Orchestrating public reforms through joint organizations: the case of a new remuneration policy in Belgian healthcare

Grégory JEMINE

Université de Liège (HEC - Management School)

Margaux BLAISE

Université de Liège (Faculty of Social Sciences)

[1] © *Public Management Review*. This paper is a self-archived version of an original article. This AAM is provided for your own personal use only. It may not be used for resale, reprinting, systematic distribution, emailing, or for any other commercial purpose without the permission of the publisher.

Please use the following reference for citing: Jemine, G., & Blaise, M. (2024). Orchestrating public reforms through joint organizations: the case of a new remuneration policy in Belgian healthcare. *Public Management Review*. DOI: 10.1080/14719037.2024.2365245

Abstract

While remuneration policies in the public sector are a powerful lever for attracting and retaining qualified staff, they are known to be notoriously difficult to change. This paper sets out to unveil how remuneration reforms unfold by exploring the case of Belgian healthcare, in which a sectoral organization jointly managed by employers and labour unions implemented a new compensation framework. Two contributions emerged from this study. First, the paper emphasizes the strengths and challenges of joint organizations in orchestrating public reforms. Second, the tensions between political objectives, managerial rationalities, and workers' expectations that arise when transforming remuneration policies are highlighted.

Keywords

Joint organizations, public reform, healthcare, remuneration policy, organizational change

Introduction

In recent years, the public management literature repeatedly reported cases of public reforms involving setting up intermediary organizations charged with overseeing change processes in local organizations (e.g. Ylönen and Kuusela, 2019). Most often, these intermediaries appear to be private management consulting firms (Galwa and Vogel, 2023; Howlett and Migone, 2013; Seabrooke and Sending, 2022). However, less attention has been paid to how non-profit intermediaries can be set up to orchestrate public reforms. This paper investigates "joint organizations", i.e. *ad hoc* sectoral structures that are jointly managed by employers and labour unions, and their capacity to support public reforms within local institutions. Joint organizations, as emanations from the sectoral social dialogue institutions, are particularly worthy of scholarly attention, as they hold the potential to enact wide-ranging reforms across an entire business sector. While such organizations feature a range of characteristics that might make them promising change agents (e.g. strong field expertise, institutional legitimacy, non-economic motives), they remain largely understudied in the public management literature to this day.

This paper analyses the work of a joint organization in the context of the development of a new remuneration framework in healthcare. In recent years, healthcare institutions in many European countries have been facing significant challenges, such as the COVID-19 crisis, a shortage of nursing staff and expert clinicians, and increasing turnover and absenteeism rates (Kirkpatrick et al., 2021; Lopez et al., 2022). Additionally, as in many other sectors, pressures are growing to promote skills, rather than qualifications, as a basis for remuneration systems, encouraging healthcare institutions to pay their "talents" for what they do, rather than the qualifications they have (Kozjek & Franca, 2020). Calls from labour unions (Tsymbaliuk and Shkoda, 2022) and from the scientific community (e.g. Galanti, 2022) have questioned the ability of public authorities to modernize their remuneration policies through structural reforms to meet contemporary challenges, such as talent attraction and retention (Kravariti & Johnston, 2020). However, due to the historical stability of remunerations in the public sector (Kessler, 2005), and since pay is known to be a highly sensitive topic in organizations (Frey et al., 2013), such reforms are bound to be particularly complex to design and implement. The scarcity of empirical studies on the subject suggests that

few countries have actually managed to undertake large-scale reforms of remuneration systems in healthcare institutions.

A notable exception that is worthy of attention, however, is the case of Belgium, which recently implemented a new job classification framework in healthcare (called "IFIC"). The primary aim of the IFIC was to align and upgrade the remuneration of healthcare professionals through a new compensation framework based on functions, rather than initial qualifications. The IFIC reform was originally initiated on the observation that healthcare institutions were operating with a wide range of homemade remuneration systems and grids, inducing inequalities between workers doing the same job. The Belgian case is interesting to study as it features a hybrid healthcare system with strong connections between public and private hospitals (Ramaekers, 2023). Designed by a joint organization formed by labour unions and employers' representatives from the private healthcare sector, the IFIC was deployed between 2016 and 2019 within private hospitals. In the wake of the COVID-19 pandemic and the ensuing demands of healthcare professionals to scale up wage rates in the sector, the Belgian ministry of health decided to extend the system to public hospitals. Hence, the Belgian case features a unique opportunity to study the strengths and challenges of joint organizations as orchestrators of public reforms.

The paper is structured as follows. First, we develop a theorization of joint organizations, a neglected type of change agent that has received scant attention in the literature. To do so, we build on the concept of "linking organizations", which are said to legitimize change, increase engagement, reduce ambiguity, and foster alignment at the local level (Heinze et al., 2016). Then, we examine the trends in remuneration policies in the public healthcare sector, underlining the scarcity of contemporary studies on the topic, and detail the peculiarities of the Belgian healthcare sector. Finally, through an empirical study of the implementation process of the IFIC within a public healthcare institution, we illustrate how the joint organization under study failed to iron out local conflicts while creating new zones of uncertainty through the constraining rules and procedures that they enforce. Hence, the paper offers a nuanced view of joint organizations, underlining their strengths and weaknesses in supporting public reforms.

Joint organizations as translators of public reforms

One of the dominant models of industrial relations in Western Europe, democratic corporatism, builds on a national system of social dialogue in which employers' and workers' representatives negotiate over the formulation and implementation of government policies (Van Gyes et al., 2017). In this model, government actors carefully select issues that will be addressed by extra-parliamentary organizations, who will be in charge of formalizing rules and procedures, hence directly participating in policy processes (Davidson, 2021). The involvement of interest groups, such as unions, in policy processes, is characteristic of many European countries such as Sweden, Austria, Norway, Denmark, Germany, the Netherlands, and Belgium, among others (Baccaro, 2002). Notwithstanding national specificities, these countries are characterized by an institutionalized system of collective relations that structures and dictates policy concertation and implementation (Van Gyes et al., 2017).

It is also well established that, in Western Europe, the governance of labour markets is strongly organized through sectoral social dialogue (Bechter et al., 2012). As an example, the Belgian model of social dialogue builds around 164 joint commissions that govern the private sector. Each joint commission brings together representatives of employers and unions who oversee a given activity sector (e.g. healthcare, food retail, steel industry, etc.) Joint commissions can conclude collective agreements that apply to all workers (and, therefore, firms) that are part of their action scope. Additionally, each Belgian worker employed in the private sector automatically belongs to a joint commission, depending on the job they perform. The collective agreements have a constraining power: within a business sector, they dictate the regulation of workplace issues such as wage conditions, night work, telework, part-time work, fair treatment, termination and restructuring, etc.

Systems of collective relations have been subject to numerous studies in the field of industrial relations. However, what has received much less attention is the creation of *ad hoc*, non-profit organizations, structured around the model of collective relations described above. In this context, we use the term "joint organizations" to designate such non-profit organizations which 1) are jointly managed by employers' and unions' representatives, both sides being equally represented in its governance, and 2) operate within a given business sector (e.g. healthcare). Joint organizations do not exactly fall into the category of the traditional, well-established "social partners" (i.e. trade unions, business associations, and public administrations); their role does not

consist in negotiating on behalf of their members and signing agreements. Rather, joint organizations are *ad hoc* emanations of social partners, set up with a specific purpose (in the present case, developing and deploying a reform of remuneration frameworks for the healthcare sector). They bring together employers' and workers' representatives who work together to this end.

Whether in the public management or in the industrial relations literature, there has been limited interest in such joint organizations over the years – perhaps indicating that they are relatively rare, because they require high levels of collaboration between employers and unions to come to fruition. Such organizations can nonetheless be found in several countries; examples include the "Sunt Arbetsliv" organization in Sweden, set up by the social partners to work on work safety issues (Larsson & Ulfsdotter Erikson, 2019) and the "Commission on Growth, Structural Change and Employment" in Germany, which led the environmental transition in the coal sector (Galgóczi, 2020). However, they have not been theorized as such, and their role in supporting public reforms has not been the subject of studies. For its part, the public management literature has a long tradition of studying public reforms and questioning the role of intermediaries in carrying out reforms; however, these intermediaries are almost exclusively private consulting firms (e.g. Howlett and Migone, 2013; O'Mahoney and Sturdy, 2016). These firms have been criticized for being driven by managerial ideals and economic interests misaligned with the bureaucratic norms characteristic of the public sector (Galwa and Vogel, 2023), and for coming up with off-the-shelf solutions that are poorly tailored to the peculiarities of the public sector (Broome, 2022; Raudla et al., 2023). In the industrial relations literature, while there have been studies of "co-management" practices within private companies (e.g. Rubinstein, 2000), less interest has been shown for joint organizations and their ability to spark innovative practices within a sector. Hence, we argue that there is room for questioning the strengths and limitations of a particular type of intermediary, i.e. joint organizations, in orchestrating public reforms.

Perhaps the closest concept to build on to better understand the work that joint organizations do is the one of "linking organizations". Linking organizations have been theorized by Heinze and colleagues (2016) as key actors of institutional change in translating field-level imperatives to the organizations belonging to this field. Linking organizations designate entities that belong to a field and act as facilitators between

macro-level organizations, such as public authorities, and local communities (Heinze et al., 2016). Hence, they actively contribute to promoting new ideas and practices, legitimizing change, and materializing public policies at the local level (Greenwood et al., 2002). In their seminal paper, Heinze and colleagues (2016) do not study social dialogue institutions; rather, they theorize the work performed by a community foundation to promote a new wellness approach within a field. Nonetheless, we suggest that there are close connections between linking organizations and joint organizations, insofar as both happen to be "*catalysts for transition*" (Heinze et al., 2016, 1143) who influence multiple organizations in the same field and "*connect a larger network of organizations to enact change*" (Heinze et al, 2016, 1161). Linking organizations provide a fruitful basis for theorizing joint organizations and the work that they do. More specifically, Heinze and colleagues (2016) defined four ways in which linking organizations would orchestrate change within local institutions.

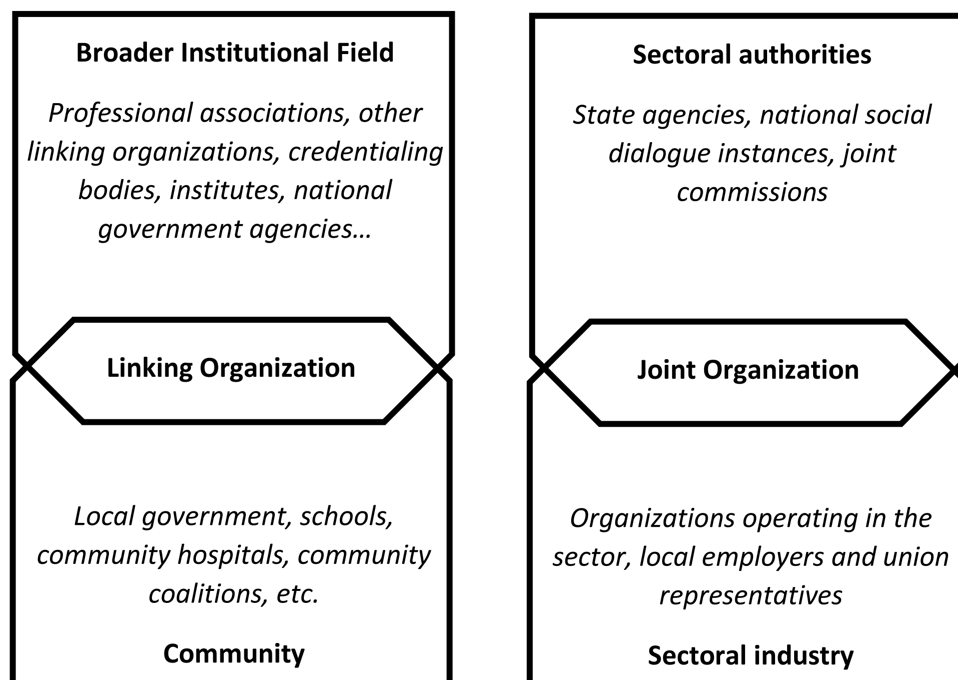

Figure 1 – The dual position of linking organizations (Heinze et al., 2016, p. 1143) and joint organizations

Ensuring legitimacy within the field. Linking organizations would play a key role in acting as "sensemakers" and "sensegivers" by making changes more intelligible and credible to local organizations (Weick et al., 2005). As they are often created in the wake of major institutional change projects, linking organizations are first in line to interpret the underlying motives behind change imperatives and define some key

principles to guide the work of local organizations (Heinze et al., 2016). Ultimately, linking organizations' interpretative work would strengthen the legitimacy of a given change within local organizations (Heinze et al., 2016). For their part, joint organizations are, by definition, working at a sectoral level, hence orchestrating changes for local organizations operating within their business sector. In this view, they should promote shared interpretations of change, increase change legitimacy within local organizations, and facilitate knowledge transfer between organizations (Waisberg and Nelson, 2018). Being governed by employers' and unions' representatives, it can also be expected that joint organizations benefit from greater legitimacy among local managers and unions.

Engaging and accommodating local actors. Linking organizations empower local actors by granting them decision-making power, providing guidance to transpose change locally, and making changes more desirable (Heinze et al., 2016). In that view, linking organizations work in close proximity with local communities, who are themselves playing an active role in implementing change at their level. Similarly, it is the very purpose of sectoral social dialogue to establish general guidelines for a business sector, which can then be adjusted at the company level (Bechter et al., 2012). Leaders of joint organizations are sectoral representatives, who are well aware of the necessity to actively engage local actors. Therefore, joint organizations should also look to enable local actors by providing them with a role and responsibilities, and making them active agents of change.

Managing ambiguity. Linking organizations have been shown to contribute to reducing the ambiguity inherent to institutional change processes by facilitating connections between local actors, and allowing them to interact and learn from each other (Heinze et al., 2016). It is well known that, within a field, normative influences are central to the adoption of change and reforms (Di Maggio & Powell, 1983). By bringing together the leaders of local communities, linking organizations enable such influences (Heinze et al., 2016). For their part, joint organizations are, by definition, bringing together both employers' and unions' leaders of a given business sector. Hence, they open up spaces of influence that reduce ambiguity and facilitate the emergence of shared interpretations of change processes. In that sense, joint organizations should also exert social normative pressures within a sector, which reduce ambiguity while promoting specific practices and behaviours.

Monitoring alignment with the field. According to Heinze and colleagues (2016), linking organizations would also act as gatekeepers, monitoring the overall alignment of local communities. This is because linking organizations are in a position to provide feedback to local actors regarding what elements are deemed consistent with the expectations, and which are not (Heinze et al., 2016). As actors of sectoral social dialogue, joint organizations are expected to play a similar role and ensure that no organization in the field is implementing change in a way that deviates from the general norm. Hence, they do play a role in policing how institutional change processes unfold on a large scale and within multiple organizations in a sector (Bechter et al., 2012).

At the end of the day, both linking and joint organizations share strong similarities, insofar as they enact and facilitate large-scale change processes that affect multiple organizations in a field or a business sector (as illustrated in Figure 1). However, joint organizations are distinct from linking organizations as they are emanations of formal social dialogue instances, anchored in antagonistic relationships between unions' and employers' representatives (Bechter et al., 2012). Joint organizations bring together actors who are durably inserted into structures of authority and power (i.e. labour and employers' federations) and embody a panel of conflicting interests. It should also be noted that, whereas Heinze and colleagues (2016) theorized linking organizations in the context of the diffusion of wellness programs, the present study focuses on a new remuneration framework, which is known to be a highly sensitive topic in organizational life (Kessler, 2005). Given these elements, joint organizations should be expected to bring in more conflicts and bargaining than linking organizations. Interestingly, Heinze and colleagues themselves (2016, 1166) called for more in-depth empirical research on how political dynamics thwart or facilitate the work of linking organizations.

In this context, this paper sets out to study the strengths and challenges of joint organizations in orchestrating public reforms at the local level, by paying special attention to power dynamics between joint organizations and public institutions. On the one hand, it can be argued that joint organizations stand out as promising change agents to build legitimacy, engage local actors, manage ambiguity, and ensure that change is consistently implemented within a sector (Heinze et al., 2016). After all, the very existence of a joint organization already signals a high degree of cooperation between employers and unions, insofar as they are managed by both sides. On the other hand, in the absence of empirical studies, it remains difficult to assess how

successful the model of joint organization is in practice. Processes through which public organizations implement reforms have often been overlooked (Fattore et al., 2017), and the public management community has recently called for paying more attention to the role of external actors in public management reforms (e.g. Raudla et al., 2023; Seabrooke and Sending, 2022). The concept of joint organization precisely emphasizes how public organizations might respond to change imperatives when driven by non-profit, sectoral actors who become essential in defining change and overseeing how it unfolds (Lawrence and Suddaby, 2006). Departing from the normative, theoretical ideal of linking organizations, we aim to unveil the strengths and challenges of joint organizations as orchestrators of public reforms, through the example of new remuneration policies in public healthcare.

Toward new remuneration policies in public healthcare institutions

The term "remuneration" is commonly used to designate the rewards that employees receive in exchange for their labour (Kessler, 2005). In this paper, we mostly discuss extrinsic rewards and use the term as a synonym for pay schemes. In the public sector, remuneration usually appears to be a fairly stable matter. Based on their initial qualifications and seniority in position, employees are traditionally assigned a given salary rate (Bach and Della Rocca, 2000). Impersonal and uniform pay scales for all public agents form the historical components of public remuneration policies. In this context, it is usually assumed that local actors have little room for manoeuvre to weigh upon these policies. Indeed, pay systems may only be adjusted through laborious negotiations between public authorities and union representatives (Kessler, 2005). Remuneration policies in the public sector are, therefore, notoriously more stable and more difficult to change than in the private sector. Moreover, pay has typically been depicted as an issue of lesser concern for public service agents who are assumed to favour performing meaningful work driven by altruistic values over maximizing their income (Chen and Hsieh, 2015; Weibel et al., 2010).

These factors explain why the debates have mostly revolved around attempts to mimic remuneration models inspired by the private sector, such as pay-for-performance schemes (Park and Berry, 2014; Weibel et al., 2020). In this view, pay schemes should be redesigned to account for output-related performance measures (Frey et al., 2013) and to reflect workers' merit (Park and Berry, 2014). These attempts, however, have been repeatedly described as "failures", notably due to poor implementation (Perry et

al., 2009) and inadequacy in the context of public organizations (Frey et al., 2013). Interestingly, in the last years, these debates have seemingly run out of steam, as publications on alternative pay schemes for the public sector have been scarce. The traditional components characterizing remuneration systems in the public sector (i.e. equal pay for all depending on qualifications and seniority) appear to remain the norm. Pay systems remain taken-for-granted black boxes that are often left unquestioned, especially at the level of public organizations themselves. For instance, while pay is a core component of the HR function, the HR literature has very little to say about how HR managers in the public sector can use remuneration as a strategic lever.

However, while remuneration policies have remained historically stable in public healthcare, pressures to "modernize" them continue to build on public hospitals. As in many other sectors, the managerial rhetoric of "talent" and "skills" has been gaining momentum. It notably encourages organizations to move away from the historical, qualification-based system of remuneration, and endorse a skills-based model, where remuneration is increasingly determined by what people actually do, rather that the qualifications they have (Kozjek & Franca, 2020). At the same time, healthcare institutions throughout the world have notoriously been facing a growing shortage of personnel in many countries for years, especially when it comes to nursing staff and expert clinicians (Kirkpatrick et al., 2021; Lopez et al., 2022). Hence, public hospitals face increasing competition from the private sector that can develop more tailored remuneration policies to attract "talented staff" (Kravariti & Johnston, 2020). From a management perspective, rethinking and upgrading remuneration policies would be a possible lever to offset the shortage of qualified staff. Furthermore, the provision of decent labour wages for healthcare workers became a growing concern in many European countries following the COVID-19 pandemic (Tsymbaliuk and Shkoda, 2022), as resignation rates in healthcare increased sharply in the last years, and healthcare organizations looked into developing new retention strategies. In this context, upgrading the pay schemes of public healthcare workers grew into a central union demand, increasingly supported by research critically underlining the limits of contemporary healthcare systems in terms of human resources (e.g. Shannon et al., 2019). Yet, few empirical studies have been conducted on actual attempts to develop and implement new remuneration policies in public healthcare.

This paper sets out to study such a reform in the context of Belgian healthcare. Belgium is an interesting context to research as it features a hybrid healthcare system with strong connections between public and private hospitals. Out of 103 general hospitals in the country, 30% are directly managed by public authorities, the rest being run as private and non-profit organizations (Ramaekers, 2023). However, many financing and operating rules apply identically to private and public hospitals. For instance, all hospitals in Belgium are equally financed by public authorities based on their amount of “justified beds”, a metric that accounts for their assumed occupancy rate based on hospital activity (Van den Heede et al., 2023). Moreover, most treatments are equally covered by public authorities regardless of the hospital type. In the same vein, the ambition to develop a new remuneration framework for the healthcare sector has been, in Belgium, the subject of consultations between the public and the private sector.

Moreover, Belgium is known to be a strongly unionized country, with a strong model of social dialogue. The new remuneration framework under study in this paper has initially been initiated, designed, and implemented by the social partners (i.e. employers’ and unions’ representatives) representing private healthcare institutions. A non-profit organization steered by these social partners was set up to deploy the new framework in private hospitals. Later, it was decided by the Belgian Ministry of Health to extend the same framework to public hospitals. Hence, the public reform was almost entirely managed by a non-profit organization bringing together social partners from the private sector. This setting is especially interesting to study from a public management perspective, as it features a particularly unique type of intermediary – a “joint organization” – charged with implementing a remuneration reform in healthcare. In a context of blurred boundaries between private and public healthcare, it allows us to better grasp 1) the extent to which “joint organizations” bringing together employers’ and unions’ representatives can be effective change agents to support such reforms and 2) how a reform to modernize remuneration systems actually unfolded in practice.

Methods

This paper focuses on a public reform implementing a unified framework of job classification for healthcare institutions in Belgium. In the early 2000s, employers’ and workers’ representatives of the Belgian private healthcare sector made the joint observation that the lack of a shared remuneration scheme across all healthcare institutions resulted in unfair pay policies, injustice feelings among health workers, and

unhealthy competition between hospitals. The sectoral social partners of the private healthcare sector created, in 2002, a non-profit, jointly managed organization, Barema, with the aim of developing a common job classification system labelled “IFIC”. It was decided that half the members of Barema’s board of directors would be employers’ representatives, and the other half union members. Over the years, Barema worked on a structural overhaul of the remuneration conditions in private healthcare. To do so, Barema hired a team of approximately twenty employees (mostly economists, data analysts, and consultants), whose mission consisted in elaborating the new framework and regulations to facilitate its adoption. In 2016, when the IFIC was deemed ready, the sectorial social partners signed a collective agreement that made it compulsory for private hospitals to transition toward the new system by 2021. These developments were followed closely by the minister of health, and in 2020, the Belgian government unlocked financial resources (approx. €500 million) to extend the system to public healthcare institutions. The COVID-19 crisis further precipitated the release of public funds to support the reform, as it was supposed to upgrade the remuneration levels of healthcare professionals in the public sector.

This paper focuses on the case of Lilypad Healthcare (fictive name), a public healthcare institution that employs 3.800 workers in Belgium. The institution encompasses three activity sectors that are psychiatric care, geriatric and palliative care, and services for the elderly. A majority of the staff consists of highly qualified healthcare professionals. Before 2021, Lilypad Healthcare had its own remuneration policy in which professional qualifications were used to determine a grade and an associated wage. At the end of 2021, they began their transition toward the IFIC system under the supervision of Barema, which is the object of the present study.

The data collection process was structured in two waves and involved a total of forty-one (n=41) interviews. First, semi-structured interviews were conducted with key actors within Lilypad Healthcare to better understand how they implemented the IFIC. Twenty-one interviews were conducted between March 2022 and May 2022 with executive committee members, directors, local union representatives, and HR professionals of the institution. At this period, the IFIC was still being worked upon, allowing us to focus on the change process itself. The choice of interviewees was driven by our intent to meet the actors who interacted with Barema and participated in setting up the IFIC system in the institution. One additional interview was conducted

with the director of Barema a few months later. Then, early 2023, we conducted nineteen additional interviews with workers from Lilypad Healthcare, including nurses, caregivers, administrative officers, medical secretaries, cooks and cleaners. This additional stage of data collection aimed to grasp the reception of the reform by workers, approximately six months after its implementation. Interviewees were asked how they were personally impacted by the reform and how they reacted to it. It should be noted that, throughout the research process, the topic was highly sensitive and controversial. Interviews were recorded and transcribed, except in some cases in which interviewees did not grant us their permission to do so, in which case we relied on extensive notes taken during the interview instead.

The data analysis included a coding process inspired by the methodological principles of grounded theory (Corbin & Strauss, 2015). A first-order analysis made it possible to identify the issues induced by a joint organization (Barema) in the hospital under study, according to informants' terms. This analysis revealed a deep divide between the formal objectives of the IFIC reform ("harmonizing" remuneration, "upgrading" healthcare professions, improving "equality", etc.) and its perceived effects on the field by managers (who claimed that their autonomy was "violated", as they felt "trapped" by the reform and its "inadequate" rules and procedures) and by workers (who expressed strong feelings of "unfairness", "deception" and "resignation"). Then, to make sense of this divide, a second-order analysis was performed to identify three decisive stages of the project (redefining job classifications, ensuring institutional consistency, performing wage simulations). These stages emphasize the nature of the interactions between local actors, i.e. Lilypad Healthcare, and a joint organization in charge of orchestrating the deployment of the IFIC system – Barema.

Results

Toward a new job classification system

The IFIC system was built on a reworked job classification framework developed by Barema that encompassed a total of 221 job descriptions associated with remuneration levels. Studies conducted by Barema highlighted the shortcomings of the local remuneration systems which often entailed financial advantages of all sorts, resulting in unfair treatment of healthcare workers across the country. Therefore, the work of Barema aimed at providing the same remuneration to workers doing the same set of

tasks. It implied a major paradigm change, as it replaced professional qualifications as the indicator for adjusting remuneration levels with a detailed inventory of the tasks inherent to each function. Through this new job classification system, the IFIC reform aspired to bring a more objective, consistent, and modern remuneration scheme for Belgian healthcare.

The reform ambitioned to cover all functions in healthcare institutions, with the notable exception of doctors and directors[1]. The job descriptions produced by Barema were the result of sustained collaboration between their analysts and representatives from healthcare institutions. That collaboration was required to provide accurate descriptions of the functions, but also to weigh them in terms of remuneration in a way that echoed the opinion of field actors. Once established, these job descriptions were to be used as a baseline with which all healthcare institutions should align themselves. Barema also defined a constraining protocol framing the implementation process of the reform. This protocol was structured around three key stages: a) identifying relevant job descriptions at the local level; b) running wage simulations; and c) informing workers on the effects of the reform on their situation. In the following section, we investigate how the implementation process of the IFIC reform took place within a public healthcare institution.

The implementation process of the IFIC at Lilypad Healthcare

Step 1 – Identifying relevant job descriptions

At Lilypad Healthcare, the transition towards the IFIC system began in January 2021. The direction had postponed the decision to take the leap for a few months. Chiefly, the project was seen as "*an attempt to set global rules which went against the historical idea of the local autonomy of hospitals*" (IFIC Director). Enthusiasm toward the IFIC reform was moderate at best among hospital directors. Lilypad Healthcare's directors spoke of the "*IFIC straightjacket*" to designate the "*constraining protocols*" that went with the reform (Deputy Director), sometimes described as "*autocratic*" and "*despotic*" (HR Director). Despite their reluctance to give up some of their local autonomy, the directors understood that they had no real choice. The government had decided to

[1] The decision to exclude these two functions was made by the social partners. In most Belgian hospitals but university hospitals, doctors are usually self-employed for financial motives, which means that regulating their remuneration would have been more complex.

enforce the IFIC system for all workers joining healthcare institutions from January 1st, 2022, which implied that Lilypad Healthcare "*had no other choice but to comply or [they] would not be able to remain attractive for the functions that had been upgraded by the reform*" (Deputy Director).

As specified by Barema, the first step consisted of identifying the jobs concerned by the reform and reclassifying them into the new categories of the IFIC system. The main rule established by Barema is that an agent should perform at least 80% of the tasks associated with a given job description to be assimilated to that function. On this basis, three scenarios can arise. If an agent meets the aforementioned criteria, he will be attributed the job description of reference. If none of the job descriptions provided by Barema works, institutions are allowed to combine them to create a *hybrid function*. A hybrid function is composed of up to three job descriptions belonging to the same remuneration level, and is only allowed if the agent performs at least 10% of the tasks of each job description, and if the hybrid function itself covers 80% of the tasks performed by the agent. Finally, if neither job descriptions nor hybrid functions work for an agent, the institution can request the creation of a *missing function* by writing a new job description from scratch, assigning a remuneration level, and submitting it to Barema for review. Barema then decides whether the associated remuneration is fair or, on the contrary, overstated – in which case the function will be only partly subsidized and the institution will have to cover the salary gap.

The procedure also stipulates that each healthcare institution had to designate a project coordinator to oversee the process. Early 2021, at Lilypad Healthcare, the Deputy Director was chosen by the executive board to fulfil this mission. The Deputy Director constituted a support committee made up of six directors and six union members in charge of overseeing the implementation of the reform. A working group supervised by the HR Director and composed of HR employees and heads of departments was set up to carry out the practical work on the job descriptions. In April 2021, this group began working on the job descriptions, not without frustration:

> "*The way I initially understood the project was, we would go on the field and question people to learn more about their jobs, so we could construct more accurate job descriptions together. But that wasn't it, at all. It turned out to be all about reading the IFIC job descriptions, comparing them with ours, and categorizing people.*" (HR employee)

Several working group members noted that they had very little leeway in the process and that decisions had to be made based on incomplete information. Because Lilypad Healthcare did not have a thorough inventory of all the existing functions within the institution, it was not always possible to merely compare between the old and the new system. Members of the working group had to rely on what managers had to say about the work of their subordinates. Besides, the working group believed that the job descriptions elaborated by Barema did not adequately reflect the complexity of their institution:

> "*From my point of view, the job descriptions were ill-suited to the work that we do in psychiatry. There are very few details about the specific acts that our staff has to perform (…) If you read the job description of a pediatric nurse, you can almost wonder if she is supposed to take care of children. I am exaggerating it, but barely.*" (Director of Nursing)

Heads of departments also pointed out adverse effects that the IFIC system could have on specialized functions:

> "*Some nurses followed additional training in geriatric care or psychiatry, but they are assimilated to the nurses with no specialization. What is, then, the point of having specializations if they are not recognized anymore? I am afraid that the reform will discourage nurses from pursuing training that does not directly allow them to shift from one function to another.*" (Director of Nursing)

Heads of departments expressed concerns that some functions were poorly covered or inadequately weighted by the IFIC system, which prompted them to introduce many requests for missing functions. By doing so, the directors attempted to defend their agents and improve their pay level as much as they could. In turn, the inflation of requests for missing functions caused concern among the working group, who feared that "*Barema could say that we were too generous and overrated some jobs*" (HR Director). While the initial aim of the reform was to harmonize job descriptions, the opportunity to create missing functions opened the door for "*everyone doing it their own way*" (HR employee). Hence, a series of tensions appeared around the redefinition of functions according to the rules prescribed by Barema.

Once they were done, the working group looked for internal validation from the project coordinator – the Deputy Director. The Deputy Director shared the work that had been done with the executive board, which was welcomed with sharp criticism:

> "*There was no institutional consistency in the work that was presented to us. Some people made jumps of four pay levels for no reason, or suddenly became paid more than their manager… It was mind-blowing, as if the salary implications of the reform had been totally understated.*" (Financial Director)

The executive committee undertook to review the whole job classification system by themselves. While the working group attempted to follow Barema's rules by operating a reclassification based on what agents actually did, the work of the executive committee appeared to be mostly driven by the desire to preserve the *status quo* in the institution and avoid sudden remuneration leaps and drops. Both logics clashed with each other, as members of the working group criticized, in turn, the attitude of the board:

> "*I said, this job description fits 80% of the work that my people are doing. This is what we are required to do by Barema, I mean, this is what this reform is about, right? But then, the board decides… in the name of "consistency"… to downgrade them by arguing that they are not, apparently, doing this type of job. I mean, board members do not even work with them…*" (Technical Manager)

> "*We realized that the board members made up missing functions for jobs that could clearly be associated with an existing job description in the IFIC. Why? Well, so that they could decide on remuneration levels by themselves…*" (HR employee)

This episode illustrates a key paradox inherent to the reform: while it promotes a logic of "equal work, equal pay", it does so by forcing healthcare institutions to implement the reform within a closed budgetary envelope. That envelope is rigorously controlled by Barema, which has the prerogative to monitor the outputs of the work performed at the local level. Therefore, healthcare institutions foresaw the risk of having to bear the overcosts of an overly generous remuneration system. The argument of "institutional consistency" was used to legitimize the board's strategy to mirror the existing situation as far as possible. However, that strategy created considerable resentment among the

members of the working group, who pointed out the inconsistency between the aims of the reform and the actual decisions made by their management.

Step 2 – Performing wage simulations

The next step of the procedure established by Barema consisted of simulating the new wages of workers concerned by the IFIC reform. Once job descriptions were identified and approved, the aim became to distinguish *green functions* – for which the IFIC wage is higher than their current wage – from *red functions* – for which the IFIC system is unfavourable. The simulation aimed to provide institutions with an overview of the actual effects of the IFIC reform on remuneration levels to ensure that the projections were financially sustainable.

Lilypad Healthcare initiated these simulations in October 2021. Numbers revealed that 83% of the workers concerned by the reform would be attributed a green function. By contrast, some critical functions, such as caregivers and some operatives, turned out to be red functions. Actors from both HR and management pointed out the gap between the reform's ambition to promote a structural upgrade of remuneration conditions and the actual effects of the process that resulted in changes either seen as largely insignificant or as fairly random:

> "*There is an outrageous inconsistency between political discourses and what we witness at Lilypad. The discourse is, the status and remuneration conditions of the nursing profession will be upgraded. What an illusion! For most functions, that upgrade is not significant at all.*" (Nursing Director)

> "*Everyone here would agree that maintenance workers were absolutely essential during the pandemic. Yet, with the IFIC system, they would lose 4% of their actual salary. This is so unfair!*" (Technical Director)

The simulations caused shared disbelief among Lilypad Healthcare managers who had placed hope in the reform as a means to increase the attractivity of health professions. The actual effects of the new job classifications, it turned out, were not in line with the initial ambitions of the reform. On the contrary, some actors were left under the impression that managerial positions were the most advantaged by the IFIC system, hence resulting in increased pay inequalities.

Step 3 – Informing workers on the effects of the reform

A significant feature of the IFIC reform is that workers were free to opt in or out of the new remuneration system. Hence, Barema made it mandatory for healthcare institutions to provide each worker with an individualized salary projection allowing them to compare old and new remuneration schemes. Workers could either decide to accept their new job description and the associated remuneration level; accept the job description while keeping their actual remuneration; or reject their new job description through an appeal system. In practice, workers were often disillusioned by the reform:

> "*The rule is, you have to perform at least 80% of a job description. I thought I would be attributed* [this job description]… *No matter how many times I turn it upside down, it works for me… But no, I got the one below…*" (Nurse)

> "*The reform was sold to us as something that would recognize people for their work, but it didn't. Many of us are bitter and disappointed, that's for sure*." (Cook)

Workers widely shared the disappointment formerly expressed by managers on the effects of the reform and how it had been handled:

> "*Our managers at Lilypad have done their best, but the rules established by Barema are so complicated, with all these exceptions and hybrid functions… It creates some sort of monster that is completely disconnected from what we experience on the field!*" (Administrative agent)

It was found that only about half of the workers with a green function accepted their new remuneration level (49%), while the other half declined to transition to the IFIC system either explicitly (32%) or by not responding in due course (19%). This is because many workers considered appealing the outcome of the reform. Appeals had to be dealt with internally, and could either be rejected or result in the decision to allocate a new function to a worker or to create a hybrid or a missing function. While some workers took a chance by filing an appeal, others were reluctant to do so:

> "*You could think that appeals are an option. To tell you the truth, it's not. It is a lot of paperwork, a lot of hassles, which everyone cannot endure. But the real issue is that it means that we are confronting our management. The system is just disheartening.*" (Administrative agent)

Ultimately, at the issue of this final stage, and accounting for the outcomes of the appeal process which are not fully detailed here, less than half of the workers initially

concerned by the reform at Lilypad Healthcare (43,6%) willingly shifted to the IFIC at the end of the process. While this figure is expected to naturally increase over time, notably due to natural turnover, it also reflects the shortcomings of the IFIC system as designed by and implemented through Barema.

The roles of Barema in implementing a new remuneration policy

This paper aims to better understand joint organizations, defined as structures jointly managed by sectoral social partners, as orchestrators of public reforms. Barema, a non-profit organization set up by labour unions and employers' representatives from the private healthcare sector, designed a new job classification framework and an associated remuneration scheme, and was mandated to implement it in public hospitals. The setting is particularly interesting, as the reform was entirely negotiated between social partners from the private sector; it also implies that the experts in charge of the reform have a sound knowledge of healthcare institutions and remuneration systems. Theoretically, we could therefore expect joint organizations to produce similar effects to linking organizations, i.e. to be key actors in translating and enacting change locally, building legitimacy, reducing ambiguity and ensuring alignment within the field (Heinze et al., 2016). Empirically, however, our findings illustrate a series of tensions between Barema and the local level, which makes it possible to better define the challenges of joint organizations as orchestrators of public reforms.

At first sight, Barema could be seen as a textbook case of a strong partnership between social partners. Employers and unions managed to set up a joint organization to design a unique job classification framework to harmonize remuneration policies in the healthcare sector, an objective that was widely shared by the social partners, both at the sectoral and the local level. While it took them many years to design a new framework, Barema ultimately managed to produce a system which was not only ratified in collective agreements, but also expanded by ministerial decision to the public sector. From a public policy perspective, building on the work performed by social partners could be seen as a fruitful way to increase the legitimacy of a reform. Barema also provided practical guidance to healthcare institutions, and guaranteed the alignment between them. Hence, Barema appears to be, after all, a remarkable example of a joint collaboration through which the reform of job classifications was thoroughly prepared.

Yet, despite all their efforts, Barema could not prevent conflicting interpretations and bargaining attempts from spawning. From the very beginning, the local actors at Lilypad Healthcare had strong concerns regarding the practical implications of the reform. Ill-suited job descriptions and inconclusive wage simulations revealed a striking gap between political discourses and the reform's local effects. Instead of reducing ambiguity, the accumulation of rules and procedures induced several elusive concepts – hybrid functions, missing functions, associated remuneration levels, green and red functions – which local actors interpreted and used in different ways. As the project progressed, the disillusion of managers and employees grew higher, and the consensus was that the reform did not have any significant implications for a large majority of workers. Barema's "*constraining protocols*" (Deputy Director) were welcomed with hostility, steering against the widely heralded principle of healthcare institutions' local autonomy. Rather than "empowered", directors felt compelled to transition to the IFIC; managers felt trapped by the framework established by Barema; and workers felt coerced into a new remuneration system. Besides, Barema allowed healthcare institutions to provide workers with extra-legal benefits (e.g. vouchers, bonuses, insurance, etc.) which, in turn, made it possible for private hospitals to maintain competitive advantages. As stated by an HR employee, "*if hospitals can grant advantages to their staff, then it perpetuates the competition that the reform aimed to remove in the first place*". Local actors, therefore, did not believe that the reform would truly set all healthcare institutions on the same footing.

Linking organizations' roles (Heinze et al., 2016)	**Observed effects of Barema at Lilypad Healthcare**
Ensuring legitimacy within the field	Decreasing legitimacy by producing conflicting interpretations of the reform
Engaging and accommodating local actors	Delegating limited responsibility to local actors by monitoring outputs
Managing ambiguity	Sustaining ambiguity through procedures leaving room for interpretation
Monitoring alignment with the field	Allowing local variations between institutions of the field

Table 1 – Observed effects of Barema

Table 1 offers a contrasting view of the theoretical roles of linking organizations (Heinze et al., 2016) and the actual effects of Barema as reported in this study. It is important to recall that Barema, unlike the linking organization studied by Heinze and colleagues, is both the designer and the implementer of the reform; they defined a new framework and a procedure to implement it, both of them being subjects of contention. Hence,

Barema is not a neutral actor merely in charge of legitimizing a reform; rather, they appear to be a part of the problem in the eyes of local actors. The case further reminds us of the inevitability of power games within local institutions. Indeed, in a reform of remuneration policies, workers will pursue their own interests, seeking to improve their position while paying attention to the fairness of the change process. Despite all Barema's efforts, it should be recalled that there are inherently conflicting roles and interests among the stakeholders at play (i.e. Barema, directors, managers, employees, unions, etc.) Therefore, joint organizations appear to be more imperfect orchestrators of public reforms than what theory would suggest.

Discussion and conclusions

The present study offered an in-depth investigation of the case of Barema and the IFIC reform in Belgium, to better grasp joint organizations while shedding light on a remuneration reform in a public hospital. It should be noted that this paper features the usual limitations associated with the single case study method. Most notably, caution should be exerted when generalizing findings to other settings (e.g. other countries, other types of reforms, other joint organizations, etc.) The data was also collected shortly after the implementation of the reform with the organization under study, which might overemphasize short-term effects, and does not necessarily provide a sound assessment of how well the reform will be accepted over time. Notwithstanding these precautionary remarks, three main contributions emerge from the study.

First, the paper explored the extent to which joint organizations, understood as non-profit organizations jointly managed by employers and unions, could effectively orchestrate public reforms. The study shows that, in practice, such organizations are not always living up to the hype of the ideal offered by Heinze and colleagues (2016). The joint organization under study struggled to ensure legitimacy, engage local actors, and manage ambiguity, because calculated behaviours at the local level prevented them from acting as efficient orchestrators of public reforms. These observations are reminiscent of organizational studies on power which underline the capacity of organizational actors to "play" with the rules of the game to support their own interests (e.g. Crozier and Friedberg, 1980; Fleming and Spicer, 2014; Salancik and Pfeffer, 1977). In this view, local actors will identify and seize opportunities to extend their power and improve their position (Crozier and Friedberg, 1980). Joint organizations' efforts to create collective practices across multiple organizations collide with the

multiplicity of interests and strategies of the actors involved within these organizations. Hence, while recent literature on public reforms has mostly focused on issues such as knowledge exchange (Wye et al., 2015), public service efficiency (e.g. Kirkpatrick et al., 2019), or identity work (Galwa and Vogel, 2023), this paper recalls the centrality of power in orchestrating them, and call for increased empirical attention to power relations in public reforms implementation (Fleming and Spicer, 2014).

Second, this paper advances our knowledge of large-scale, structural attempts to enhance remuneration policies of public healthcare workers. In many countries, ever since the COVID-19 pandemic, healthcare institutions are facing staff shortages and pressures to modernize their remuneration systems (Kirkpatrick et al., 2021; Lopez et al., 2022). Calls have been made to solve the structural issues about remuneration in public healthcare that were made salient by the pandemic (Galanti, 2022; Naughton, 2023). However, the elaboration and implementation of policy responses to healthcare workers' demands remains largely understudied. This study underlines the challenges of modernizing remuneration systems in healthcare through a unified job framework between private and public hospitals. In the hospital under study, the reform was often perceived as unfair and underwhelming by managers and workers alike, which illustrates the difficulty in conciliating political objectives, managerial rationalities, and workers' expectations. Further studies of similar projects could perhaps draw on the literature on organizational justice (e.g. McFarlin and Sweeney, 1992) to better grasp individuals' subjective perceptions of remuneration reforms in healthcare.

Third, we argue that future developments could connect research on joint organizations with wider debates on consultocracy in the public sector (Ylönen and Kuusela, 2019). Management consultants have become central actors in the implementation of public reforms (Seabrooke and Sending, 2022). However, their motivations and solutions have been shown to be driven by managerial ideals and economic interests that are misaligned with the bureaucratic norms characteristic of the public sector (Galwa and Vogel, 2023). Hence, a common concern identified in the literature is the risk that consultancies come with off-the-shelf solutions that are poorly tailored to the peculiarities of the public sector (Broome, 2022; Raudla et al., 2023). By contrast, there is no relationship of economic dependency between joint organizations and public institutions. Unlike private consulting firms, joint organizations are not financially dependent upon procurement contracts; their choices and decisions are not

driven by the pursuit of economic gain (Wye et al., 2015). This reduces the risk of reforms being driven or influenced by opportunistic attempts from external consultancies to maximize their profit. Additionally, joint organizations are made of experts with a sound knowledge of the sector they work for, who design solutions that are directly aligned with the reforms' objectives, hence facilitating harmonization (Broome, 2022) and reducing the risks of ill-suited approaches that are not tailored for the public sector (Seabrooke and Sending, 2022). Therefore, joint organizations might be seen as a consulting model that is better aligned with the public sector specificities, driven by field considerations (rather than profit) and serving the public interest (rather than "shareholders") (Radnor and O'Mahoney, 2013). For these reasons, they might be considered as a promising alternative to private consulting firms to support public reforms, and deserve further attention from researchers and policymakers alike. Future studies might look more specifically into joint organizations as an alternative to private consulting, and seek to establish whether they could avoid the pitfalls commonly associated with private consultancies in supporting public sector reforms (Raudla et al., 2023).

References

Baccaro, L. (2002). “The construction of “democratic” corporatism in Italy”. *Politics and Society* 30(2): 327-357.

Bach, S., and Della Rocca, G. (2000). “The management strategies of public service employers in Europe.” *Industrial Relations Journal* 31(2): 82-96.

Bechter, B., Brandl, B., and Meardi, G. (2012). “Sector or countries? Typologies and levels of analysis in comparative industrial relations”. *European Journal of Industrial Relations* 18(3): 185-202.

Broome, A. (2022). “Gaming country rankings: Consultancies as knowledge brokers for global benchmarks.” *Public Administration* 100: 554-570.

Chen, C., and Hsieh, C. (2015). “Does Pursuing External Incentives Compromises Public Service Motivation? Comparing the effects of job security and high pay.” *Public Management Review* 17(8): 1190-1213.

Corbin, J., and Strauss, A. (2015). *Basics of Qualitative Research, Techniques and Procedures for Developing Grounded Theory* (4th ed.). Sage.

Davidson, R. (2021). “After accommodation? Inclusion and exclusion of emancipation interests in Dutch “democratic corporatism””. *Acta Politica* 56(1): 163-180.

Di Maggio, P., and Powell, W. (1983). “The Iron Cage Revisited: Institutional Isomorphism and Collective Rationality in Organizational Fields”. *American Sociological Review*, 48(2), 147-160.

Fattore, G., Iacovone, D., and Steccolini, I. (2017). “Managing successful change in the public sector: a view from the consultants’ world.” *Public Management Review* 20(4): 587-606.

Frey, B., Homberg, F., and Osterloh, M. (2013). “Organizational Control Systems and Pay-for-Performance in the Public Service.” *Organization Studies* 34(7): 949-972.

Galanti, C. (2022). “National heroes, disposable workers. How collective action in the health and social care sector during the pandemic negotiated with the self-sacrificing worker ideal.” *Gender, Work and Organization*: 1-19.

Galgóczi, B. (2020). “Just transition on the ground: Challenges and opportunities for social dialogue”. *European Journal of Industrial Relations*, 26(4), 367-382.

Galwa, J., and Vogel, R. (2023). “In search of legitimacy: conflicting logics and identities of management consultants in public administration.” *Public Management Review* 25(2): 404-428.

Greenwood, R., Suddaby, R., and Hinings, C. (2002). “Theorizing Change: the Role of Professional Associations in the Transformation of Institutionalized Fields.” *Academy of Management Journal* 45(1): 58-80.

Heinze, K., Soderstrom, S., Heinze, J. (2016). “Translating Institutional Change to Local Communities: The Role of Linking Organizations.” *Organization Studies* 37(8): 1141-1169.

Howlett, M., and Migone, A. (2013). “Policy advice through the market: The role of external consultants in contemporary police advisory systems.” *Policy and Society* 32(3): 241-254.

Kessler, I. (2005). "Remuneration Systems.” In *Managing Human Resources: Human Resource Management in Transition*, edited by Bach, S. and Edwards, M., 243-267.

Kirkpatrick, I., Sturdy, A., Alvarado, N., Blanco-Oliver, A., and Veronesi, G. (2019). “The impact of management consultants on public service efficiency.” *Policy and Politics* 47(1): 77-95.

Kirkpatrick, I., Altantar, A., and Veronesi, G. (2021). “Hybrid professional managers in healthcare: an expanding or thwarted occupational interest?” *Public Management Review* 25(2): 859-878.

Kozjek, T., and Franca, V. (2020). Talent Management in the Public Sector. *Central European Public Administration Review* 18(2): 53-71.

Kravariti, F., and Johnston, K. (2020). Talent management: a critical literature review and research agenda for public sector human resource management. *Public Management Review* 22(1): 75-95.

Larsson, B., and Ulfsdotter Erikson, Y. (2019). Enhancing the effectiveness of social dialogue articulation in Europe: Case Study for Sweden. Working paper.

Lawrence, T., and Suddaby, R. (2006). *Institutions and Institutional Work*. The Sage Handbook of Organization Studies, 215-254.

Lopez, V., Anderson, J., West, S., and Cleary, M. (2022). “Does the COVID-19 Pandemic Further Impact Nursing Shortages?” *Issues in Mental Health Nursing* 43(3): 293-295.

McFarlin, D., and Sweeney, P. (1992). “Distributive and Procedural Justice as Predictors of Satisfaction with Personal and Organizational Outcomes.” *The Academy of Management Journal* 35(3): 626-637.

Naughton, M. (2023). “Mobilising societal power: Understanding public support for nursing strikes.” *Industrial Relations Journal*: 1-17.

O’Mahoney, J., and Sturdy, A. (2016). “Power and the diffusion of management ideas: the case of McKinsey and Co.” *Management Learning* 47(3): 247-265.

Park, S., and Berry, F. (2014). “Successful Diffusion of a Failed Policy: The case of pay-for-performance in the US federal government.” *Public Management Review* 16(6): 763-781.

Perry, J., Engbers, T., and Jun, S. (2009). “Back to the Future? Performance-Related Pay, Empirical Research, and the Perils of Persistence.” *Public Administration Review* 69(1): 39-51.

Radnor, Z., and O’Mahoney, J. (2013). “The role of management consultancy in implementing operations management in the public sector.” *International Journal of Operations and Production Management* 33(11/12): 1555-1578.

Ramaekers, D. (2023). *Données phares dans les soins de santé : hôpitaux généraux*. Report from the SPF Santé publique (Belgium).

Raudla, R., Ylönen, M., and Kuusela, H. (2023). "Debate: Management consultants and public management reforms." *Public Money and Management* 43(5): 432-433.

Rubinstein, S. (2000). The Impact of Co-Management on Quality Performance: the case of the Saturn Corporation. *Industrial and Labor Relations Review* 53(2): 197-218.

Seabrooke, L., and Sending, O. (2022). "Consultancies in public administration." *Public Administration* 100: 457-471.

Tsymbaliuk, S., and Shkoda, T. (2022). "Labour remuneration in the healthcare sector of Ukraine in terms of decent work concept." *Employee Relations* 44(1): 191-209.

Van den Heede, K., Balcaen, K., Bouckaert, N., Bruyneel, L., Cornelis, J., Sermeus, W., and Van de Voorde, C. (2023). Improving hospital nurse staffing during the pandemic: Implementation of the 2019 Fund for Health Care Staff in Belgium. *Health Policy* 128: 69-74.

Van Gyes, G., Terlinden, L., and Vanderkerckhove, S. (2017). "Belgian social dialogue since the crisis : The ups and downs of an organized system of industrial relations". *Talking Through the Crisis*: International Labour Office (ILO), 59-105.

Waisberg, I., and Nelson, A. (2018). "When the general meets the particular: The practices and challenges of interorganizational knowledge reuse." *Organization Science* 29(3): 432-448.

Weibel, A., Rost, K., and Osterloh, M. (2010). "Pay for performance in the public sector – Benefits and (Hidden) Costs." *Journal of Public Administration Research and Theory* 20(2): 387-412.

Weick, K., Sutcliffe, K., Obstfeld, D. (2005). "Organizing and the Process of Sensemaking." *Organization Science* 16(4): 409-421.

Wye, L., Brangan, E., Cameron, A., Gabbay, J., Klein, J., Anthwal, R., and Pope, C. (2015). "What do external consultants from private and not-for-profit companies offer healthcare commissioners? A qualitative study of knowledge exchange." *BMJ Open* 5(2): 1-9.

Ylönen, M., and Kuusela, H. (2019). "Consultocracy and its discontents: A critical typology and a call for a research agenda." *Governance* 32: 241-258.