In need of a collaborative response
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CHAPTER 1
General Introduction

Definition of the problem

People living in a deprived neighbourhood generally tend to have worse health than those living in more affluent neighbourhoods. This is, to a large extent, a reflection of the clustering of people with lower socioeconomic status in these neighbourhoods (Pemberton & Humphris 2016). The existence of socioeconomic health inequalities is well documented. Since the early 1980s this topic has received considerable attention in the Netherlands and other Western countries; nevertheless, it is considered difficult to tackle due to the complexity of the problem (Mackenbach & Stronks 2004, Perenboom et al. 2005, Storm et al. 2016). Actions to deal with health inequalities are mainly aimed at various determinants of health and take various forms. Although it might be said that ‘the evidence base on how best to tackle health inequalities is in its infancy’ (Kings Fund 2010), all efforts made to add to this base may contribute to achieving a decrease, as is encouraged by the World Health Organization (WHO-EURO 1985).

Most of the determinants of health lie outside of health care and, in general, it is advocated that interventions to tackle health inequalities should take place in other policy areas such as education, income, or housing, environment (Kickbusch 2010, Peters et al. 2016). This is not to say, however, that interventions from
the health care sector are not important. Although interventions within health care might be considered to merely lead to treating the symptoms, and could even provide an alibi not to deal with the underlying causes of health inequalities (Braithwaite et al. 2016, Mackenbach 2003), it remains a determinant that may contribute to better health. Health care can play a part in preventing disease but, perhaps more important, it can play a role in preventing that health problems due to disease worsen. To make ‘an appeal to other areas’ is ‘only credible if one fully made use of one’s own possibilities’ (Mackenbach in Stronks & Hulshof Eds. 2001, p.107). Considering that working in deprived neighbourhoods is perceived by many primary care professionals as an ‘endless struggle’ (O’Brien et al. 2010), that they experience more stress and burn-out (Mercer & Watt 2007, Pederson & Vedsted 2014), and that patients in deprived neighbourhoods experience worse quality of life even if corrected for multimorbidity (Lawson et al. 2013), all interventions within health care are worth trying and those that work should certainly be made use of.

In this dissertation, we focus on one possible strategy, i.e. collaboration between primary care (PC), public health (PH) and social care (SC) to improve health in deprived neighbourhoods.

The rationale for collaboration between PC, PH and SC lies in the complex and multi-faceted character of the health problems among deprived populations. The fact that populations in deprived neighbourhoods are relatively unhealthy is partly attributable to a higher prevalence of unhealthy lifestyles and low self-management of disease (Goldman & Smith 2002). In the Netherlands, despite investments in promoting healthy lifestyles (e.g. programmes to promote physical activity, and smoking cessation services), these efforts have not resulted in decreasing the gap in life expectancy of 6-7 years between the lowest and highest educated groups (Mackenbach & Stronks 2002). The available evidence suggests that people in lower socioeconomic groups less frequently participate in health promoting services, while utilisation of care is high due to multimorbidity, with a slightly higher use of primary care and a slightly lower use of specialised care than people in higher socioeconomic groups (Westert et al. 2010). Reasons for less frequent uptake include the fact that health-promoting services are fragmented and hardly structurally embedded in regular care (Martin-Misener & Valaitis 2009). For in-
stance, public health measures might not reach some individuals because they do not feel addressed by such messages, or simply because they do not understand the message because they need a ‘familiar’ professional to explain how the message has meaning for their health. An example of how these types of problems could be solved with collaboration, is when general practitioners help patients with social problems by listening to the patients and referring them to local services that they know will provide the support the patient needs (Popay et al. 2007a).

Against this background, promoting collaboration between health-promotion services (or public health services in general) and primary and social care is considered a fruitful strategy to improve the health of the population in deprived neighbourhoods. With collaboration between PC, PH and SC the health-promoting services might become better embedded in society. Moreover, many public health measures do not seem to fit the health needs of these populations, given (for example) the differing ethnic and cultural background of these groups. Collaboration between PC, PH and SC may bring solutions leading to a better match between health-promoting services and the health needs in deprived neighbourhoods (Green et al. 2000, Plochg 2006). An example is a collaborative project in which diabetes education was given to patients in their native language by community health workers, who also offered cultural competency workshops to health care providers, leading to improved patient communication (McElmurry et al. 2009).

However, although seen as promising nowadays, collaboration between PC, PH and SC is not new. The call for this type of integration arose in the 1970s following publications such as the Lalonde Report (1974), the WHO Declaration of Alma Ata (1978) and, later, the WHO Ottowa Charter (1986). In 2012, in a joint issue of the American Journal of Public Health and the American Journal of Preventive Medicine, authors and editors highlighted the potential of integrating public health and primary care and, at the same time, tempered the expectations. There are still unsolved difficulties related to managing and implementing integrated PC and PH (Lewis et al. 2000, Scutchfield et al. 2012, Koo et al. 2012) and there is a need for more evidence demonstrating how to benefit from this integration (Scutchfield et al. 2012, Koo et al. 2012, Gourevitch et al. 2012, Porterfield et al. 2012). Very few studies have explored the ways in which collaboration between
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PC, PH and SC can actually develop. Also, insight is lacking into the conditions that are critical for its success, and into the impact of the collaboration in terms of (for example) uptake of effective preventive interventions or counteracting the high utilisation of care. Therefore, with the goal to contribute to tackling health inequalities, the work in this thesis aims to add to the empirical research and gain more insight into the why, the how and the what of collaboration between PC, PH and SC as a means to improve health in deprived neighbourhoods (Stronks & Hulshof red. 2001, Braithwaite et al. 2016).

Research aims

This thesis aims to contribute to both the theory base and evidence base of collaboration in the Netherlands between public health, primary health care and social care, as a method to address the needs in deprived neighbourhoods.

This aim is reflected in the main research question:

Is collaboration between primary care, public health and social care a potentially effective measure to improve the health of people living in deprived neighbourhoods?

More specifically, three main objectives (with 7 sub-studies) were addressed (see Table 1).

Objective 1
To better understand the health needs of patients living in deprived neighbourhoods and the difficulties professionals encounter in providing care to these populations

This was addressed by taking into account the perspectives of patients with multimorbidity and of the professionals working in the deprived neighbourhoods. More insight and a better understanding of the needs of patients in a deprived neighbourhood was gained from a literature study. In a scoping review, the
Table 1. Overview of the studies in this thesis

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<td>Problems from viewpoint of patients</td>
<td>Thematic analysis (interpretative)</td>
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<td>3</td>
<td>Objective 2</td>
<td>Difficulties encountered by professionals in deprived neighbourhoods and their views on solutions</td>
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<td>Qualitative analysis</td>
<td>28 respondents (professionals from a broad range of disciplines, including general practitioners, physiotherapists, social workers, etc.)</td>
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<td>Objective 2</td>
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<td>Mixed methods</td>
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</tr>
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1 Findings from Chapter 7 also provide insights useful for Objective 2 and are therefore also discussed in the Main findings in the General Discussion.
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self-reported experiences of the health care process of patients with multimorbidity were analysed. This was done based on the assumption that these experiences largely overlap with the experiences of persons in deprived neighbourhoods, because of the higher concentration of patients with multimorbidity in deprived neighbourhoods (Violan et al. 2014, McLean et al. 2014). In addition, a qualitative study provided more insight into what professionals working in deprived neighbourhoods perceive as being patients’ needs.

Thus, Objective I encompassed two research aims/sub-studies:

1) to understand the experiences of patients with multimorbidity with the healthcare process and identify the main themes underlying their experiences

2) to identify the difficulties encountered by health and social care professionals in deprived neighbourhoods and their perception of what is required to solve these problems

Objective 2
To concretize collaboration between primary care, public health and social care in deprived neighbourhoods and the underlying rationale

This entailed a literature review and a case study. To clarify why collaboration is expected to help solve the problems (described in Objective 1), a qualitative evidence synthesis of the literature on collaboration was performed, focusing on collaboration between primary care and public health. Then, a case study was conducted to show how collaboration is shaped in two pilot projects conducted in deprived neighbourhoods in two cities (see below: Case studies).

Thus, Objective II also had two research aims/sub-studies:

3) to derive from the literature the rationale underpinning collaboration between primary care and public health
Objective 3
To gain insight into outcomes reached after collaboration between primary care, public health and social care was implemented in deprived neighbourhoods

To measure the outcomes after implementation of collaboration, three studies were performed. First, because no suitable tools were available to measure the intended outcomes of the collaboration at the level of professionals, a questionnaire was developed. In the second study the quantitative outcomes of the questionnaire, and the qualitative data emerging from the case study, were used to evaluate implementation of the collaboration in terms of process and outcome. The third explorative study compared expected and actual utilisation patterns using standardised insurance claims data.

Thus, Objective III encompassed three aims/sub-studies:

5) to develop a questionnaire to measure outcomes related to implementation of the collaboration between health and social care professionals

6) to obtain insight (by means of a case study) into the changes achieved through implementation of collaboration between primary care, public health and social care

7) to examine the impact of collaboration between primary care, public health and social care on the utilisation patterns of residents in deprived neighbourhoods in two cities
Case studies

This thesis made use of the availability of two pilot projects conducted in deprived neighbourhoods in two Dutch cities that started just prior to the data collection for this thesis.

These pilot projects took place within the context of covenants between: i) ‘Agis Zorgverzekeringen’ (an insurance company taken over by ‘Achmea’ in 2011) and the Amsterdam city region (‘stadsregio Amsterdam’) and the municipality of Amsterdam (‘Naar een vitaal en gezond Amsterdam’), and ii) between Agis and the municipality of Utrecht (‘Utrecht gezond!’). Agis and the Public Health Service of Amsterdam (GGD Amsterdam) and the Public Health Service of the Utrecht district (GGD region Utrecht) approached the department of Public Health of the Academic Medical Center (AMC/UVA) for evaluation. After approval by the Netherlands Organisation for Health Research and Development (ZonMw), the two pilot projects (one in the deprived neighbourhood Amsterdam North, and one in the deprived neighbourhood Utrecht Overvecht) could function as case studies for this thesis.

The aim of the pilot projects was to: i) change the organisational policies and performance of professionals through the implementation of collaboration to match the health needs of the population, and ii) to structurally integrate preventive care into an infrastructure within public health, primary health care and social care. It was expected that this would promote the uptake of preventive care by the population and strengthen the self-management of the population.

Research methods

Data for the sub-studies of research aims 1 and 3 were derived from literature, whereas data for the remaining 5 sub-studies were collected from the two case studies, making use of programme theories and mixed methods (Table 1). Because the pilot projects were still in the process of implementing collaboration
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(making evaluation alone less interesting), the evaluation took place within action research (Øvretveit 1998, Lewin 1995, Funnel & Rogers 2011, Rossi et al. 2003, W.K. Kellog Foundation 2004). This type of set-up enabled to: 1) reveal what was actually achieved in the process of implementation, 2) focus on details and on the implementation approach as a whole, 3) measure/evaluate the intermediate results, and 4) support the implementation. Table 1 presents an overview of the studies in this thesis, the method of analysis used, the study population, and the data resources.

Overview of the thesis

This thesis is divided into three parts.

Part I describes the problems in deprived neighbourhoods from the perspective of patients with multimorbidity (Chapter 2) and from the perspective of the health and social care professionals (Chapter 3). Together, these two studies provide a clearer picture of the problems that collaboration between primary care, public health and social care might help to solve.

Part II explains and interprets the concept of collaboration to elucidate how collaboration can contribute to improve health in deprived neighbourhoods. The underlying rationale is explored in Chapter 4 and the concept is described in Chapter 5.

Part III describes the outcomes of the implementation of collaboration. Chapter 6 describes the development of a measurement instrument, Chapter 7 presents the evaluation of the process and the outcomes of the pilot projects and, finally, Chapter 8 explores the impact of the collaboration on the utilisation patterns of the residents involved.
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