

ORIGINAL ARTICLE

Coproducing care and support delivery in healthcare triads: Dutch case managers for people with dementia at home using strategies to handle conflict in the healthcare triad

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Abstract

Dutch policy stipulates that people with dementia should remain at home for as long as possible. If they need care, they must preferably appeal to family, friends and neighbours. Professional help and nursing homes are deemed last resorts. Therefore, case managers must coproduce their public services increasingly in healthcare triads with both people with dementia (PWDs) and their informal caregivers. Case managers are professionals who provide and coordinate care and support for PWDs and their informal caregivers during the entire trajectory from (suspected) diagnosis until institutionalisation. The literature on coproduction has focused on the bilateral interactions between service providers and users rather than the multilateral collaborative relationships through which many public services are currently delivered, as is the case in dementia care. Little is known about how frontline workers, case managers in this study, handle conflicts in these healthcare triads. Our study addresses this gap in the coproduction literature and explores the action strategies case managers use to handle conflicts. We interviewed 19 Dutch case managers and observed 10 of their home visits between January and May 2017. We focused on the end stage of dementia at home, just before admission to a nursing home, as we assumed that most conflicts occur in that phase. The findings reveal that the case managers use a variety of action strategies to resolve and intervene in these conflicts. Their initial strategies are in line with the ideals underlying coproduction; however, their successive strategies abandon those ideals and are more focused on production or result from their own lack of power. We also found that current reforms create new dilemmas for case managers. Future research should focus on the boundaries of coproducing public services in triadic relationships and the effects of current welfare reforms aimed at coproducing public services in healthcare triads.

KEYWORDS

action strategies, case managers, conflict, coproduction, healthcare triads, welfare state reform

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1 | INTRODUCTION

Like many Western European welfare states, the Dutch welfare state has been remodelled. In 2015, a policy change was enacted as a transition from a welfare state (citizens as clients) to a participation society (citizens as coproducers) with the aim of rekindling solidarity, social cohesion and tailor-made nearby care and decreasing public expenses. Similar policy changes have been implemented or debated in other countries (Bakx et al., 2015; Pavolini & Ranci, 2008; Ranci & Pavolini, 2013). In the UK, for instance, these policy changes were dubbed 'the big society' (Blond, 2010). In Belgium, policy makers discuss responsabilisation (Verhaeghe & Quievy, 2016); and in Italy, there is a call for 'moral neoliberal citizenship'. Each of these refers to a society in which citizens are willing to take more responsibility for themselves and each other, and public service delivery is coproduced.

In the context of dementia care, Dutch policy stipulates that people with dementia (PWDs) remain at home for as long as possible. If they need care, they must preferably appeal to family, friends and neighbours. Professional help and nursing homes are deemed last resort provisions. Admission requirements for nursing home care have been tightened, and nursing homes are accessible only for those who need 24-hr care and/or permanent supervision. The independent 'Center of Care Assessment' (Centrum Indicatiestelling Zorg, CIZ) uses objective criteria to determine whether a PWD is eligible for nursing home care (Bakx et al., 2015; CIZ, 2017; Maarsen & Jeurissen, 2016; Pavolini & Ranci, 2013). The increased focus on community-based care is presented as a response to the changing preferences among citizens and is assumed to be beneficial for both informal caregivers and PWDs. Replacing paid professionals with unpaid family members is also seen as an effective way to slow down the increasing healthcare expenses coinciding with the ageing population (Maarse & Jeurissen, 2016; Ossenwaarde, 2007; Ranci & Pavolini, 2013).

Case managers (CMs) play a pivotal role in helping PWDs and their informal caretakers remain at home for as long as possible. As in other countries (e.g. France, Hong Kong, India, the UK and the US), case management is a strongly promoted intervention in the Netherlands, and dementia CMs are becoming a well-established part of the care for PWDs (Lange et al., 2018). The role CMs fulfil varies widely between countries along with variation in the health structures in which they operate (Reilly et al., 2015:7; Somme et al., 2021:426). Some countries adopt a more brokerage model in which CMs assess the needs of clients and connect these to appropriate health and social services. Others adopt an intensive case management model in which CMs provide care to clients themselves (Iliffe et al., 2019:953). Dutch case managers are assigned as permanently involved professionals (i.e. nurses or social workers with additional training on case management) to provide and coordinate care and support in treatment, health and social care. Their efforts are aimed at community-dwelling people with dementia and their families during the entire trajectory from (suspected) diagnosis until institutionalisation or death (Huijsman et al., 2020).

What is known about topic

- Case managers must coproduce their services with people with dementia and informal caregivers at their homes due to current Dutch welfare state reforms.
- The coproduction literature has overlooked the multilateral relationships through which public services are now delivered and how frontline workers handle conflict in these relationships.

What this paper adds

- Our paper addresses a gap in the coproduction literature.
- Case managers have developed a variety of action strategies that run parallel to the complexity to resolve and intervene in conflicts. Their initial strategies are in line with the ideals of coproduction; however, their successive strategies are more focused on production or their own powerlessness.
- Current reforms create new dilemmas for case managers.

In dementia care, coproduction is stimulated in a context in which formal care is increasingly replaced by informal care and PWDs are expected to stay longer at home, which will increase their dependency on others as their mental abilities deteriorate. As a result, CMs must increasingly coproduce their services in 'healthcare triads' with both PWDs and their informal caregivers at their homes. Healthcare triads in this study comprise the PWD, the informal caregivers and a case manager who together assess patients' and informal caregivers' needs and connect these needs to appropriate health and social services or provide care themselves (if able to do so).

Coproduction can be defined as 'regular, long-term relationships between professionalised service providers and service users or other members of the community, where all parties make substantial resource contributions' (Bovaird, 2007:847). Coproduction can take many forms, including codesign, coevaluation and coimplementation of services (Filipe et al., 2017:2). During the implementation of services, client involvement is an essential and inalienable component of (public) services and a key determinant of both their quality and performance (Alford, 2009; Brandsen et al., 2018; Bovaird et al., 2015; Osbrone & Strokosch, 2013; Osborne et al., 2018:18; Voorberg et al., 2015:72). Coproduction in healthcare is described as a way of working together to improve health and to create user-led, people-centred healthcare services (Filipe et al., 2017:2). Traditionally, coproduction is studied by focusing on the bilateral interaction between service providers and service users rather than examining the multilateral collaborative relationships through which many public services are now delivered, such as in dementia care (Baker & Irving, 2016:380). Little is known about how public service providers handle these multilateral relationships and, in our case, coproduce their services in healthcare triads. These multilateral relations are especially complicated as CMs need to handle conflicting

needs, demands and expectations. To the best of our knowledge, no studies have been performed on how service providers handle conflict in multilateral collaborative relationships during the implementation of public services. Although there is much literature on the action strategies (coping mechanisms) used by frontline workers in the street-level bureaucracy literature, this literature primarily focuses on conflicting demands between policy and practice (see, e.g. Brodtkin, 2003; Evans, 2010; Hill & Hupe, 2002; Lipsky, 1980; Maynard-Moody et al., 2003; Tummers, 2014). Such conflicting demands are relevant contextual features for this study (and will be discussed) but are different from the conflicts within the healthcare triad. In this paper, we will address this gap in the literature and explore how CMs handle conflict in these triads. The central research question is the following: what action strategies do CMs in dementia care use to handle conflict in the healthcare triad? Understanding how CMs handle conflict is relevant to understanding disparities in the efficacy of their services and the success of policy reforms.

In this study, we focus on the end phase of dementia at home, immediately before admission to nursing home care, because we assume that in this phase, conflicts often occur and have the most invasive impact on PWDs, family members and their relationships. To address the progressive nature of dementia, PWDs must navigate unknown terrain, (re)negotiate new balances in an ever-changing dynamic, and make decisions ranging from the application of home care to admission to nursing home care (Etters et al., 2008; Schoenmakers et al., 2010; Schulz et al., 2004; Pashby et al., 2009;). This process is fraught with complex family, ethical and legal dilemmas (Barber & Lyness, 2001; Miller et al., 2016:1,142; Smebye et al., 2015). Conflict in this process is a common phenomenon (Gwyther, 1995; Peisah et al., 2006). We assume that especially in the end phase of dementia at home, this complexity reaches its climax, with fertile ground for conflicts as a result.

2 | MATERIALS AND METHODS

In this study, a qualitative research design was chosen to explore what action strategies CMs use to handle conflicts in the healthcare triad. This seems to be an understudied phenomenon in the literature. Qualitative methods are appropriate for explorations to develop or refine theories and valuable to provide rich descriptions of complex phenomena in a real-life context (Sofaer, 1999).

The qualitative data gathering methods in this study are primarily semistructured face-to-face interviews with 19 CMs (see Table 1) and observational research. Interviewees were selected via convenience sampling using the first author's network, which implies no generalisability on statistical grounds and generalisability only on patterns of professional work itself is possible (Bornstein et al., 2013; Etikan, 2016). CMs were selected in three different regions of the Netherlands (Breda, Rotterdam and 's-Hertogenbosch). Data were gathered between January 2017 and May 2017. Respondents were asked to recall two cases from their caseload: one in which it was relatively easy to lend support and one in which that was difficult.

They were then asked to reflect more in general on dilemmas. What would they do if (1) the PWD's needs or perspective conflict with those of the primary caregivers, (2) involved caregivers have conflicting needs or perspectives and (3) the PWD's or caregiver's needs and perspectives conflict with what you think would be best in the situation?

Respondents were also asked to provide the factors that determine whether a PWD is admitted to a nursing home. During the interviews, CMs were presented action strategies shared by previous interviewees and were asked if they recognised, used, adapted or extended these action strategies. The sample size was not predetermined, and additional participants were recruited until saturation was reached, meaning that no new action strategies were mentioned (Guest et al., 2006; Morse, 1994). The interviews lasted approximately 50 min and were recorded and transcribed verbatim.

In addition to the interviews, nonparticipant observations of home visits by CMs were conducted to substantiate the findings, and information was recorded as it naturally occurred (Creswell, 2009:179; Sandelowski, 2000). All CMs were asked if the first author could attend their house calls of clients close to admission to nursing home care. This resulted in 10 home visits by four CMs (see Table 2). This study was presented to an ethics board that decided that under Dutch law, no formal ethical approval was required (MEC-2017-348).

Home visits were only observed after the CMs acquired explicit written permission from all parties involved. Participants were assured complete anonymity. Moreover, the participants could withdraw from the study at any moment for any reason. During and after the house calls, field notes were made. The recorded observational data consisted of descriptive notes (portraits of the participants, reconstructions of dialogues, descriptions of the physical settings and accounts of events) and reflective notes (the first author's personal thoughts, such as feelings, impressions and hunches) (Creswell, 2007).

The interviews and observational data were pooled and analysed together by the first and third authors using the steps outlined by Braun & Clark (2006). First, the authors familiarised themselves with the data. Second, initial codes were generated by the first and third authors and discussed. Third, both authors further analysed the data and developed themes using NVivo. Fourth, the themes were reviewed, compared and discussed; and intercoder agreement was reached. Fifth, the names and definitions of the themes were finalised with all authors. Sixth, the analyses were incorporated in the manuscript (Kiger & Varpio, 2020).

3 | RESULTS

3.1 | Conflict in the healthcare triad

Our findings confirm that CMs must handle conflict in the healthcare triad on a regular basis. We found several types of conflict: (1) PWD—informal caregiver(s), (2) informal caregiver(s)—informal caregiver(s),

TABLE 1 CMs' characteristics

| Respondent | Vocational training | Region | Hours worked |
|------------|---|-----------|--------------|
| CM 1 | Nursing plus advanced training case management dementia | Breda | 24 |
| CM 2 | Nursing plus advanced training case management dementia | Rotterdam | 28 |
| CM 3 | Social work, plus advanced training case management dementia, Health sciences (university degree) | Rotterdam | 24 |
| CM 4 | Nursing (lower level training), social work, plus advanced training case management dementia | Den Bosch | 28 |
| CM 5 | Social work, plus advanced training case management dementia | Rotterdam | 34 |
| CM 6 | Social work, plus advanced training case management dementia | Rotterdam | 33 |
| CM 7 | Nursing plus advanced training case management dementia | Breda | 17 |
| CM 8 | Nursing plus advanced training case management dementia | Rotterdam | 32 |
| CM 9 | Nursing and social work (both lower level training) | Rotterdam | 32 |
| CM 10 | Nursing and social work (both lower level training) | Rotterdam | 34 |
| CM 11 | Nursing plus advanced training case management dementia | Den Bosch | 28 |
| CM 12 | Nursing lower level training, social work, plus advanced training case management dementia | Den Bosch | 30 |
| CM 13 | Nursing lower level training | Den Bosch | 32 |
| CM 14 | Nursing plus advanced training case management dementia | Breda | 24 |
| CM 15 | Nursing plus advanced training case management dementia | Breda | 24 |
| CM 16 | Nursing | Breda | 8 |
| CM 17 | Nursing | Den Bosch | 28 |
| CM 18 | Nursing, plus advanced training case management dementia, Health sciences (University degree) | Den Bosch | 24 |
| CM19 | Nursing, plus advanced training case management dementia | Breda | 24 |

(3) CM–PWD, (4) CM–informal caregiver(s) and (5) CM–client system (PWD and caregiver(s)). We use a central case to outline some of these conflicts and to show that different conflict types (CTs) occur at the same time (Figure 1).

CM8 is involved with a couple. The woman has dementia. The couple has had a traditional division of roles throughout their marriage. The woman takes care of her husband. Because of her dementia, the woman can no longer (properly) fulfil this role. The man does not understand this and continues to expect his wife to care for him. For example, he takes

her to the supermarket, stays in his car and expects his wife to do the shopping. The woman becomes insecure due to her inability to perform her caring tasks and constantly asks her husband how to do things. The mistakes his wife makes, her forgetfulness and her behaviour irritate the man immensely [CT1].

CM8 sees worrying signs in the couple's son. He says his father beats his mother. CM8 knows father and son have a very disturbed relationship and she is not sure that the son is telling the truth [CT2]. The son wants his mother to be admitted. The man wants

TABLE 2 Home visits with clients

| Client | Gender | Diagnosis | Age | Living situation | Primary carer(s) |
|--------|--------|----------------------|-----|-------------------------------|------------------|
| 1 | Male | Alzheimer | 96 | Together with wife and 2 sons | Wife and sons |
| 2 | Female | Unknown | 85 | Alone | Children |
| 3 | Female | Alzheimer | 84 | Alone | Children |
| 4 | Male | Alzheimer | 87 | Alone | Niece |
| 5 | Female | Alzheimer | 85 | Alone | Daughter |
| 6 | Male | Alzheimer | 88 | Together with wife | Wife |
| 7 | Male | Dementia and aphasia | 60 | Alone | Sisters |
| 8 | Female | Alzheimer | 70 | Together with husband | Husband and son |
| 9 | Male | Alzheimer | 95 | Alone | Children |
| 10 | Female | Alzheimer | 76 | Together with husband | Husband |

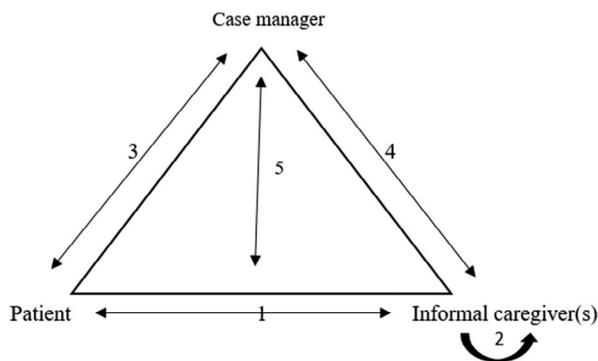


FIGURE 1 Healthcare triad

will never go against his will. She also knows people with dementia cannot oversee changes and therefore avoid them [potentially CT5].

CMs outline that prior to admission to nursing home care, they regularly face conflict. For example there was a lack of consensus about issues of impairment (e.g. the seriousness of the PWD's disease), the required quantity and quality of support for the PWD and their informal caregivers, and the process of institutionalisation. These conflicts are often a melting pot of issues caused by dementia, for example the PWD's cognitive deterioration, the informal caregiver's overburdening, the PWD's and informal caregiver's lack of insight into the disease and difficulties in accepting the disease.

TABLE 3 Action strategies to deal with conflict in the healthcare triad

| Focus | Strategies | Explanation |
|------------------------|-------------------------|---|
| Focus on co-production | Mediate | Intervene in order to bring about agreement or reconciliation in the client system through compromise, removal of misunderstanding etc. |
| | Educate | Change cognitions to align perspectives in the triad. |
| | Seduce | Using tricks to persuade or induce someone to go along with interventions wished for by others in the triad. |
| | Pressure | Sketching doom scenarios to align perspectives. |
| Focus on production | Inaction | Let time go by and wait until the fuzziness disappears and it is clear how to intervene best. |
| | Choosing sides | To ally or agree with one person or group of persons in the client system. |
| | Overrule | To exercise control or influence over the client system, for example by forming coalitions with other professionals. |
| Act in desperation | Deflect | Passing on responsibility to deal with the conflict to others. |
| | Letting things escalate | Inaction aimed to reinforce rather than reduce the upcoming or existing crisis in the healthcare triad. |

his wife to stay at home [CT2]. The woman says she does not want to be admitted and wants to stay with her husband at home [CT1]. However, CM8 knows the woman is very dependent on her husband and

However, difficulties in letting go of each other, competing needs among PWDs and informal caregivers, and conflict between the professional perspective and lay perspective also exist. These issues

are embedded in (sometimes complex) informal relationships and dynamics and full of ethical dilemmas, as in the central case.

The man does not like CM8's visits and lets her in occasionally [CT4]. He sometimes tells CM8 about incidents between him and his wife. For example, he tells her he slapped his wife when she did not want to give him the TV remote control. He also tells her he gets angry when the wife burns their cooking and "the food is again terrible and not to eat" [CT1]. CM8 knows the man has always been a hot-tempered man.

CM8 noticed that during the two weeks the woman was in the hospital for a medical problem, the man and his wife did not seem to miss each other. She wonders how this relates to their wish to remain living at home together. CM8 wonders what to do [potentially CT5].

3.2 | Handling conflict in the healthcare triad

Table 3 gives an overview of how CMs handle these conflicts. The table shows their focus and how this focus is turned into action strategies. Both focus and action strategies can seemingly be placed on a continuum. On the one side is the scenario in which CMs succeed in getting everyone (again) on the same page and agree upon interventions and outcomes (both 'co' and 'production'). On the other end is the scenario in which CMs feel powerless, fail to get everyone (or anyone) on the same page and act in desperation.

3.2.1 | Focus on coproduction

When confronted with conflict, all CMs first try to overcome this conflict together with PWDs and informal caregivers, keep them both involved and (re)reach a consensus on interventions and outcomes. This is both a pragmatic and a principal approach. It is pragmatic because CMs need all parties' involvement to make sense of the situation and to intervene effectively. CMs tell that making judgements in conflicting cases is difficult. Like in the central case, it is often hard to map out the needs of all involved and how to best act in their interest. Most conflicts are fraught with ethical dilemmas. Should CM8 go along with the man's and wife's wishes to remain living at home, or should she follow her instincts and the son's concerns and protect the couple against themselves and each other? Therefore, when PWDs and caregivers disagree on interventions or outcomes, they often also refuse to cooperate with suggested interventions, leaving CMs with little room to intervene and 'help' them.

The brother says he [PWD] should be admitted to a nursing home. In terms of care and from my professional point of view, I agree. He [the PWD] would then

get the 24-hour care he needs. However, the man refuses to leave his home at all [CT1 and CT3]. Two weeks ago, it almost led to a crisis. His GP called and said the man should be admitted. (...) He also spoke with the man's brother. If he wants the man to be admitted, it must happen with the help of the courts. Then, it is forced. Do you really want that? So many people don't want that (CM1).

Their focus on 'co'production also originates from principles. CMs recognise that both PWDs and their informal caregivers are affected by dementia; therefore, they strongly believe that both have the right to codecide on what should be done. However, they also note that this principle is hard to put into practice when CMs feel PWDs and their caregivers are no longer able to make the right decision for themselves or each other, as in the central case.

Many CMs describe that their focus on coproducing their services abruptly stops when PWDs must be admitted to a nursing home. The CIZ only considers PWD criteria to decide on eligibility for nursing home care and does not consider any informal caregivers' criteria. This is problematic to many CMs as the caregivers' level of overburdening most often makes admission to nursing home care inevitable. Therefore, admission to nursing home care in the Netherlands also means that PWDs get separated from their caregivers who are not allowed to move with them.

To get everyone on the same page, CMs use several strategies. They act as mediators to help parties overcome disputes and work towards a common definition of the problem and solution (*mediation*). Furthermore, they invest time in educating PWDs and their informal caregivers about dementia (*education*). They offer informal caregivers information about (the effects of) dementia on PWDs to better understand the PWD's needs and behaviour.

During a meeting with CM17, a woman with dementia, her husband, and her son extending day care was discussed. The woman hates day-care and talks negatively about it (limited range of activities and must spend her day with "drooling idiots telling the same stories over and over again"). CM17 expounds the day-care professionals' depiction, which refutes the woman's story (mediation). The woman does not react directly, looks at her husband and seems to try to find support for her story. The man does not react. The woman sticks to her version of the story. After some time, the woman leaves the meeting (picked up for day-care). The man tells CM17 that he finds caring for his wife burdensome and would like to have more time for himself. He finds CM17's information very helpful. He was already questioning his wife's depiction of day-care but did not want to see his wife as a liar. He is also afraid to extend day-care "[name wife] told me if I will try to extend day-care, she will no longer go at all and I am afraid to lose 'my day' [day woman goes to

day-care]". He also does not want "to make decisions for his wife but with his wife". The son shares that his father has always struggled to set boundaries for his mother. CM17 reacts with compassion, explains how the woman's dementia affects her and her perception of reality and starts to provide directions on how the man could (or should) deal with his wife (education and mediation). The way the man used to make decisions with his wife might no longer be feasible. They explore new ways of shared decision-making (mediation). He also emphasises that the man must care for himself as well (education).

Another strategy that is used is seduction. Seduction often takes the form of reframing a situation or making up a story to make choices more attractive.

CM5 set out a case of a very proud, vain, status-oriented woman who absolutely did not want to be admitted to a nursing home. She said she persuaded the woman to accept admission to nursing home care by telling her a brand-new, luxurious nursing home had been built and a special place was kept for her [dealing with CT1 and CT3].

Reframing can take a more force-full form (*pressure*). CMs sometimes try to scare PWDs and caregivers by sketching doom scenarios. For example when PWDs and caregivers are reluctant to organise nursing home care, CMs tell them that if nothing is organised when the PWD needs to be admitted, the PWD can end up in a nursing home at the other end of the Netherlands.

The overarching aim of these strategies is to help parties redefine the way they think about the issue of dispute and work towards a common definition and solution to the problem.

3.2.2 | Focus on production

When CMs feel they are unable to get everyone on the same page, they appear to switch over to 'production'. The focus changes from reaching a consensus to obtaining a result that in their view best suits the client system's interest.

As mentioned earlier, in conflicting situations, it is often unclear how to best intervene and what outcome is the best. CMs therefore frequently explicitly choose to do nothing and wait until the fuzziness of a situation has disappeared and a solution for a conflict presents itself (*inaction*).

The mrs is very proud she is still able to do a lot herself, although she is quite far in her dementia. Her sense of time is limited; she sometimes walks outside at night. Her hygiene is very bad, and she refuses care [CT1 and CT3]. The sons would like to see her

admitted. The mrs herself does not [CT1]. In addition, I am a bit in between because you take away her autonomy and her freedom. On the other hand, her hygiene is very bad. It is necessary. Her sons are right about that (CM5).

CMs also gave different examples in which they chose sides between different caregivers or PWD and caregivers (*choosing sides*). They often take the side of whom they share similar values, interests and goals, which, in practice, most often is the informal caregivers.

You sometimes have admissions where you think if the partner wasn't so overburdened or the children, the patient could stay at home for another six months. Admission to nursing home care, then, is more for the partner than for the patient [CT1]. But who am I? 24 hours, 7 days a week, is a different story (CM17).

If the aforementioned strategies do not work, CMs may also 'overrule' by taking over the reins and decide what to do. CM5 described a couple with mild mental disabilities where the situation got out of hand due to major conflicts, and then she decided to act against their wishes. She said the following: 'I came on a Friday. There was such major conflict. I thought I cannot leave these people alone like this [the man and woman wanted to keep living at home]. The woman must be admitted immediately via a crisis admission. I did everything myself. I arranged a place and put them in a taxi. I thought this situation must be ended now [dealing with CT5]'

3.2.3 | Act in desperation

In some cases, CMs note fundamental issues are at stake, such as the PWD's and informal caregivers' well-being, health or safety; and feel they must intervene to break through and de-escalate the situation, but at the same time know there is little they can do about it. Examples include PWDs or caregivers resisting (any) interventions, having different perspectives on situations, or having already tried every strategy. In these situations, CMs feel powerless or ineffectual and then seem to abandon their focus on coproduction and production and switch over to a mode to handle their (feelings of) ineffectuality. They build an argument regarding why they are not responsible for the situation (*deflect*). They push back responsibility to the client system since 'it is their own process' (CM3), 'who am I to have an opinion about this' (CM16) and 'I cannot intervene as long as they refuse to cooperate' (CM12). They may pass on responsibility to other professionals, such as the general practitioner, for example by strictly sticking to their official responsibility or blaming others for not being able to intervene as they do not have the 'final call'. CMs also appear to pass on responsibility to existing laws, regulations and policies, for example by blaming others, such as the CIZ, for their inability or limited tools to 'solve the situation'. This strategy is the odd one out. It is not focused on doing it together (co) or reaching an

outcome (production), and it becomes a self-defence strategy. In a sense, CMs exclude themselves from the triad.

CMs also use more forceful ways to handle this deadlock. They build pressure and purposefully wait for a crisis to emerge, so PWDs and caregivers have little or no choice (*letting things escalate*). CMs most often coordinate this strategy with others involved, so no one involved intervenes to counter escalate.

We got nowhere with him. Therefore, I was a kind of curious. The gas was closed off, but he would put an iron pot in the microwave. When he felt cold last winter, he put an iron in his bed. He smokes a lot. He goes outside with his mobility scooter, but this is basically no longer safe. Then, I think that it would be good if he would take a fall and end up in a hospital. That would speed things up [dealing with CT1 and CT3] (CM15).

Waiting for a crisis to emerge also appears to be an effective method to skip formal procedures. For example to be eligible for nursing home care, PWDs, caregivers and the CIZ must go through several procedures. If they are not willing to do so, a crisis can bypass these procedures. All nursing homes must have several 'crisis beds' for PWDs who must be admitted immediately.

We made a pact: the GP, the family caregiver and her daughter. We let everything be, and we know that we are heading for a crisis of some sort. Maybe she will take a fall, which is a possible storyline, and she may take a fall in her own house. Then, she may be admitted [to a nursing home] via the hospital [dealing with CT1 and CT3] (CM19).

4 | DISCUSSION

This paper starts from the recognition that conflict among CMs, PWDs and informal caregivers complicates the coproduction of public services and the realisation of the ideals behind current welfare state reforms. These ideals seem to rest on the assumption that healthcare triads share or can easily come to share a common set of beliefs about valuable interventions and outcomes. Consequently, access criteria to services do not always recognise conflicting needs in the client system and may focus on PWDs' needs only, thus blocking important exits to eliminate dysfunctional coproductive partnerships and preventing the interests of the client system from being served best.

Our paper shows that the reforms focus on coproduction to create tailor-made nearby care, together with the increasing involvement of informal caregivers to enhance solidarity and social cohesion and decreasing public expenses, create new dilemmas for CMs. Values, expectations and needs can be unclear or even clash in healthcare triads, especially for CMs working with PWDs at home. These clients become increasingly dependent on informal caregivers and

are less able to formulate their own desires and needs. Additionally, because of this dependency, care can become very demanding for informal caregivers that their health and well-being may be seriously at risk. Therefore, coproduction in this triad is a complex matter and is riddled with ethical challenges related to whose interests should be served (when and how); the PWD or the informal care-giver. Moreover, policy and regulation do not seem to recognise the complexities. From a policy perspective, informal caregivers mostly play a facilitating role in optimising the self-reliance of clients with dementia. In particular, in regard to access to nursing home care, the needs of informal caregivers are not considered formally. Our study shows that from the perspective of CMs, informal caregivers that are actively involved in caring are as much seen as clients as the PWD. From the informal caregivers' perspective, admittance to a nursing home may be even more required because of their own needs than because of the needs of the PWD.

This study also shows that CMs have developed a variety of strategies to handle conflicts in the health triad. The strategies most often used seem to be largely in line with the ideal of coproduction (mediate, educate, seduce and pressure) and help parties redefine their way of thinking about the issue of dispute and work towards a common definition and solution to the problem. Other strategies show the limits of coproduction and the need to recognise that CMs sometimes must take matters in their own hands to serve the interests of the client system best (inaction, choosing sides and overruling) and deal with the ethical challenges involved. However, some strategies seem to be undesirable from multiple perspectives. When CMs act in desperation and deflect responsibility or even feel the need to 'let things escalate', better alternatives should be available. Especially in these circumstances, it would be helpful if policy and institutional rules would allow (next to the needs of clients) for the interests and needs of informal caregivers to play an explicit and formal role in decisions on access to institutional care.

These findings add to the debates in the coproduction literature. First, the findings add to the debate on the extent to which coproduction ideals apply to people with severe vulnerabilities such as people with dementia. Coproducing public services with PWDs and informal caregivers in healthcare triads is a next step towards services tailored to the individuals' needs and the preferences of PWDs and informal caregivers. All parties in the healthcare triad must engage in the negotiation of goals, interventions and the distribution of obligations through dialogue (Ewert & Evers, 2014; Monrad, 2020; Nabatchi et al., 2017) Our study shows the complexity of this process when PWDs lose their cognitive abilities and informal caregivers struggle with their surrogate role. Especially at the end phase of dementia at home, both PWDs and informal caregivers struggle and cannot live up to their expected role as 'expert-patient', leaving CMs behind to make sense of their situation and tailor services to their interests. CMs must make sense of who is entitled to articulate, interpret or fill in the needs of PWDs and informal caregivers. This challenging shared decision-making in a process fraught with ethical

dilemmas requires a range of skills for CMs. Examples include the ability to gain insight into PWDs' and informal caregivers' positions and interests; to influence these positions and interests and coinciding behaviour and to reflect on their own positions, interests and behaviour.

Our study also adds to the notions made in the coproduction literature that this negotiation area is never an equal playing field. This is most often portrayed as negotiation between the powerful and powerless. Public service providers are portrayed as powerful as they function as allocators of public services, and public service users are portrayed as powerless as access to public services will only be provided if public service users fulfil the conditions and requirements set by the public service provider (Born & Jensen, 2010). Service users can influence the service allocation using 'voice', but their only real power is 'exit'. Our study shows that this counts for all participants in the triad. CMs feel they must 'exit' the triad in the end, most often together with informal caregivers, when they feel ineffectual.

The strategies outlined in this study have addressed a gap in the current coproduction literature and shed the first light on how professionals handle conflict in multilateral collaborative relationships (Baker & Irving, 2016:380). However, this study has some limitations. The analyses were based on interviews in three regions in the Netherlands. This specific institutional and policy context could affect the generalisability of the results. Moreover, by gathering and analysing data following scientific standards, we reached saturation, and this allowed us to fully explore CMs' general focus in action strategies (coproduction, production and their own ineffectuality). However, further research may provide a more comprehensive overview of all possible action strategies used by CMs and potentially other professionals. Nevertheless, our study has taken an important first step in exploring understudied parts of coproduction in healthcare triads. We suggest that further research should be undertaken on how professionals handle conflict within triadic relationships with PWDs and informal caregivers. Our study has used the literature on coproduction, but potential interesting links could be made with the literature on street-level bureaucracy. Therefore, we have focused on the healthcare triad, but it might also be interesting to study how a group of coproducing professionals handle conflict with the client and within the entire care provider system. It would also be interesting to compare different types of professionals in different client contexts, such as those working in youth care and handling conflict while coproducing their services with parents and children.

DATA AVAILABILITY STATEMENT

The data are not available on request due to privacy and ethical restrictions.

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