Good health for all: an ethnographic study of frontline professionals in general and mental healthcare and social welfare

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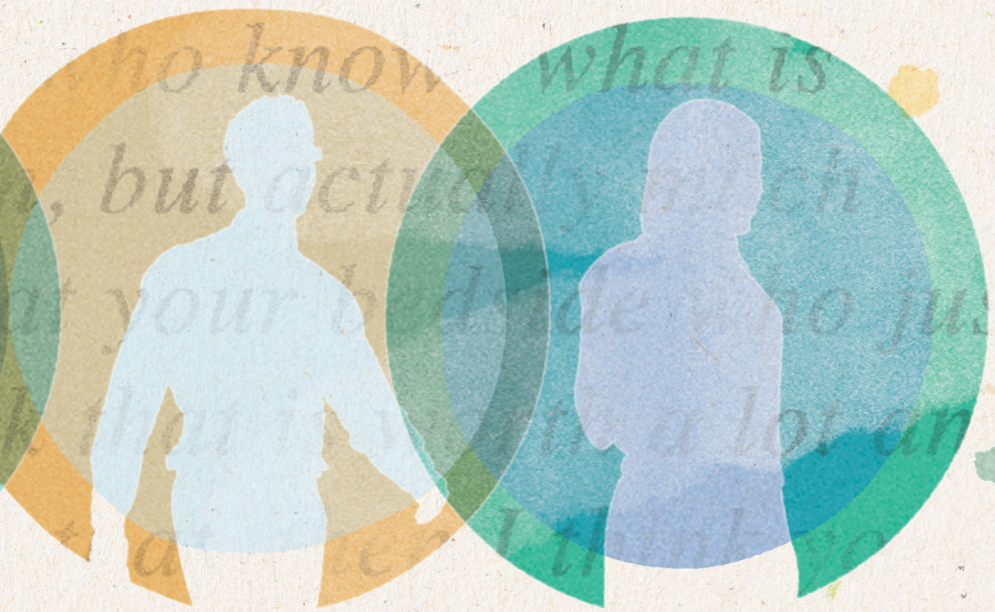
Chapter 6

Conclusion and discussion



6.1 Introduction

The conceptions, roles and reasonings explored in this dissertation together shape how frontline professionals relate to other professionals and to their clients with combined psychosocial problems. The introduction of this thesis indicated that in The Hague, the Netherlands, many people live with combined psychosocial problems. Furthermore, there are inequalities between people living with and without problems such as medical issues, poverty and depression, and, such problems are mostly evident among people with a lower socioeconomic status (SES) (SCP, 2023). Furthermore, these combined problems among vulnerable clients create a need for collaboration between frontline professionals across professional and organizational borders, whereas many incentives go against such collaboration.

My main motivation was to increase our understanding of how frontline professionals relate to clients with combined problems and other professionals, because it can contribute to awareness in or around the aspects of persistent combined health problems and health inequalities. Efforts to address such combined problems in public health are mostly focused on studying effects of social determinants on health (a.o. Kikuchi et al., 2023; Nutbeam & Lloyd, 2021), while the role of frontline professionals in caring for clients is often not taken into account. Therefore, throughout this dissertation, I focused on studying frontline professionals in care and social welfare, which includes questions that are relevant for both public health and public administration. Combining insights from public health and public administration is relevant to understand the organizational- and professional aspects of interprofessional collaboration and street-level professionals. Moreover, drawing on an anthropological lens and emic perspective allowed for studying health conceptions, roles in collaboration and reasonings from the professionals' perspective. This approach was essential in uncovering implicit norms, values, and interpretations that guide professionals' work in care, including their interaction with each other and with clients. Frontline professionals' work, in turn, is relevant to promoting equitable health outcomes for clients with combined psychosocial problems. In this chapter, I answer the following overarching research question:

RQ: *How do frontline professionals relate to other frontline professionals and clients in caring for clients with combined psychosocial problems*?

By answering this question, the dissertation has aimed to understand the frontline professional's perspective in caring for people with combined problems. To answer the research question, this dissertation focused on frontline professionals working in organizations in general healthcare, mental healthcare and social welfare who work across professions and organizations in caring for clients with combined problems (a.o. Haaglanden ,2021; Actieprogramma Preventie, 2020; RVS 2020).

In this concluding chapter, I discuss the main findings of the empirical studies in relation to each other and to the literature to date. Furthermore, I answer the overarching research question and how the anthropological lens contributes to this question relevant for public administration and public health. A summary of the empirical findings of each empirical chapter will be presented in section 6.2. After that, in section 6.3, an answer to the general research question will be provided. In section 6.4 the theoretical and methodological implications will be discussed. In section 6.5, the limitations and recommendations for future research will be outlined and lastly, in 6.6 the societal and practical relevance of the findings will be discussed.

6.2 Summary of empirical findings

This section presents the conclusions of each empirical chapter separately. Each chapter addressed a distinct sub-question using different methods, thereby exploring different aspects of the same phenomenon – how frontline professionals in care and social welfare relate to other professionals and clients in caring for clients with combined psychosocial problems.

Health conceptions

Chapter two conceptualized the health conceptions held by various frontline professionals in general healthcare, mental healthcare and social welfare by focusing on how frontline professionals view and approach health. This chapter answered the following research question: *How can the health conceptions of frontline professionals in general healthcare, mental healthcare and social welfare be conceptualized?* I used an inductive semi-structured interviewing approach, with various types of frontline professionals who all work with clients with psychosocial problems, and who collaborate across professional and organizational boundaries. In doing so, this chapter conceptualized professionals' health conceptions and it emphasized the importance of these conceptions in care.

This chapter has found that frontline professionals' health conceptions differ in three main dimensions: 1) health definitions, 2) alignment with clients and 3) contextualization of clients' health. Thereby, this study shows that professionals' health conceptions not only consist of what professionals think constitutes health, but also include beliefs about what clients are expected to do and how professionals should support them in becoming or staying healthy. Additionally, the findings showed that frontline professionals have beliefs about what should be expected of other stakeholders in the client's broader context when determining appropriate health goals and care approaches. These findings are a first building block in theorizing frontline professionals' health conceptions. This study furthermore explored the interplay between the different health conceptions and found that frontline professionals in care and social

welfare combine health conception dimensions — health definitions, alignment with clients and contextualization of problems — in various ways when caring for clients with combined problems.

This chapter focused on the health conceptions of frontline professionals, the next chapter went into how health conceptions translate into practice – by exploring how health promotion roles are shaped by professional identity.

Frontline professionals' identities and roles

Chapter three focused on health promotion roles and professional identity of frontline professionals in caring for clients with combined problems by answering the following research question: What kind of health promotion roles do frontline professionals in general healthcare, mental healthcare and social welfare have and how are these shaped by their professional identity? I used ethnographic fieldwork to explore professionals' health promotion roles.

The findings of the study indicated how various frontline professionals promote health according to two roles: reframing and customizing health promotion and that this is associated with how they identify as pragmatic or holistic professionals. Even though the reframing role often co-occurred with the pragmatic identity and the customized role with the holistic identity, this relationship is not deterministic. My findings also showed that professionals' health promotion roles and professional identities transcend professional backgrounds.

Moreover, resonating with broader developments in healthcare from reactive to proactive care (De Valck et al.. 2001; Waldman & Terzic, 2019), the types of health promotion roles in this study differed based on how professionals *manage complexity*, *client autonomy* and how they *involve the client context* in health promotion. Thereby, health promotion roles are more layered than the fixed attitudes and tasks described in the health promotion literature (Geense et al., 2013), because they are shaped by professional identities and they are situational. The latter means that frontline professionals do not follow a single, static role; instead, they shift between roles, based on how they manage complexity, client autonomy and how they involve the client context.

This third chapter focused on how various frontline professionals in care and social welfare identify professionally and which health promotion roles they use. Chapter four then explored how these professionals collaborate across professions and organizations to care for clients.

Interprofessional collaboration in fluid teams

Chapter three demonstrated how identity is a relational concept, formed through promoting health with clients and other professionals (a.o. Weick, 1995; Ashforth, 2000). Therefore, it was relevant for chapter four to explore how frontline professionals promote health together with other professionals.

Chapter four focused on how team fluidity plays a role in interprofessional collaboration in care for clients with combined problems by answering the following research question: *What does interprofessional collaboration look like in a fluid team context?* I used ethnographic fieldwork to explore interprofessional collaboration in a context of team fluidity among frontline professionals in general healthcare, mental healthcare and social welfare who work across professional and organizational boundaries in caring for clients. A key focus of this study was how team fluidity, and thereby, differences and changes in membership, plays a role in interprofessional collaboration (Kerrissey et al., 2020).

The chapter found how frontline professionals collaborate interprofessionally in a context of team fluidity and how they experience this based on seven behaviors in collaboration; *creating alternative communication lines*, *organizing valued spaces*, *bridging knowledge gaps*, *bridging communication gaps*, *bridging partner matching gaps*, *negotiating responsibility overlaps* and *negotiating safe work environments*. These behaviors were identified using sensitizing concepts, as identified by Schot and colleagues (2020), which guided the analysis. The empirical research showed that most interprofessional collaboration takes place informally through fragile interpersonal relationships in which membership change and difference create tensions. Primarily, membership change, but also differences between members, increase the difficulty regarding interprofessional collaboration in fluid team contexts.

SES reasonings

Chapter five highlighted how frontline professionals relate to other professionals, but the other chapters also showed that in collaboration in care and social welfare, it is relevant to know more about how frontline professionals relate to the clients they care for.

This fifth chapter found how frontline professionals interpret their clients by exploring how frontline professionals in general healthcare take socioeconomic status (SES) into account in their daily decision- making with clients by answering the following research question: *What reasoning do frontline professionals in healthcare use regarding cues associated with varying socioeconomic statuses?* By means of a qualitative interview study with general practitioners (GPs) who work directly with clients with combined problems and who encounter differences in SES on a daily basis, I explored the mechanisms through which frontline professionals in general healthcare interpret SES cues when developing treatment plans with clients. In doing so, this study deepened existing insight into the role of SES in decision-making (Harrits & Møller, 2014; Raaphorst & Groeneveld, 2018).

In this chapter, I identified and conceptualized three SES reasonings in shaping GPs' approach to patient care. First, *status preservation reasoning*, refers to how GPs determine the need for status preservation by combining SES indicators and interpreta-

tions of patients' stability. Second, *social distance reasoning*, refers to the way in which small social distance creates recognition and helps GPs prioritize when developing a treatment plan for clients. Third, *together reasoning* refers to how GPs use patients' busyness and educational level to determine the extent to which they develop treatment plans together. Conceptualizing these different SES reasonings shows how GPs interpret and use various SES cues in their decision-making when developing treatment plans with patients. SES cues thus shape their approach to patient care in ways that impact patient care by aiming for *status preservation*, *prioritization* and *togetherness*.

6.3 General conclusion

Within this section the overarching research question will be answered by combining the findings of the different empirical studies. The overarching research question is:

How do frontline professionals relate to other frontline professionals and clients in caring for clients with combined psychosocial problems?

This general research question will be answered in two parts. The first part of the research question is about how frontline professionals relate to other frontline professionals in caring for clients with combined psychosocial problems. The second part of the research question is about how frontline professionals relate to clients with combined psychosocial problems.

First, I outline my findings on how frontline professionals relate to other frontline professionals in caring for clients with combined psychosocial problems. How frontline professionals relate to other professionals is shaped not only by characteristics of the team context – change and difference – but also by professionals' health conceptions and their professional identities. I have explored how frontline professionals work in a context of team fluidity. This focus is particularly relevant because there is a high prevalence of frontline professionals working with clients facing combined psychosocial problems and they inherently work in settings characterized by high levels of membership change and difference. This dissertation shows that in contexts of team fluidity, frontline professionals engage in seven behaviors related to interprofessional collaboration, including *creating alternative communication lines*, *bridging knowledge and communication gaps*, and *negotiating responsibilities*. These behaviors, in which change is the main driver, show many similarities but also some differences compared to the behaviors in interprofessional collaboration of professionals working in fixed teams (Schot et al., 2020). The differences are especially relevant given the prevalence of combined issues nowadays. What is different in contexts of team fluidity is that pro-

fessionals by definition have to work in diverse and constantly changing contexts, as a result of which they work with many different people. The dissertation showed that this, for instance, means that professionals in fluid team contexts experience unclarity regarding who to approach and when. Moreover, it can be difficult to know who to trust and to know who is responsible. Therefore, interpersonal relationships are fragile, but crucial to foster interprofessional collaboration. Notwithstanding the advantage of the ability to complement each other with different professional backgrounds, high turnover and changing team composition increase the challenge of identifying and reaching appropriate partners for collaboration in fluid team contexts.

Apart from team fluidity, I have also explored how frontline professionals see health and how they want to work towards this in collaboration with other professionals. The way in which professionals give meaning to health and care is strongly connected to how they relate to other professionals. Health conceptions are not only individual understandings, but are shaped in interprofessional collaboration. In fluid team contexts, interprofessional collaboration is therefore not only about dividing tasks, but it is also a negotiation of professionals' values and perspectives inherent to health conceptions. Moreover, when frontline professionals care for vulnerable clients together, misunderstanding due to varying health conceptions may impact their abilities to do so. For instance, *health definitions* are relevant, because having different ideas of what health means may impede the ability to work towards (similar) goals together. To be able to understand each other and reach health goals together, professionals also emphasize the importance of assessing contextual sources. By *assessing the social context* of the client, frontline professionals emphasize that they do not only try to get more information from clients about their social context, but also from their larger environment including other professionals involved with the client. Frontline professionals may gather such information through clients or by contacting other professionals directly. Frontline professionals view relating to other professionals as important, especially because they also *assess other problems* than the ones presented by the client. However, professionals see obstacles in practice such as limited time and resources to engage in time consuming relational work with professionals beyond their own specialty.

Besides contextual sources, the dissertation has also found that professionals relate to other professionals in the way they interpret their own role in care and, thereby, how they identify as professionals. For instance, those who identify as *pragmatic professionals* value the ability to carry out their work in ways they prefer and they value setting boundaries around what they can and cannot do for a client. Pragmatic professionals often use the *reframing* health promotion role, primarily using collaboration by involving other professionals with different and complementing expertise to safeguard the boundaries of their own expertise.

I now turn to the findings regarding how frontline professionals relate to clients with combined psychosocial problems and their health and care. How frontline professionals relate to clients is shaped not only by health conceptions, but also by their health promotion roles and their SES reasonings towards clients. First, when professionals define clients' problems in terms of a *mental health definition*, they actively *seek alignment* with the client. This means that professionals aim to establish an equal relationship with clients, allowing space for clients' experiences and preferences regarding health. Second, frontline professionals who define health as *competence and behavior*, argue that clients should be responsible and able to communicate their own health needs and these frontline professionals see a less active role for themselves. Only when they think the situation might get dangerous, those professionals take over with what they think is important for the clients' health. Third, frontline professionals who assess the clients' *social context* in caring for the client emphasize that not all clients may be able to take care of themselves, even with the help of their social network. What is central in these findings, is that frontline professionals emphasize the importance of personal responsibility through competence and behavior, but they also acknowledge the possible impact of contextual aspects.

Exploring professionals' health promotion roles, the research has suggested that frontline professionals relate to clients through two health promotion roles. First, in *reframing* health promotion, professionals take the lead by reframing clients' needs into something they can address within their professional boundaries. Within this role, it remains unclear whether the professionals' practices really focus on the problem which is prioritized by de client. This finding is in line with how professionals with a *pragmatic* professional identity value setting boundaries around what they can and cannot do for the client. Second, frontline professionals *customize* health promotion and determine the direction of care in close relationship with the client. The client is given the lead and responsibility in expressing which problems should be dealt with. This finding aligned with how professionals with a *holistic* professional identity appreciate collaborative efforts with clients. These health promotion roles show, among others, how professionals deal with client autonomy.

Frontline professionals in general healthcare relate to clients' SES in terms of *status preservation, social distance and togetherness* in developing a treatment plan with clients with combined psychosocial problems. This finding suggested that how professionals relate to the SES of clients with combined problems and how they intend to develop treatment plans with them is shaped by social and relational positioning. First, general practitioners relate to clients by emphasizing the need to preserve clients' status by combining SES indicators and interpretations of clients' stability. Second, general practitioners relate to clients to whom they perceive as having a small social distance, using recognition as a reference point when developing the treatment plan.

Third, general practitioners base their approaches to creating a treatment plan together with clients on clients' busyness and educational level.

The findings of this dissertation thus pointed out how various frontline professionals relate to other professionals and to clients with combined psychosocial problems in relevant ways. They do so in the way they see health and healthcare, in the expectations they have of themselves, of other professionals and of clients, in the way they behave in relation to other professionals and to clients and in the way they reason about clients' SES.

6.4 Implications

This dissertation contributes to public health and public administration by using an anthropological lens and emic perspective to study how frontline professionals relate to other professionals and clients in caring for clients with combined psychosocial problems. Thereby, the dissertation has implications for the literature on health conceptions, health promotion, interprofessional collaboration in care, teamwork and street-level bureaucracy, particularly on the role of clients' SES in frontline decision making. The combination of the public health and public administration disciplines and the anthropological lens enabled me to primarily take a formative approach towards conceptualization and theory building.

This dissertation contributes to the literature on health conceptions, which is an important strand within public health, by addressing the currently limited conceptualizing of professionals' health conceptions, which tends to mainly focus on differences in health beliefs and it only includes medical professionals such as GPs and nurses (Armstrong & Swartzman 1999, Colombo, Bendelow, Fulford and Williams 2003, Huber et al. 2016, Levesque and Li 2014). By including frontline professionals from various backgrounds in the context of caring for clients with combined problems, this dissertation offers a broader understanding of health conceptions among frontline professionals in care and social welfare. More specifically, this dissertation contributes to the conceptualization that frontline professionals' health conceptions, besides multiple *health definitions*, also consist of beliefs about *how to pursue* health together with clients, their context and with other professionals. Thereby, this dissertation advances the literature on health conceptions by changing the focus from individual beliefs to a more relational conceptualization that is situated in everyday practices of professionals working in complex care contexts. This dissertation opens the door for other researchers who could test these health conception dimensions among other professionals, in various care contexts and in actual care practices. This would offer insight into whether these dimensions conceptualized in this dissertation can be observed across different care contexts and how they can inform everyday professional practice.

This dissertation, furthermore, contributes to the health promotion literature in public health by addressing the currently limited conceptualization of professionals' health promotion roles as attitudes towards specific tasks (Geense et al., 2013). What this dissertation contributes is a conceptualization of broader health promotion roles as *reframing health promotion* and *customized health promotion*. I find that these health promotion roles go into what professionals do, but also into *how* they do this and *what* they find important in doing so. This finding is relevant to health promotion, because a professionals' role is determined by how they see and value themselves. By exploring a possible causal link with professional identity, I also find how health promotion roles are shaped by professionals identify as *pragmatic and holistic* professionals. This finding adds a novel theoretical layer to the literature on health promotion: rather than seeing health promotion roles as profession-specific tasks, this dissertation finds that health promotion roles are relational and they emerge through how professionals identify as professionals, what they value and how they interpret their interaction styles. This finding paves the way for other researchers to further explore why and when frontline professionals prioritize certain health promotion roles in interaction with clients and other stakeholders. This dissertation shows how health promotion roles are associated with how professionals identify as professionals. This finding deepens our understanding of why frontline professionals promote health in particular ways. The findings also raise new questions: for instance, why do professional identities and roles transcend professions? A possible explanation is that, when professionals in such complex contexts constantly collaborate with various professionals and organizations, they develop similar values and ways of working through socialization. These findings also open new directions for theory building. The dissertation's indication of a causal link between health promotion roles and professional identity invites further empirical testing and conceptual development of health promotion roles. Researchers could, furthermore, study how professional identity and health promotion roles interact in other professional care contexts.

This dissertation similarly contributes to the literature on interprofessional collaboration in care and the literature on teamwork by exploring the link between interprofessional collaboration and a fluid team context, while focusing on complex care outside of hospitals. The literature on interprofessional collaboration, which is inherently interdisciplinary, does not explicitly include team fluidity in its analysis and mostly focuses on fixed teams (Schot et al., 2020). This dissertation finds that, in a fluid team context, frontline professionals collaborate according to seven behaviors and that *change* is the main driver differentiating these behaviors from those behaviors found in fixed teams (ibid.). For instance, constant change in team members prevent professionals from relying on established lines of communication, as is possible fixed teams (Gilardi et al., 2014; Nugus & Ferero, 2011). Instead, professionals establish *alternative communication lines* to create safe and *valued spaces* that are often based on fragile in-

terpersonal connections. Moreover, potentially relevant professionals may unknowingly be excluded from the team as they encounter challenges accommodating professionals from various organizations and with various professions in the team. These findings are also relevant to the literature on teamwork from management sciences, which typically focuses on data about hospitals and ad hoc disaster response teams (Kerrissey et al., 2020; Valentine & Edmondson, 2015; Rashid et al., 2013). Instead, this dissertation adds empirical evidence to the literature on teamwork from a frontline professionals' context with tasks that are less delineated than in hospitals (Kerrissey et al., 2020; Rashid et al., 2013). The frontline care context in this dissertation thus increases our theoretical understanding of the challenges and practices that are relevant for frontline professionals in fluid team contexts. These findings create room for researchers to further explore the possible causal link between interprofessional collaboration and team fluidity by testing my findings among other frontline professionals in fluid team contexts beyond this one. Literature on interprofessional collaboration in care has so far given little attention to the difference between fixed and fluid team contexts. This dissertation offers a starting point in studying the implications of these differences.

This dissertation also contributes to the street-level bureaucracy literature on the use of SES in decision-making (Harrits, 2019; Raaphorst et al., 2018; Harrits & Møller, Raaphorst & Groeneveld, 2018), which is prominent in public administration. While existing research often focuses on the outcomes of SES-based differentiation, this research contributes by shifting the focus to *how* professionals differentiate. It uncovers the mechanisms behind this differentiation and conceptualizes the reasonings — *status preservation*, *social distance*, and *together reasoning* — that guide general practitioners' differentiation when developing treatment plans with clients. These reasonings help explain the grounds upon which frontline professionals differentiate between clients in practice. For instance, *status preservation reasoning* around SES enhances our understanding of frontline professionals' reference points that may impact their deservingness and resource allocation judgments (Bothfeld & Rosenthal, 2018). Moreover, by shedding light on the subtle mechanisms through which frontline professionals interpret and use socioeconomic cues, this research contributes to the literature on equity in decision-making. Furthermore, *social distance reasoning* around SES contributes to the literature on social distance (Groeneveld & Meier, 2022; Harrits & Møller, 2024) by showing how recognition regarding social status of the client matters for professional decision-making. In social distance reasoning, recognition is thus a form of informal expertise which guides decision-making. This raises questions regarding the extent to which personal identification is a legitimate base for differentiation in care. These findings imply that decision-making is not only about how much discretionary room professionals have, but that frontline professionals' interpretations of clients' SES are also very relevant for how they work with clients and for what they see as good care for a specific client. These findings also have implications for other researchers on the use

of SES in decision-making, who could, for instance, use these reasonings to test them among other frontline professionals both in- and outside of care. They could explore whether similar reasonings emerge, especially in different professional- and organizational contexts, and how they shape actual decision making in frontline work. Moreover, I cannot elaborate on how these findings contribute to (in)equality, because it was not the focus of this research. However, I expect that these professionals' reasoning about clients' SES may have implications for how professionals address clients, how they lead to differential or tailored treatment in frontline work and, in turn, for the health outcomes of vulnerable clients.

The anthropological lens and ethnographic methods in this dissertation also have implications for the depth of the findings on how frontline professionals relate to other professionals and their clients in caring for clients with combined problems, which is relevant for both public administration and public health. Although ethnographic methods are increasingly used in public health and public administration (see o.a. Brodkin, 2011; Cecchini, 2021; La Grouw et al., 2024; Maynard-Moody & Musheno, 2022; Zacka, 2017; Long & Zacka, 2019), it is still a rather novel approach is both disciplines. This dissertation is based on ethnographic research, which followed the everyday work of frontline professionals in general healthcare, mental healthcare and social welfare who work with clients with combined psychosocial problems. These methods are grounded in medical anthropology, which has long explored how people themselves understand and navigate health and care practices (a.o. Singer, 1995). Ethnographic research is particularly well-suited for this study, as frontline work is essentially something that happens in everyday, on the ground interactions. Ethnography allows for the observations of how frontline professionals relate to both other professionals and clients in multiple and changing situations (Van Hulst et al., 2017). Moreover, in a broader sense, ethnography is essential for research in the care context, because it shows the micro-level interactions, values, experiences and perspectives in care practices, that are otherwise hard to grasp. This is especially relevant in care settings, where much of what shapes behavior, interaction and decision-making is embedded in tacit knowledge and everyday routines.

The anthropological lens allowed me to inductively study how frontline professionals relate to other professionals and clients from the professional's perspective. In the second chapter, the anthropological lens allowed me to study professionals' health conceptions. What we learn from this inductive, emic analysis — based on professionals' own perspectives is that frontline professionals' health conceptions do not only consist of various dimensions of health beliefs, but that they also consist of beliefs about how to pursue health together with clients and with other professionals. In the third chapter, the anthropological lens has furthermore helped me to understand professionals' actual health promotion roles and how they are shaped by professional identity (Barnhoorn et al., 2022; Geense et al., 2013). The emic perspective, in particular, allowed me to explore and conceptualize how frontline professionals themselves interpret and enact

health promotion and how this is embedded in everyday practice, which may differ from formal role descriptions or policy expectations. Similarly, in the fourth chapter, the emic perspective captures how interprofessional collaboration is shaped in practice through formal arrangements, but especially through informal routines, negotiations, and meaning making that might otherwise not be observed. As such, the emic perspective enabled me to create new insight into what interprofessional care actually looks like for frontline professionals in a fluid team context. In the fifth chapter, the emic perspective allowed me to grasp how frontline professionals interpret socioeconomic status in their decision-making process. By asking open-ended questions and engaging with their prior experiences in the workplace, I was able to uncover and conceptualize the mechanisms through which frontline professionals reason about their clients' status indicators in developing treatment plans with clients.

6.5 Limitations of the study and recommendations for future research

There are some recommendations that arise from constraints related to the research approach. When starting this research, the intention was to include both the professional's and the client's perspective. However, it soon became clear after starting the doctoral research that include the client's perspective was not feasible due to time constraints. I then decided to create a comprehensive picture from the professional's perspective. However, in line with this limitation, I recommend other researchers to shed light on the clients' perspective to find out how care and interprofessional collaboration are experienced by those who are on the receiving end of care. Studying the client perspective is important because clients, often vulnerable, may also shape care together with the professionals. Understanding how they do so from their perspective is relevant. Researchers could for instance ask how clients experience health promotion and how health promotion roles are linked to power-sharing with clients. In line with this, future research could study how SES reasonings of frontline professionals relate to the experienced burden of clients. Another avenue for future research linked to the clients' perspective is to explore other potential stakeholders within the context of clients. In doing so, researchers could explore how both frontline professionals and clients relate to other stakeholders in the broader client context, such as informal caregivers, family, and friends.

Another constraint in this research is that the anthropological fieldwork is highly impacted by unforeseen circumstances, such as the murder of a frontline professional in a potential observation location and the Covid-19 pandemic. These external circumstances prevented me from carrying out my fieldwork as planned, leading to long periods (weeks and months) of waiting and uncertainty regarding if, when and how I would be able to begin and continue data collection for this dissertation. One of the changes

that was made because of these circumstances is that I did observations at another GP practice and at another mental healthcare location than planned initially and interviews were done months later than planned beforehand. Another challenge during Covid-19 was that some parts of the fieldwork shifted to online settings behind computers, whereas interviews and fieldwork meetings would have mostly have taken place in person before the pandemic. Doing observations online, or even over a respondent's phone on speaker mode, meant that I could not always grasp everything that was being said. Is also made it more difficult to observe non-verbal and implicit communication between professionals, to notice contextual details, and to reflect on them with respondents immediately after. However, as part of the professionals' work also moved to digital means, doing ethnographic research online became less of a limitation, because professionals got used to it. Additionally, an advantage of partly doing fieldwork online was that it was feasible to attend a large number of meetings and hold a large number of interviews from the comfort of my home office. However, in the later stages of my fieldwork, both the respondents and I were fortunately able to be physically present more frequently, although some meetings remained online. Moreover, the physical location of the researcher in the field influences what can be observed and accessed (Trangbæk and Cecchini 2023). I realize that I could have included different respondents or observed different interprofessional meetings had this research not taken place during Covid-19, or if I had I met different respondents in the beginning of my fieldwork. These circumstances likely influenced the specific form and detail of the findings. However, since my selection of respondents was theory driven and I followed qualitative research standards (a.o. Nowell & Albrecht, 2019), I am confident that the mechanisms identified in this research would still have emerged, even under slightly different circumstances. Such challenges are inherent to anthropological research, because you have to be there to do the fieldwork. Future researchers could do comparable research into the changes in interprofessional care, with attention to the impact of technology during and after the pandemic.

While almost all the empirical data in this dissertation is on frontline professionals including those in general healthcare, but also in mental healthcare and social welfare, the fourth empirical study, discussed in chapter five, only includes general practitioners. I chose to only include general practitioners in this empirical study, because they are the first professionals to interpret clients and to make a decision regarding a treatment plan based on that interpretation. Their reasoning could thus be relevant for how SES plays a role in frontline decision-making in care. However, this type of research into SES reasonings could also be relevant among other frontline professionals, because various professional groups interpret clients with varying SES backgrounds in their decision-making. Other professionals, such as nurses or professionals in social welfare, could have other considerations. Comparing SES reasonings between frontline

professionals from different professions could create valuable insight into how SES is observed and integrated in the work of frontline professionals in and beyond care.

There are also some recommendations for future research that arise from the findings of the dissertation. In this dissertation, I have developed conceptualizations and I have explored potential causal mechanisms. Whereas I have not tested these mechanisms, I leave room for future research to do so. For instance, the three SES reasonings are conceptualized based on in-depth interviews with GPs. Future research could test these reasonings in several ways. One approach is to observe GPs' actual decision-making practices. Another is to compare their reasoning with those of other frontline professionals, in order to develop a theory on SES reasoning among frontline professionals more generally. Additionally, experimental methods such as vignette studies could be used to access how SES cues impact their reasoning. Moreover, surveys could be used to explore how recognizable the reasonings are for frontline professionals. Future research could also explore how frontline professionals' SES reasonings are relevant for how they relate to other professionals in caring for clients with differing SES backgrounds. Insight into how differing SES reasonings may shape expectations about roles, responsibilities, and appropriate care strategies of other professionals could help to better understand how holding different SES reasonings can impact their ability to understand each other's perspectives and consequently to provide care together.

While I have studied the actual work practices in health promotion and in interprofessional collaboration, I have not tested the conceptualized health conception dimensions in those work practices. What further study should explore is how the three health conception dimensions are connected in actual work practices and thus how health conceptions shape and are shaped by socialization processes in for example professional training, work experiences and in interprofessional collaboration (Levesque & Li, 2014; Dinmohammadi et al., 2013). Moreover, to test the validity of the health conceptions of frontline professionals in care and social welfare and to further conceptualize them, comparative research is needed – for instance, comparing professionals across domains, regions or organizational contexts. This dissertation focused on how frontline professionals relate to other professionals and clients in caring for clients with combined problems. To explore whether and how the uncovered mechanisms actually play a role in the health of clients, participative action-based research with interventions is needed, in which clients and professionals work together towards change. Such change could involve raising awareness among frontline professionals about their reasonings around SES. It could also include fostering reflection on how professional identity and health conceptions shape care practices. Finally, it may require facilitating interprofessional dialogues in which professionals make their underlying assumptions about health, care, clients and collaboration explicit.

Finally, the dissertation finds that interprofessional collaboration often happens informally, based on fragile interpersonal relations in which change and difference in

team membership create tension. This raises the question of what can support such fragile forms of interprofessional collaboration. Future research could explore how various forms of leadership may shape the conditions for effective collaboration, and how it can connect policy paradigms that work in terms of collaboration across professional and organizational boundaries.

6.6 Societal and practical implications

Understanding how frontline professionals relate to other frontline professionals and their clients in care for clients with combined psychosocial problems is essential for understanding and improving care for clients with combined problems. This section offers both the societal implications for the care and health of vulnerable people and the practical implications for improving interprofessional collaboration and addressing the needs of those with combined problems.

The insights from this dissertation underline the societal importance of relational practices within public health, especially in light of the transition and transformation in care. Policy frameworks such as integrated care agreement (IZA) and the Health and Active living agreement (GALA) in the Netherlands ask a broad, integral health view, in which interprofessional collaboration between various domains is central (NFU, 2025; RIVM, 2024). Such a transformation thus requires more than policy change alone. It also calls for changes in how frontline professionals are socialized in their perspectives and approaches to care, their identities and roles in collaboration and their reasoning towards clients. These deeper layers of transformation receive little attention in current policy discourse. This dissertation highlights that addressing how frontline professionals relate to other professionals and clients in transformation is essential to realizing the ambitions of integrated care. Considering these policy developments, frontline professionals working with clients with combined problems should know how to relate to other professionals and to clients in contexts of team fluidity. The findings in this dissertation show that frontline professionals who work with other professionals and clients with combined problems, such as health problems, combined with debts and psychological problems, do need relational and reflective knowledge and skills that are different from professionals in less complex contexts. The findings also provide practical insights for frontline professionals and other stakeholders on how they should relate to other professionals and clients. For instance, frontline professionals working with combined problems need quick adaptability to changing and diverse team members and unforeseen situations and empathy to ensure a safe and inclusive work environment is essential. Furthermore, understanding professionals' health conceptions may affect health promotion through how professionals relate to clients and other professionals. This implies that knowledge of health conceptions and health promotion roles in care

for vulnerable people is relevant practically, because this adds to awareness of possibly different ideas about and approaches to health and care between professionals. Specifically, by explicitly conceptualizing these possible differences, this dissertation creates room for dialogue and collaboration among professionals, their managers and clients by enabling alignment of goals, roles and responsibilities in care practices. Understanding how professionals relate to other professionals and clients furthermore facilitates professionals and managers to question their own assumptions about professionals and about clients with varying SES backgrounds. Such reflection potentially supports professionals to make better use of each other's expertise and to better align with their clients' needs.

The insights form this dissertation can also support local and regional initiatives that aim to foster new forms of collaboration — such as improving mutual understanding and learning each other's language and roles — as well as the implementation of policy in organizations working with clients with combined problems. By researching how frontline professionals relate to other professionals and clients across professions and organizations, this research provides valuable insight for translating policy initiatives into the everyday work of frontline professionals in care and social welfare. Based on the findings, I recommend managers to actively create the conditions for interprofessional collaboration, by not only encouraging it in policy, but by enabling it in practices on the ground. This includes facilitating shared physical spaces where professionals from different organizations and professions can meet and build trust. My research for example showed an organization where professionals were expected to collaborate with professionals from another organization, but the lack of physical workspace hindered opportunities to meet and interact outside of formal case consultations. This situation seemed to play a role in competitive feelings regarding the ability to use actual workspaces and feelings of distrust when caring for clients together. Possibilities for informal contact are especially important in collaboration across professions and organizations. It is therefore also important that managers, together with frontline professionals, and professionals across organizations, take the time to reflect on how the intended collaboration is experienced. Such reflection is especially relevant considering frameworks for frontline professionals, which are often focused on organizational aspects like task redistribution (Zorginstituut Nederland, 2012), but increasingly recognize the value of normative reflection regarding professionalism including leadership and interprofessional collaboration (NFU, 2020).

This dissertation further demonstrates that care, even when it is tailored towards clients, cannot be seen apart from value judgments related to aspects of SES, such as lifestyle. Although reasoning around SES often happens implicitly, it may play a role in the decision-making of frontline professionals. The findings underline the importance of studying how frontline professionals relate to both clients and other professionals, as what one person sees as the right care, might be perceived as wrong or even stigma-

tizing to another. In their daily work, frontline professionals, therefore, should reflect on normative assumptions, for instance around status preservation and social distance towards clients. Such reflection and awareness of underlying assumptions are not only relevant for relating to clients, but also for self-awareness and for relating to other professionals. Through professional's awareness of assumptions about SES, professionals could realize how they, often unconsciously and possibly unintentionally, shape their reasoning towards clients. Since reasoning around clients' SES can affect the kind of care clients receive, it may also impact their actual health outcomes. Additionally, reflecting on their own assumptions about SES could help frontline professionals to better understand other professionals, especially when collaborating with professionals with different reasonings and standpoints. Such reflections could thus help prevent misalignment in collaboration and it could reduce the risk of implicit discrimination. This refers to the risk that professionals' interpretations of clients' SES subtly shape how they interpret needs and involve clients in developing a treatment plan, potentially leading to unequal treatment, even when seen as personalized care. Thereby, seeking to understand how professionals and clients relate to one another is essential for addressing health inequalities.

Altogether, the findings of this dissertation offer valuable input for health promotion practice by encouraging frontline professionals to reflect more on their own health conceptions, how they pursue health together with clients and other professionals, and how they use assumptions about SES. In daily routines, such reflection may receive little attention, as professionals indicated they rarely take time for it, but also found it useful and meaningful when we engaged in it during our conversations. I therefore recommend creating space for reflection, for example in team meetings or professional development, potentially linked to broader initiatives such as appropriate care programs. In this way, the findings of this dissertation can contribute to strengthening reflective health promotion practices in everyday care.

The dissertation's findings are relevant for policymakers and professionals, but also for clients and client representatives, such as client councils (a.o. Rijksoverheid, 2025a). For client councils advocating for the voices of clients to be heard in the care process, this dissertations' findings are relevant as they shed light on how professionals interpret their role in care and clients' health and needs. As such, the dissertation highlights the importance of understanding the professionals' perspective in their decision-making, which can empower client representatives to advocate for openness about the reasoning used in decision-making to ensure that decisions made by professionals align with the best interest of clients. In doing so, this dissertation also creates insight into broader discussions on equality, diversity, inclusion and values in decision-making of other frontline professionals who work with clients with combined problems in and beyond care.