroep Populatiemanagement, 2016b, p.3). As a replacement of the special order, the idea was to guarantee the healthcare organizations that they will be compensated for the costs of the innovative healthcare arrangements by means of quarterly payments related to the costs falling under the Wmo 2015. This required the Team to carefully administrate their dealings with the clients in order to make visible which healthcare arrangements they offered and their subsequent associated costs. Enschede was required to have access to this administration in order to approve the healthcare arrangements and to reimburse the costs made by the healthcare organizations. At the same time, the Consortium was required to take a look at which healthcare arrangements would have been offered outside of the Pilot, which entailed the normal healthcare arrangements that could not be experimented with, in order to see if the healthcare arrangements offered in the Pilot were in any way contributing towards the realization of the Pilot's objectives. This constitutes proof of the willingness of the involved organizations to solve the incompatibilities with the working method of the Pilot that derived from their grown practices in order to realize the Pilot's objectives. The commitment of these organizations enhanced the innovation process thereby contributing to the development of a social innovation.

4.6. The role of resource slack

A social innovation requires the exploration, development and implementation of new ideas. In order to achieve this, one requires the re-allocation of people, attention, energy and time. In other words, the success of a social innovation is dependent on the availability of slack resources. Section 4.4. regarding the administrative culture already indicated how risk-averseness from the healthcare organizations led to a lack of the allotted time for members of the Team to realize their daily affairs, for which a recommended solution has been posed.

However, a closer look should also be taken at the availability of slack resources for investments in the form of training and consulting activities for the Team. After all, section 4.2. mentioned that the Team supposedly employed a non-innovative method of working to which one can partly attribute the lack of a development of innovative healthcare arrangements. Thus, apart from the coach that was assigned to the Team, the Team might have benefitted from additional training as well. The only

training the Team actually received was an "inspiration session" at the "Betekenisfabriek", an internet marketing service company in Enschede, in which the Team was challenged to "think outside the box" (Projectgroep Populatiemanagement, 2016a, p.2). The Team would have probably benefitted a lot more from real training sessions in relation to the development of innovative healthcare arrangements. One could think for instance about lectures of case studies in regards to alternative ways of healthcare provision. Basically, the Team should not have only been stimulated to think outside the box, but they should also have been taught about the actual development of innovative healthcare arrangements. However, it does seem likely that the reason why the Team did not receive any additional training is due to the fact that it had not been recognized that additional training could be beneficial. Thus, the observation of a lack of training for the Team ought to be regarded not as a lack of slack resources, but as a problem to be dealt with in the new Pilot.

Lastly, the availability of financial resources was adequately present. The project group was assigned a budget of 7.500 euro during the research phase of the Pilot (Projectgroep Populatiemanagement, 2015, p.11) and in the year 2016, a budget of 14.000 euro was made available for hiring external support for the Pilot itself, the Team, communication and any other unforeseen costs (Projectgroep Populatiemanagement, 2016a, p.6). Both of these budgets were abundant enough to finance all that was required. Thus, a lack of slack resources did not seem to be apparent during the realization of the Pilot.

4.7. The role of the citizens

The decision to embark on the journey of social innovation is always made with the end users in mind. In regards to the Pilot, the innovative healthcare arrangements were supposed to be developed for people that require extramural healthcare. Thus, it would only seem logical to involve the citizens in the co-creation process for whom the Pilot wished to develop a social innovation. As a matter of fact, in the research phase of the Pilot, there had also been research done about what kind of subpopulation in Wesselerbrink might benefit the most from new kinds of healthcare arrangements. This subpopulation consisted of people who were supposed to be low-skilled, single, meaning they lived by themselves, and already making use of at least three healthcare arrangements (Projectgroep Populatiemanagement, 2015, p.14). However, not at any point during either the research phase or the actual duration of the Pilot had any attempt been made to involve these citizens in the co-creation process. This might explain why many potential clients indicated that they did not see the need for any "innovative healthcare arrangements", as mentioned in section 4.1. on the role of the environment. Additionally, this might also explain why the Team struggled to develop innovative healthcare arrangements. If citizens belonging to the target subpopulation would have been involved

with the co-creation process, then they would have also been able to indicate in what way their existing healthcare arrangements could have been improved. Subsequently, this would have made it a lot easier for the Team to think of ways in which they could improve the extramural healthcare offered to the potential clients of the Pilot. Thus, the following lesson can be extracted to the benefit of the new Pilot:

The literature mentioned the necessity for citizens to show the willingness to be involved with the co-creation process. In addition, citizens should also feel a sense of ownership towards the challenge that is supposed to be solved, which means the willingness of the citizens should depend on intrinsic motivation. De Vries (2017) mentioned that in the new Pilot, potential clients will no longer be located and persuaded to participate, but instead, the future clients of the Pilot will consist of the already existing clients of the involved healthcare organizations. Furthermore, the new Pilot will not be conducted in all of Wesselerbrink, but only in two zip codes of Wesselerbrink that happen to contain a lot of elderly people of whom most of which are already using multiple healthcare arrangements (de Vries, 2017). Seeing as the new Pilot will be conducted in a far smaller area than all of Wesselerbrink, which contained approximately 18.000 people in 2014, it should not be too hard to contact the potential clients after which they should be persuaded to actively join the co-creation process (Projectgroep Populatiemanagement, 2015, p.15). Emphasis should be put upon how they will benefit from the innovative healthcare arrangements by indicating what potential changes they could expect in their existing healthcare arrangements. This should also ensure that the potential clients will feel an intrinsic sense of motivation to take part in the process of co-creation. If the potential clients are successfully persuaded to join the innovation process, then this will most definitely contribute to the realization of the new Pilot.

5. Conclusion

This thesis intended to provide an analysis of an experiment regarding alternative ways to provide extramural healthcare. This experiment, called the Pilot, was developed with the aim of achieving at least one of three separate objectives referred to as the Triple Aim by Berwick et al (2008), namely: to improve the individual experience of care, to improve the health of the population, and to reduce the healthcare costs per capita for the given population (Projectgroep Populatiemanagement, 2015, p.7). In order to reach the Triple Aim objectives, the Team, which consisted of employees of the municipality Enschede and nine healthcare organizations, was supposed to successfully develop innovative healthcare arrangements. To that extent, the realization of the Pilot represented an innovation process that was supposed to lead towards a social innovation. Bekkers (2016, p.12) referred to social innovation, as defined by Voorberg et al (2014): "…the creation of long lasting outcomes that aim to address societal needs by fundamentally changing the relationships, positions, and rules between the involved stakeholders, through a process of participation and collaboration". Thus, the following main research question was formulated:

To what extent did the innovation process facilitate the failure to successfully develop a social innovation in the Pilot?

In order to answer the main research question, it was necessary to provide an analysis of the time during which the Pilot was conducted. However, there are various ways to conduct an analysis of a social experiment and to that extent, it was important to first determine which specific factors the analysis would focus at in terms of the development process of the Pilot. Therefore, the following sub-question had been formulated:

Which factors are important to the development of the Pilot?

The answer to this sub-question formed the starting point of this thesis. After formulating an introduction and the background to the topic of the thesis, the theoretical framework first conceptualized the definition of social innovation seeing as it is a rather vague concept to begin with. Subsequently, the theoretical framework described the factors that were important to the development of the Pilot. These factors are the environment in which the Pilot was conducted as well as six other factors, namely: the learning process factor; the leadership factor; the administrative culture factor; the internal procedures, routines and systems factor; the resource slack factor and the citizens factor.

Now that it was made clear which factors the analysis of the development of the Pilot would focus at, it was possible to provide a combined answer to the main research question and the second sub-question, which ran as follows:

Which lessons can be extracted from the outcome of the Pilot?

The analysis started with the environment in which the Pilot was conducted. The rising costs of healthcare in the Netherlands seemed to have triggered the decision for the development of the Pilot. To that extent, Wesselerbrink was a suitable neighborhood to conduct the Pilot in, because the amount of people making use of healthcare arrangements in this neighborhood are above average. Therefore, an improvement in the provision of healthcare could easily be detected in this neighborhood. Furthermore, the Team had been provided with clear regulatory norms, the so-called boundaries within which the Pilot was supposed to be conducted. A point of improvement would be for Enschede to have its citizens properly assess their innovative capacity so that it can be improved. However, the actors involved with the Pilot did manage to make adequate use of the available social capital and the informal networks.

The learning process during the Pilot's development lacked any kind of risk definitions, which seriously hampered the ability of the team to develop innovative healthcare arrangements. In comparison, the progress of the Pilot was regularly evaluated, which means there existed a feedback loop that allowed for intervention in the innovation process whenever it was required.

The role of leadership during the Pilot's realization was ambiguous. On the one hand, political and linking leadership were present, but transformative leadership for the Team was clearly lacking. Had there been a proper leader present who exhibited transformative leadership, then it would have been far more likely that the Team would have managed to successfully develop innovative healthcare arrangements.

In regards to the role of the administrative culture, the employees of all of the involved organizations in the Pilot seemed to be able to cooperate well with each other. However, the healthcare organizations itself did not seem to be flexible to the extent that they allowed their employees to conduct more time towards the activities of the Team. Had the Team been shown more leniency in regards to allowing for more time to conduct their work, this would have seriously improved their capabilities to deliver results for the Pilot.

The analysis in regards to the role of the internal procedures, routines and systems revolved mainly around the extent to which organizations involved with the Team managed to overcome their grown practices. This seemed to be the case as the organizations clearly exhibited the willingness to solve the incompatibilities with the working method of the Pilot that derived from their grown practices in order to realize the Pilot's objectives.

The availability of slack resources seemed to be a concern in regards to the healthcare organizations not allotting enough time to the Team to realize their daily affairs. However, when it came to making available a financial budget to the benefit of reaching the objectives of the Pilot, this did not seem to constitute a problem.

The citizens, in the form of the potential clients the Pilot was specifically targeting, were not in any way involved with the co-creation process. This constitutes a serious defect and in order to realize the objectives of the new Pilot, it is vital that the potential clients will be involved with the innovation process right from the beginning.

Finally, the main research question requires an answer. *To what extent did the innovation process facilitate the failure to successfully develop a social innovation in the Pilot?* The previously summarized conclusions of the various factors that were analyzed basically provided the answer. Simply put, the innovation process just did not facilitate the development of a social innovation enough. This answer is based on a number of reasons. For instance, one cannot hope to successfully launch a social innovation without involving the end-users, meaning the citizens, with the process of co-creation. In addition, the Team, who were supposed to develop the innovative healthcare arrangements, was not offered enough time, not enough knowledge and no transformative leadership, which in the end meant that these innovative healthcare arrangements were never created. However, innovation is also a process of sense-making and transformative learning and the decision to launch a new Pilot, instead of abandoning the attempt for social innovation altogether, clearly means that there exists hope within the Consortium that the new Pilot will manage to reach the Triple Aim objectives. Thus, when the lessons derived from the analysis in this thesis are taken into consideration, in addition to the lessons already written down in the evaluations of the project group, there exists a good chance that the innovation process behind the new Pilot will ensure the successful development of a social innovation.

5.1. Limitations and suggestions for further research

Although it was possible to extract several lessons from the innovation process behind the Pilot in terms of what could have been improved, the analysis also had its limitations. The analysis was conducted post factum on the basis of secondary data consisting of policy documents and an interview with the leader of the project group Tjalling de Vries. This means that the conclusions that were drawn were always based upon what the project group indicated that happened during the innovation process. Thus, a more complete analysis could have been provided from the perspective of an outsider who closely monitored the innovation process as it was occurring. Tjalling de Vries communicated

on behalf of the project group that the willingness to cooperate with the author of this thesis and to involve him closely with the innovation process was clearly present. Unfortunately, the Pilot was terminated prematurely, which in turn led to a post factum analysis. However, seeing as the new Pilot has not started yet at the time of this writing, while it is also supposed to be conducted for a couple of years, a suggestion for further research would be to analyze the innovation process behind the new Pilot once it has commenced.

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