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Making integrated care happen: Middle managers' views on leadership for promoting multidisciplinary collaboration at the early stage of the Finnish social and healthcare reform

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ABSTRACT

Different forms of health and social care integration are promoted in many countries to address the complex needs of the population. This qualitative study explores integrative leadership from the perspective of middle managers. The study examines how national and regional integration aspirations are converted into micro-level multidisciplinary collaborations through leadership actions in primary health and social services. The study was conducted at the early stages of major social and health services reform in Finland. The data forms a cross-section of 11 interviews with middle-level managers from different sectors in a new wellbeing services county. Thematic analysis revealed that managers view integrated care positively, considering it efficient and useful. Their main goal is to create public value, including cost-efficiency. The managers believe that their task is to promote multidisciplinary collaboration by developing visions, structures and processes that support professionals in implementing changes in daily work. Many aspects of integrative leadership, such as shared goals and collaborative processes, were identified. More contradictory issues, such as tensions and conflicts between stakeholders, complex accountabilities, legitimacy and power imbalances, were almost absent in the data. These issues should be addressed in organisations, and their role should be studied further as a potential barrier to the successful implementation of integrated care.

1. Background

During recent decades, calls for integrated care and integration of health and social care have been emphasised both within health systems as well as in research [1–3]. In Finland, health and social services were reorganised under the same organisation and budget through a major structural reform in 2023 [4]. This paper focuses on how middle managers in these new organisations (i.e. wellbeing services counties) plan to use leadership to transform strategic integration aspirations of the reform into micro-level multidisciplinary collaborations, thereby actualising integrated care. The study focuses on leadership. Integration is viewed from the organisational and system perspective [5,6].

A consensus has not been reached regarding the exact definitions of integration and integrated care [1,7]. Integration is considered to include multiple, coherent methods and models at different system levels to precipitate connected and aligned collaborations. The result can be referred to as integrated care, which encompasses quality care and enhanced patient experience and creates the common good [1,5,7]. We approach integration through Valentijn et al.'s definition of integrated primary care referring to 'ambulatory care settings in which a network of multiple professionals and organisations across the health and social care system provide accessible, comprehensive, and coordinated services to a population in a community' [6].

Integrated care has been promoted to improve patient satisfaction

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and the perceived quality of care and access to services, although the evidence concerning the effectiveness of different models remains mixed [3,8]. Integration efforts are necessary due to the changes in care needs resulting from population ageing and multimorbidity often requiring multidisciplinary collaboration even crossing the sectoral boundaries of health and social care [8–10]. Integrated care and the integration of services occur and are promoted at different levels of the service system, often referred to as the *macro* (system), *meso* (organisational and professional) and *micro* (clinical) levels [11]. Processes at different system levels also interact with each other and are linked through normative and functional integration [11,12]. Several contextual factors, barriers and enablers have been identified to affect integration of services in primary care [6,9,13].

Previous initiatives have aimed to facilitate integration of health and social services and to promote multidisciplinary collaboration in primary care. However, the sustained implementation of integrated care policies has often been problematic and/or partial [12,14,15]. Research has revealed that reforms can also result in unintended outcomes [16], largely due to the complexity of implementation [17]. Beyond the challenges at the policy level, studies on mergers also highlight numerous integration difficulties (e.g. strategic and socio-cultural) and potential conflicts at the organisational level [18,19].

Translating reform policy goals into street-level action can be challenging because, for example, professionals' actions and attitudes do not necessarily support the desired changes [20,21]. Research has increasingly recognised the need to understand managers' and professionals' roles as more multifaceted, highlighting their capacity to act as both facilitators and potential barriers in implementing reform policy goals [22,23].

Leadership and management are key factors in the successful implementation of integrated care reforms (e.g. [10,14,15,24–26]). Various terms, such as integrative, collective, collaborative, connective, complexity and systems leadership, have been used in the literature to describe leadership approaches related to integrated care [15,24,27,28]. Morse [27] suggests that integrative public leadership could provide an umbrella term to describe cross-boundary leadership and form an interdisciplinary framework for research. Integrative leadership refers to various leadership styles that accept shared leadership as a source of effectiveness [29]. The concept encompasses dynamic abilities to integrate different leadership elements with strategic decision-making objectives [30,31]. Integrative leadership has been described as 'bringing diverse groups and organisations together in semi-permanent ways, and typically across sector boundaries, to remedy complex public problems and achieve the common good' [32].

Researchers have identified five different discourses by middle managers on cross-boundary collaboration in Finland [15]. These discourses were labelled 'ideal', 'structure', 'defence', 'money' and 'support' talk; the first being dominating and forming a positive ground for collaboration [15]. However, to promote integrated care, the multidisciplinary collaboration must be governed and supported at multiple levels of the system [11]. At the micro and meso levels, for instance, differing backgrounds of employees; hierarchies between professions; and divergent cultural assumptions, values and procedures may hamper collaboration between professionals [12].

Bryson et al. [32] provide a description of the interconnected aspects of integrative leadership and cross-sectoral collaboration. In their synthesis of previous frameworks and empirical work, they outline how leadership with other capacities align the interconnected aspects of initial conditions, structures, processes and outcomes and accountabilities to create public value that would not be achieved without cross-sectoral collaboration. These are demonstrated in Fig. 1.

As a concept, public value considers how (public sector) organisations, through the mediating role of managers, create 'the common good' through public policies (e.g. [1,33]). The definitions of public value are numerous, and scholars emphasise different aspects of the concept [34], drawing attention to managers' roles and the collaborative components of creating public value (e.g. [35–38]). Linking public value to public services is not, however, straightforward because the society represents a 'mosaic of values'. Consequently, public values are generated through collaboration among diverse societal actors to achieve shared objectives and address collective and individual needs [40,41]. Public values cannot be reduced to the aggregate of individual ones [39]. They are shaped by collective processes, guided by shared principles and influenced by interactive learning and societal experiences

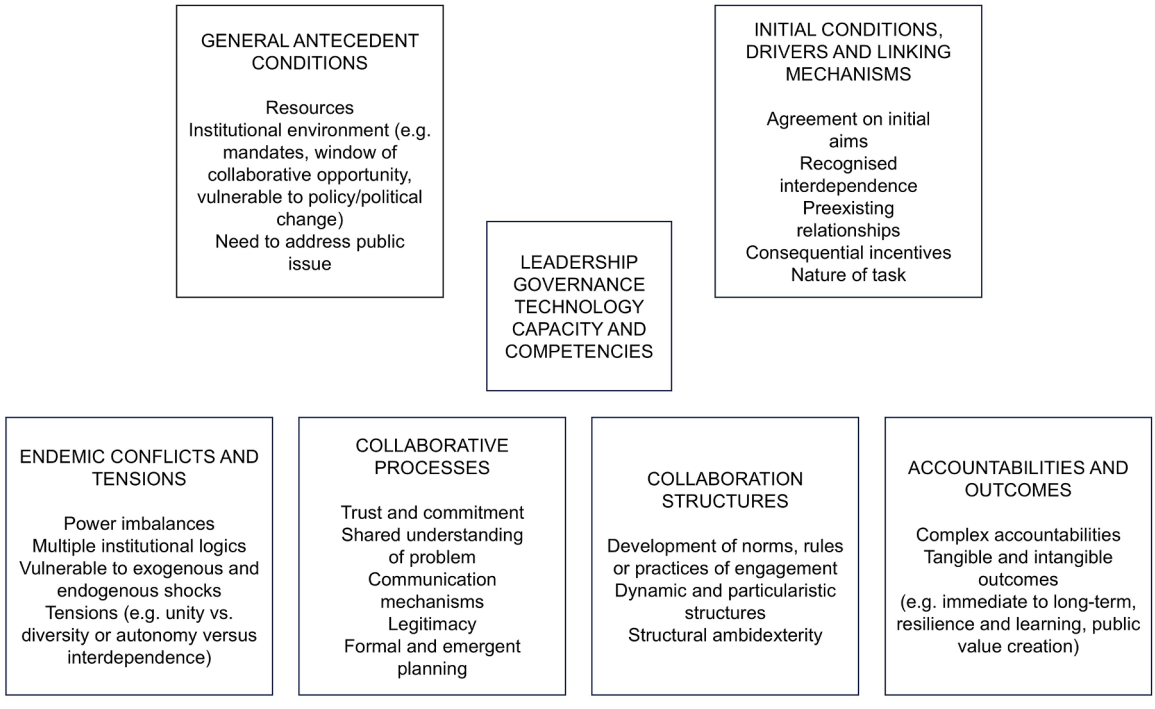

Fig. 1. Issues concerning integrative leadership arranged according to Bryson et al. [32].

[40,41].

The context of this study is a structural health and social service system reform in Finland in 2023. As a result of the reform, the responsibility for organising health and social services was transferred from over 300 municipalities to 22 wellbeing services counties (WBSC) [4]. Table 1 presents the main objectives of the reform and the structural changes resulting from it. In Finland, integrated care has been a key policy priority since the early 2000s, resulting in several models and plans for both governance and service delivery [4]. However, implementation of the developed models has been challenged by, for instance, system fragmentations and the difficulty in working across sectoral boundaries. The level of readiness for implementing integrated care also varied across the country [42,43].

While research concerning the barriers of integrated care has been active, most of the work has addressed the implementation or later stages of the process [12]. In this study, we explore integrative leadership in the context of the initial phase of a structural reform in one of the new organisations (WBSC) established through the reform. We focus on middle managers' plans to actualise integrated care in primary-level health and social services via the promotion of multidisciplinary collaboration, that is, converting macro- and meso-level objectives into micro-level changes through leadership actions. The questions of cross-sectoral collaboration are relevant, as the new WBSCs are built on multiple antecedent organisations which shape the collaboration through, for example, historical and cultural backgrounds and conflicting interests and logics of the old organisational practices and ways of working [12,32].

Table 1
A summary of the Finnish health and social services reform and the main characteristics of the studied region.

The national health and social care reform
Main objectives and drivers [4]
Reduce inequalities
Ensure the quality of health, social and rescue services
Improve access to (primary) care
Control costs
Improve vertical and horizontal administrative integration within the system, ensure that people in need for integrated services are identified and that service chains are defined and coordinated [4,46]
Structural changes
Responsibility for organising health and social services from over 300 municipalities to 22 wellbeing services counties (WBSC)
Primary health services (including maternal and child health clinics, school and students' health services, mental health and substance use services and rehabilitation), specialised health care, social services, care for the elderly and rescue services organised under the same administrative structure
Funding from municipalities to the state
The local context of the study
Geography
A large central city and surrounding municipalities. The WBSC also includes rural areas.
Distances between the central city and the other municipalities vary from <20 km to 100 km.
Population
The central area with younger population and slight net immigration. Rural areas are losing inhabitants.
Organisation of health and social services
Prior to the reform, the majority of the municipalities organised primary health and social services independently, some of them in (partial) collaboration with neighbouring municipalities.
Specialised health care was previously organised by a hospital district in the region, including a university hospital. Primary health and social care services were generally managed and delivered separately within the municipal organisations. This often resulted in silos and barriers to multidisciplinary collaboration although integrated care had been promoted even before the national reform [42,43].
After the reform, the primary and specialised health care services, and social and rescue services of >20 municipalities were merged under one WBSC organisation.
Organisational structures and leadership positions were partially under negotiation at the time of the data collection.
Integration
Some sectors and areas were more accustomed to multidisciplinary collaboration than others.
Integration had been promoted through projects, mainly focusing on certain services or patient/client groups.
Prior to the reform, service integration between sectors was mainly local.
Following the reform, the aim was to promote integrated care at the regional level.

2. Methods

The data for the study were derived from semi-structured interviews with 11 middle managers responsible for primary health and social services in a newly formed WBSC. The details of the region are provided in Table 1.

In this study, we wanted to ensure that the data include a wide range of different professional and sectoral viewpoints to allow for a thorough analysis of the leadership promoting multiprofessional collaboration while forming a new organisation. Therefore, the interviewees were individually selected based on the information gathered from the organisation's web pages and utilising snowball sampling. The sample consists of a broad cross-section of the management from different healthcare and social service fields. Although the number of interviewees is limited to 11 managers, the interviewees form an extensive multidisciplinary sample of middle-managers responsible for implementing the new health and social care structures and functions of the study region. Representatives of elderly care were the only group of leaders who could not be reached for this study. The interviewees had different professional backgrounds, including physicians, nurses, social workers, social scientists and psychologists. All had several years or decades of experience in management and leadership positions. As the organisation was still forming at the time of the interviews, we cannot provide detailed information on the quantitative proportions of the managers interviewed compared to the total number of managers in the organisation. Repetition of certain themes was observed early during the interviews, especially regarding the questions on interpretations of integration and its requirements. Yet, information gathering was continued to cover the different perspectives on leadership and multiprofessional collaboration which was the primary aim of the data collection.

The new WBSC organisation in question commenced full functioning on 1 January 2023. The interviews were completed between October 2022 and June 2023. Given that the research concerned the implementation of a massive structural reform, the data collection spanned across an extended period to respect interviewees' schedules. The interviews were conducted via Microsoft Teams or telephone in Finnish by the first author. Each interview lasted approximately 60 min. Before and at the beginning of the interviews, the participants received information about the study and their rights as study participants. They were asked to provide verbal, audio-recorded informed consent before the interview commenced. Interviews were audio recorded and transcribed verbatim. The interview guide consisted of themes concerning leadership in different situations, namely the health and social care reform and the partially overlapping COVID-19 pandemic, focusing on multidisciplinary and cross-sectoral collaboration. The interviewees were asked to define service integration and its benefits. They were also invited to contemplate on what successful collaboration and integrated care looks like from a leadership perspective.

A thematic analysis was applied to examine the data [44]. The analysis process shifted from an early inductive phase of thematic analysis into a more deductive phase of interpreting the results utilising an integrative leadership framework by Bryson et al. [32]. Abductive reasoning was applied because of the need to reflectively overcome the normative ideas of organising integrated care. ATLAS.ti (version 23) was used as a technical tool.

In the inductive phase, the transcriptions were read closely by the first author to identify interviewees' descriptions and ideas regarding integrated care, multiprofessional and cross-boundary collaboration and

the role of managers in generating the change. Twenty-four codes were created and categorised into four initial themes. Through joint discussion, the research group delineated three final themes through which the following research question can be answered:

How do health and social service managers define integration, and what kinds of roles and activities have they identified for leadership in facilitating multidisciplinary collaboration?

The first author performed the second phase of the analysis in collaboration with the next four authors (SP, HP, MH and MS). The inductively formed codes and themes were discussed and refined together along the analysis process and then connected with previous discussions on organisational theory through a phase of deductive analysis [45]. The three themes obtained from the first analysis phase were examined from the perspective of integrative leadership to identify which aspects of the framework were present in the managers' interpretations and what entities of integrative leadership might have been excluded from their reasoning [32]. The analysis process is visualised in Fig. 2.

3. Results

3.1. Leadership activities clear the way for collaboration

Several leadership activities were identified as necessary for enabling multidisciplinary collaboration. The managers themselves held the notion that leadership in the organisation must be cohesive across different sectors, which starts with developing integration within the administrative structures, including financing. The managers also need to be aware that the decisions and actions are in alignment with achieving the goals:

> *It would be extremely important for managers to now create a shared vision. After all, while performing their day-to-day work, the staff expect to know that they have the support of their managers. The staff should know that they are working in a direction that is expected of them. (interviewee 8)*

For an integrative manner of working to be realised, a change in thinking and acting must be enacted at the level of frontline work. To achieve this, space for common discussions, sharing and continuously learning from each other must be fostered. This was regarded as a distinct leadership task with which the interviewees had previous experience:

> *What this requires from management, from day-to-day management, is in a sense [forming] an organisational culture which enables dialogue. This, in turn, allows us to put the client's needs at the centre. (interviewee 5)*

To support multidisciplinary collaboration, communicating its importance and directing resources to facilitate collaboration and implementing related strategies at all managerial levels were highlighted. These results show that, quite understandably on the eve of the reform, the managers' attention was directed to the elements of collaboration structures and processes of Bryson et al.'s framework [32]:

> *Securing and developing the structures of the multidisciplinary work, and then the cooperation of managers, are perhaps more my own field rather than traditional management. (interviewee 7)*

Other elements, such as legitimacy, were rarely addressed (see Fig. 1). The lack of human resources and inconsistent understanding and communication of the goal and means to obtain it were envisaged as threats to successful integration.

3.2. Working together efficiently forms the core of integration

A widely shared idea among the interviewees was that creating a sustainable basis for integrated care and multidisciplinary collaboration requires the development of a shared language. This was clearly present among the managers:

> *It occurred to me yesterday at one of the meetings, I was wondering how well we think and speak alike, even though perhaps we haven't yet been able to lead the functions in a similar way [towards the goals]. (interviewee 2)*

The issues of shared culture and thinking as well as an understanding of and appreciation for others' expertise were addressed by relaying prior accounts of such occasions. According to the managers, this development can be optimally precipitated by providing the opportunity to the personnel to be inspired about the usefulness of multidisciplinary collaboration:

> *I see them working together and planning together. For some, legal obligations might change. They discuss together: Now we need your help to get*

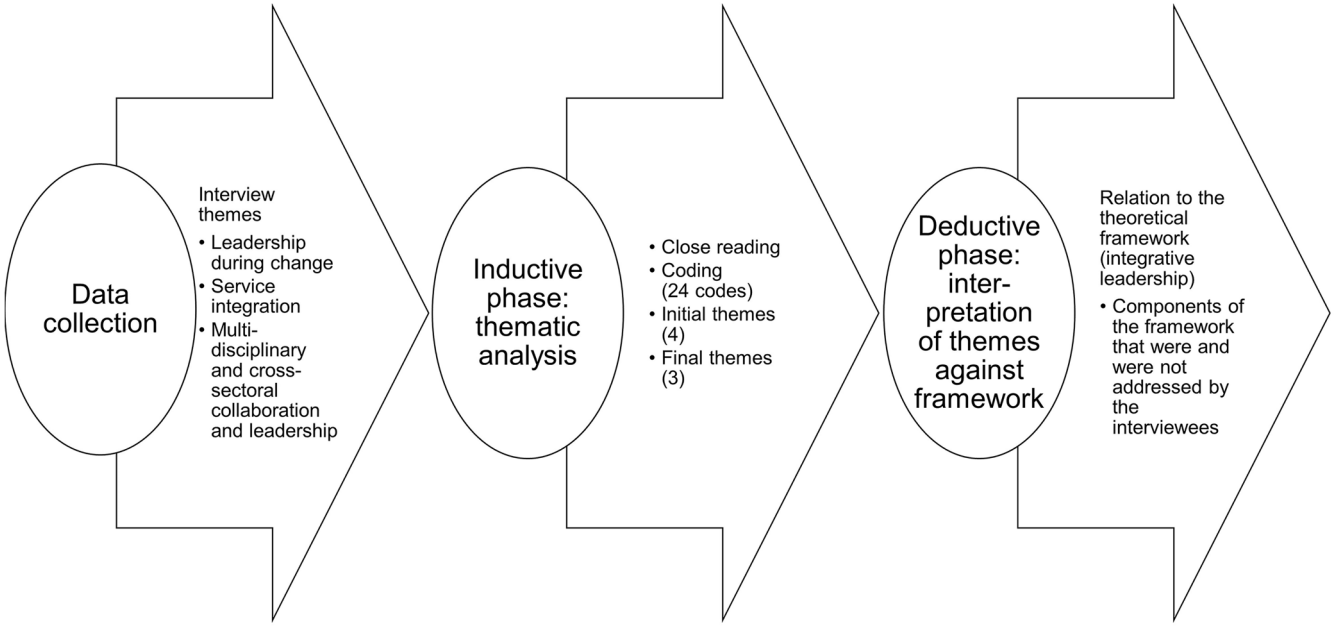

Fig. 2. The process of data collection and analysis.

this done. And when this happens spontaneously and is done together, there is no need for formal commanding. (interviewee 9)

This was intended to be facilitated by providing space for creating connections between professionals across organisational barriers. In other words, the managers must modify the structures and underscore the imperative to view all professionals as equals. From the management's perspective, once a shared understanding has been formed, people would be able to perceive their work as a collective task of well-coordinated services.

Whilst management should be integrated to ensure organisational alignment in striving for change in working principles, the actual integration needs to transition from the 'strategic papers to the level of frontline work'. For integrated care to be realised, collectively formed and accepted processes and practices need to be defined to ensure clarity regarding the daily work. It would then be possible to create 'a good flow' in the work between sectors and at all levels and to remove overlapping work, as described by one of the interviewees:

If there are structures and practices in place for this, then things will run smoothly in day-to-day work. (interviewee 1)

Observing the benefits of multidisciplinary collaboration in person was believed to motivate the personnel to work in new ways and to foster self-organisation and well-being at work; thus, offering a solution to the critical challenge of retaining the workforce in the sector. Ultimately, integration was regarded as beneficial also for the organisation and the managers due to the added self-organising collaboration between teams and units. The managers stated in many ways that integrated care heavily depends upon everyone being involved in the effort:

Of course, you have to get everyone involved. At times we have experienced that one has a lot of drive and energy to do things, but the other does not have the resources or opportunities to participate in that moment. It's not possible to do this on your own. (interviewee 1)

Misgivings were also identified. Firstly, the turnover of personnel was perceived to lead to the extensive need for the orientation of new employees, risking both continuity of care and collaboration. Secondly, various organisational barriers such as siloed structures, processes and conflicting priorities were identified as potential threats to successful intersectoral and multidisciplinary collaboration. Multidisciplinary collaboration and the coordination of services had been developed before, and 'everyone could see the benefits'. The difficulty appeared to lie in incorporating the ideal into the busy daily work pointing to antecedent conditions, such as institutional environment, and collaboration structures and processes depicted in Bryson et al.'s framework [32] (see Fig. 1). The theme of working together also includes entries on leadership, capacity and competency [32]. Some conflicts and tensions were identified – these were often connected to antecedent conditions. Even if the interviewees stated that there was still considerable work to be done to create better-integrated services, their overall stance was highly positive.

3.3. Integration is about creating public value through coordinated care paths

Integration was defined, for instance, as 'working together for the benefit of everyone' or collecting different professionals and services to 'encircle the person needing them'. Integration was frequently regarded as 'a seamlessly flowing entity of different services'. Thus, the needs of the residents were the leading justifications for the service integration. Frequent attenders of health and social services as well as people with complicated service needs were specified as those benefiting the most from integrated services, although, according to the interviewees, everyone can gain from the coordination of services.

Health equity was sometimes addressed in discussions. However, financial constraints, efficiency and efficacy were offered as arguments for striving towards integrated care. Integration was even considered an inevitable necessity for achieving the goals of cost-effectiveness that the WBSC encounters:

I argue that if we do not succeed in integration at all levels, then that will dictate the rise or fall of the WBSC. Our population is aging fast. If we don't get this to work better than how it's currently done, then we'll run out of money. (interviewee 4)

The descriptions of creating public value through coordinated care paths encompass many aspects of antecedent conditions, drivers and linking mechanisms presented by Bryson et al., including resources, addressing a public issue and interdependencies [32]. Learning and resilience were highlighted, particularly in respect to the COVID-19 pandemic and the even greater uncertainty experienced due to the incompleteness of structural reform. While public value and benefits for the clients were identified as desirable outcomes, several benefits for the organisation were described. These benefits could motivate the professionals and managers to strive for integration:

There is a certain 'we spirit', of course, that one sees that we are now one entity and that we are all around the same customers and work. (interviewee 3)

4. Discussion

In this study, we explored how middle managers in primary health and social services define integration and in what ways they contend that leadership can facilitate multidisciplinary collaboration and thereby promote integrated care. We focused on the role of leadership in supporting multidisciplinary collaboration during the early phase of a large-scale structural reform.

Although this study was conducted in a single WBSC and is based on a limited number of interviews, it reflects international and national discourses and provides insights regarding the characteristics of managers' thought processes about integration and integrative leadership. The managers defined integration primarily through the clients' perspective—coordinated services that are assembled based on the needs of the individual—although benefits for the organisation and the professionals were also identified by most of the interviewees. Our results indicate that the managers who participated in this study had widely adopted the ideology of integrated primary care and integrative leadership [6,32].

The organisation in question and the Finnish health system are transitioning towards a new position regarding integrated care [43,46]. The current Finnish healthcare structure pursues a whole-system integration including collaboration between several stakeholders to promote public health. However, the full integration uniting different viewpoints, interests or ways of knowing into a new entity in which all interests are satisfied without compromise [27] or whole-system integration supporting both a population-based and person-centred approach to care [7] still seems to be beyond the purview of the thinking of the middle managers. While communicating the same aspirations and rather high hopes for integration, at the time of the interviews and close to the implementation of the reform, the managers were quite understandably directing their plans towards more practical issues for achieving a satisfactory level of horizontal organisational and professional integration [7]. This resonates with the recent findings on the maturity of integration in the Finnish WBSCs [43].

The imbalance between expectations and real-life results of integrated care still calls for more research to build a robust understanding of the phenomenon [45]. Referring to one of Leutz's five laws of integration 'integration costs before it pays', Miller et al. [47] argue that the expectations towards integration are more hopeful than the actual benefits, while practical difficulties are often under-estimated. The benefits of integration often take more time than is beneficial from the political point of view, because integrating, for example, different

professional cultures or managing strategic change are long-term actions [47]. In addition, in healthcare contexts, leaders are often experienced in their own field while integration requires experience of implementation and processes in wider settings, a systems thinking approach as well as the ability to reflect and adapt one's leadership behaviour [47,48].

Most aspects of the integrative leadership framework were identifiable in the managers' discussions (see Fig. 1). These findings mirror the conclusions of previous research on integrated care system leadership [10,48]. On the other hand, some important entities of the integrative leadership framework were not addressed. These included issues that can be experienced as difficult and controversial and are rarely discussed in the health and social sectors: power imbalances, legitimacy, multiple and conflicting institutional logics and complex accountabilities between stakeholders. This raises questions regarding whether renegotiating these topics is a core task for integrative leadership and a means to ensure the successful implementation of new, multidisciplinary ways of working to promote integration.

Specifically, a shared language appears to have been found within the administration of the organisation, and the interviewees used very similar phrasing. This is of immense interest as it was brought forward as an important issue by other Finnish researchers only some years ago [15]. The five discourses of cross-boundary collaboration identified by Hujala et al. in their study conducted in another region in Finland were present in our data [15]. In this study, ideal talk was dominating: integrated care was depicted as crucial for solving even the most urgent and difficult challenges of the sector, including a sufficient workforce and financing. Structure talk was also present—building structures that facilitate collaboration throughout the organisation was regarded as one of the primary managerial efforts of the reform. Notably, the participants pointed out the substantial need for processes to be developed for the same purpose, mirroring the interconnectedness of these two elements of integrative leadership [32].

Money talk was present more as a driver [32] rather than a barrier to integration, as was the case in Hujala et al.'s study [15]. Although the outcomes were described strongly from the perspective of quality of care and experience of the clients/patients, cost-effectiveness and cost savings followed as other aspects of public value [33]. Thus, funding constituted a potential barrier but was also used as a strong argument favouring integration. This may reflect the shift from professional logic towards managerial- and outcomes-focused logics presented in the health and social care sector during the past decades [49]. Defence talk was relatively limited in our interview material. Instead, support talk, as described by Hujala et al. [15], was present in the form of sharing positively framed experiences of collaboration and collective thinking in boards and other groups.

The managers clearly acknowledged the importance of leadership in forming collaborative processes and structures to facilitate multidisciplinary collaboration. Our results show that the managers' ideas on leading multidisciplinary collaboration are well in line with the findings of previous research on successful leadership in integrated health and social services [47,48]. Descriptions of certain leadership components identified by Sims et al., such as 'inspiring intent to work together'; 'creating the conditions'; 'balancing multiple perspectives', were numerous in the data [50]. 'Clarifying complexity' [50] was discussed often in relation to the even greater uncertainty concerning the reform than what was experienced during the COVID-19 pandemic [51]. This was caused by the lack of clarity even on the basic structural issues and it underlines the importance of collaboration structures [32]. Nonetheless, the managers still seemed to be 'shaking off' the remaining historical structures and cultural assumptions that might constitute barriers to the development of integrative leadership and collaboration [3,12,52]. Multidisciplinary collaboration as a means of service integration was believed to take place at the micro level 'once the conditions are favourable and everyone understands it as an important task' relating to the professionals' actions and attitudes as an impetus, or a barrier, to implement the desired change [17,20]. This can be interpreted as highlighting organisational readiness and staff engagement [25].

Studies with longitudinal and ecosystemic [53] study designs would provide more information regarding how and to what extent integration is eventually implemented in the interplay of different levels and what outcomes are reached. The systematic analysis of the data utilising a former framework in the context of an ongoing change process revealed gaps in leadership approaches that can serve as starting points for future research and practical actions in other regions or countries. Legitimacy, power imbalances and tensions between multiple institutional logics were left virtually untouched and should be addressed both by the researchers as well as managers and decision-makers [12,32,50,54]. Renegotiations to settle these matters is also an interesting topic to further inform the operationalisation of the integrative leadership framework [32].

5. Conclusions

After having recently experienced a historically large structural reform, the Finnish health system is being developed towards providing more integrated services. In this unique structural context, research on how structures and changes in them can affect the transformation of services and ways of working should be conducted. Leadership plays a crucial role in promoting change, and when it comes to integration, a strong and collective motivation exists in relation to this endeavour. According to this study, however, some controversial aspects that might hamper achieving the goals have not yet been discussed. These tensions must be addressed if a high level of integration within and between organisations is desired.

CRediT authorship contribution statement

Soila Karreinen: Writing – review & editing, Writing – original draft, Visualization, Resources, Methodology, Investigation, Data curation, Conceptualization. **Satu Paatela:** Writing – review & editing, Writing – original draft, Validation, Conceptualization. **Henna Paananen:** Writing – review & editing, Writing – original draft, Visualization, Methodology, Conceptualization. **Moona Huhtakangas:** Writing – review & editing, Conceptualization. **Markku Satokangas:** Writing – review & editing, Conceptualization. **Harri Jalonen:** Writing – review & editing, Conceptualization. **Liina-Kaisa Tynkkynen:** Writing – review & editing, Validation, Supervision, Project administration, Funding acquisition, Conceptualization.

Declaration of competing interest

The authors declare that they have no competing interests.

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