In need of a collaborative response
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CHAPTER 9

GENERAL DISCUSSION

People living in a deprived neighbourhood, with lower socioeconomic status, generally tend to have worse health than those living in more affluent neighbourhoods. In this dissertation, we focus on one possible strategy to improve health in deprived neighbourhoods, i.e. collaboration between primary care, public health and social care. In deprived neighbourhoods, although there is a higher prevalence of unhealthy lifestyles and low self-management of disease there is also less frequent uptake of health-promoting services, presumably because health-promoting services are fragmented and insufficiently structurally embedded within regular care. Collaboration between primary care, public health and social care may be a fruitful strategy to achieve the aim that the health-promoting services become better embedded in the healthcare system and (ultimately) in society, and that the health-promoting services better fit the health needs in deprived neighbourhoods.

The aims of the work in this thesis were: 1) to better understand the health needs of patients living in deprived neighbourhoods and the difficulties professionals encounter in providing care to these populations, 2) to concretise the collaboration between primary care, public health and social care in deprived neighbourhoods and the rationale behind such collaboration as a response to the health needs of the population, and 3) to gain insight into outcomes reached in a case
study after collaboration was implemented between primary care, public health and social care in a deprived neighbourhood. The findings related to these objectives may contribute to the theory base and evidence base of the collaboration between public health, primary healthcare and social care, to foster health improvement in deprived neighbourhoods.

This thesis made use of the availability of two pilot projects conducted in deprived neighbourhoods in two Dutch cities that were initiated around 2006, prior to the data collection for this thesis. The two pilot projects (one in the deprived neighbourhood Amsterdam Noord, and one in the deprived neighbourhood Utrecht Overvecht) functioned as case studies.

**Main findings**

*Part I  Health needs of patients in deprived neighbourhoods*

Two studies were undertaken to better understand the health needs of patients living in a deprived neighbourhood. First, we did a scoping review on self-reported experiences of the healthcare process of patients with multimorbidity (Chapter 2), based on the assumption that these experiences are highly relevant for the experiences of persons in deprived neighbourhoods, because of the higher concentration of patients with multimorbidity in such neighbourhoods. It was found that patients with multimorbidity experienced a mismatch between the problem-by-problem approach used by professionals, and their daily experience of living with multiple diseases (Chapter 2). For example, in the patients’ perspective, professionals had a viewpoint that was too restricted to a single condition and they experienced discontinuity in the care process because it was not adapted to their multiple needs. The main experiences were that: i) professionals lack a ‘holistic view’ and ii) there were system-related difficulties, including (amongst others) a lack of professional-to-professional communication.

Second, a qualitative study was performed among professionals working in the two pilot projects to explore the difficulties health and social care professionals face when delivering care to patients living in a deprived neighbourhood, and their views on what would help overcome these difficulties (Chapter 3). This
provided an understanding of what professionals perceive to be needed for their patients. According to the professionals, the difficulties of providing adequate care to patients in deprived neighbourhoods stem from i) the complexity of their problems, ii) how patients deal with these problems, and iii) the way patients interact with the professionals. These difficulties are interrelated and may accumulate over time. In the interviews, professionals gave their views on what would help overcome these difficulties. These ‘positive enablers’ fell into four categories: 1) professionals knowing each other and working from a shared perspective, 2) activating and coaching patients to take greater responsibility for their own well-being, 3) taking a holistic approach to health, and 4) organising collaboration at the neighbourhood level.

In short, we found that the patients’ needs stem from the complexity of their problems due to multimorbidity, as well as from the difficulties in the interaction between professionals and patients. In addition, professionals perceive difficulties due to the patients’ own way of dealing with problems. Both patients and professionals seem to agree that a holistic approach is needed. Another need that was expressed by patients is that professional-to-professional communication is required; this is in line with the professionals’ view that improvements based on professionals knowing each other better and working from a shared perspective, will help them to better respond to patients’ needs. Professionals also mentioned the need for coaching and activating patients.

**Part II  How does collaboration between primary care, public health and social care, address the health needs of patients in deprived neighbourhoods?**

In the second part of the thesis we aimed to get more grip on the policy theories underlying collaboration between primary care, public health and social care, based on a literature search (Chapter 4). To elucidate how collaboration between primary care, public health and social care could make professionals and the care/support provided in a deprived neighbourhood better fit the needs of patients with multiple problems, two empirical case studies were evaluated (Chapters 5 and 7).

First, we made a theoretical analysis of literature on integration of the delivery of primary care and public health services (Chapter 4). In the literature, three
types of policy theories could be identified regarding why collaboration between public health and primary care would help improve health, i.e. type I ‘Improvement of healthcare system functioning’; type II ‘Improvement of the health of the population’; and type III ‘Population health management’. The first type of policy theory underlying integration of primary care and public health is based on what we labelled as an ‘inside out’ reasoning: because the healthcare system is not functioning (motive), a strong primary care providing public health services which provide better care to individuals and, thus, an improved functioning of the healthcare system (expected outcome), will be achieved through strengthening primary care with more public health services/responsibilities for public health aspects/tasks (process of change). The second type of policy theory underlying integration of primary care and public health is based on ‘outside in’ reasoning: i.e. improvement of population health by a greater reach of public health (expected outcome) will be achieved through primary care performing public health tasks, thereby reaching public health goals through primary care (process of change). The third type of policy theory underlying integration of primary care and public health is the balanced juxtaposition of both sectors: i.e. improvement of health management (expected outcome) will be achieved through collaboration between primary care and public health (process of change).

This last type seems to fit the collaboration exemplified in the case studies and resonates with the Triple Aim concept (Berwick et al. 2008) that unifies three aims: 1) improving the experience of care, 2) improving the health of populations, and 3) reducing per capita costs of health care. Berwick et al. (2008) state that the preconditions for this include the enrollment of an identified population, a commitment to universality for its members, and the existence of an organisation (an ‘integrator’) that accepts responsibility for all three aims for that population. The triple aim essentially implies population health management and, as a consequence, new organisational forms that require the integration of public health and primary care on an equal basis.

Second, we analysed two case studies to see how collaboration between primary care, public health and social care could address the health needs of patients in deprived neighbourhoods (Chapter 5 and 7). Chapter 5 provides a description of the ‘way of working’ as emerged in daily practice in the first 2.5 years of the
pilot projects. This description (clarified by the use of two programme theories) was used throughout the study period to support the development of the projects. Although we found that the definition of the problem and the way of working often differed between each studied neighbourhood, in each of the two projects the emphasis was on getting professionals to think and behave differently.

The project in Amsterdam Noord focused on adult patients with multiple needs in the area of welfare and health care who are insufficiently able to take control of their lives to deal with these problems. The envisaged improvements involved an approach that consists of developing a work protocol (1client-1client supervisor-1plan) and a network organisation, coordination for the work protocol, and supplementary training. The project in Utrecht Overvecht focused on adult patients with an accumulation of problems and risks in multiple areas of life (in all combinations), which manifest themselves in the healthcare and welfare systems as complaints that are perceived by professionals as being rather ‘vague’. Together with professionals and providers, in Utrecht Overvecht a common vision was developed in which the improvement of the patient’s health plays a central role: professionals agreed that they should assist patients in making an active contribution to their own health in terms of behaviour. In addition, the improvements envisaged involved actions (such as Project Relax in Overvecht, in which social workers, public health and primary care professionals worked together to support patients in dealing with psychological complaints), a network organisation, area meetings, and a training trajectory. In both pilot projects, the emphasis was on enabliing professionals to think and behave differently, thereby improving care delivery. The point of departure was the idea that professionals consider, diagnose and treat patients with all their societal, social and healthcare problems as a whole, thereby fitting the ‘Population health management’ policy theory type (Chapter 4). It is often proposed that the structure of the healthcare system has to be modified: summarised by Kodner and Spreeuwenberg (2002) as the ‘integrated approach’. A characteristic of this integrated approach is that processes, structures and systems are designed in such a way that patients receive coordinated and professional services that are geared to one another. In both our projects, in addition to the integrated approach, the strategy was to improve care delivery by challenging professionals to work in a way that was based on a more
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generalist, coaching, and population health based approach.

In Chapter 7 we analysed in more detail how the collaboration between primary care, public health and social care addressed the health needs of patients in the deprived neighbourhoods of Utrecht Overvecht up to 2013. We examined how health and social care professionals renewed their expertise (generalism, coaching and population health orientation) and learned more about the pilot project’s management: this was based on the following principles: 1) learning by doing, 2) working ‘bottom-up’ with direct application in practice, and 3) professionals being given room to experiment. As found in Chapter 5, the development of expertise focused on three inter-related areas: population health orientation, generalism and coaching, as well as development of the collaboration and communication skills necessary to practice them. New ways of communicating with patients, and being sensitive to the realities of their everyday lives, were encouraged. Solutions had to be found for the fragmentation of available services, as well as for patients who were unable to get help or support themselves. Therefore, expertise in generalism was more than just gaining a holistic attitude, it also entailed ‘good stewardship’. Another challenge for professionals was that co-morbidity influences the capacity of self-management. Thus, coaching aimed to ‘activate’ patients by giving them insight into their own possibilities and responsibilities. The intervention’s emphasis on population health orientation helped professionals feel that they were not alone, and that they were facing the challenges of multimorbidity together with other professionals. The pilot project’s management challenged professionals to arrive at solutions together. The room and support given to experiment was seen as crucial, as was the widely-supported mission of the pilot project which brought cohesion to its many activities. The presence of influential professionals capable of ‘thinking out of the box’ and sharing their findings with enthusiasm, worked as a catalyst. The pilot project’s ‘total solution’ (encompassing primary care, public health and social care) led to a way of working that appeared sensible and effective, as it shifted the focus to solving the deeper origins of health problems, rather than merely treating the symptoms. The pilot project’s management was able to unite the different health and social care organisations behind a common goal.

In short, the pilot projects aimed to find a solution for the fragmentation in
primary health, public health and social care and the mismatch between this fragmented system, in order to better deal with the needs of patients with complex problems. Collaboration was instrumental for professionals to take patients’ needs as the starting point and, through knowing each other and working from a shared perspective fitting a population health orientation, merge their way of working to activate and coach patients within a holistic approach, fitting generalism. This integration fits the ‘Population health management’ policy theory type and resonates with the Triple Aim concept.

Part III  Outcomes of implementing collaboration in a deprived neighbourhood
In three different studies, the outcomes of collaboration between primary care, public health and social care were examined. The expertise of the healthcare professionals involved was measured (Chapters 6 and 7) and the care utilisation patterns of the population explored (Chapter 8). One of the case studies took on a slower pace than was expected at the start of the study. Whereas the pilot project in Utrecht Overvecht could bear on the activities that started in 2006 prior to the pilot study (that started end 2008), the pilot project in Amsterdam Noord had its start at the end of 2008. Since the measurement of outcomes in Amsterdam Noord was not yet possible, Chapters 7 and 8 measure and explore the pilot project in Utrecht Overvecht only.

First, we developed a questionnaire to measure the professionals’ gain in expertise using a mixed-methods approach. Because we were not aware of any tools to measure the intended outcomes of the collaboration at the level of the professionals, we developed a 26-item questionnaire and conducted a preliminary validation (Chapter 6). The questionnaire was constructed in four phases, including: i) examining the literature to select and construct items, ii) an expert consultation, iii) a field consultation, and iv) testing the questionnaire. Factor analysis identified six areas of expertise that were central to the pilots; these could be grouped within the three expertise areas of generalism, coaching, and population health orientation:
1. generalism: ‘holistic attitude towards patients’ and ‘consideration of the patients’ social context’,
2. ‘coaching’, and
3. population health orientation: ‘preventive action’, ‘valuing knowledge on local (social) determinants of health’ and ‘valuing knowledge on local facilities’.

Second, in the case study in Utrecht Overvecht, the questionnaire was used to evaluate the outcome of implementation of collaboration between primary care, public health and social care in terms of expertise of the healthcare professionals (Chapter 7). The questionnaire was concurrently used alongside qualitative data (i.e., semi-structured interviews, field observations, dialogue sessions, and documentary review). The qualitative findings show that professionals in Overvecht were developing professional expertise in generalism, coaching and population health orientation during the pilot. Professionals were becoming more adept at understanding the common causes behind patients’ complaints, unravelling their multiple problems, and encouraging patients to be more active in addressing their own health and well-being. A widely-supported mission brought cohesion to the professionals’ way of working. However, these findings were not supported by the quantitative data measuring the professionals’ attitudes.

Third, the outcome of the improved collaboration and renewed expertise among professionals in terms of healthcare use of patients was studied (Chapter 8). Ultimately, the hypothesis was that the changes in healthcare delivery should also impact on the healthcare consumption of GP care and also at the hospital level, e.g. due to the changing referral behaviour of GPs. Since we had access to the Agis Health Database of the major healthcare insurer, we had utilisation data on about two-thirds of all residents in Overvecht. We compared the trends in healthcare use in the period 2006-2011 in Overvecht with the trend in two control districts. It was found that the utilisation of total GP care had increased more in Overvecht than in the control districts. In Overvecht a more pronounced decreasing trend in total hospital use was found as compared to the control districts, in particular from 2008 onwards. In addition, we observed a change in the type of GP care use in Overvecht, i.e. the number of regular consultations, long consultations, GP home visits, and evening/night/weekend consultations, were increasingly
higher than expected. Overvecht also showed the largest decrease between actual and expected use of ambulatory care, clinical care, and one-day hospitalisations.

In short, we found evidence to support the expectation that collaboration between primary care, public health and social care may lead to professionals indeed becoming more adept at understanding the common causes behind the patients’ complaints, and unravelling their multiple problems by working more along the lines of generalism, coaching and population health orientation. In addition, evidence was found to support the expectation that collaboration between primary care, public health and social care might lead to an increase of GP care and a decrease in hospital use.

**Reflections**

**Reflecting on methodology**

A mixed-methods approach was used for the work in this thesis. A broad array of research methodologies was applied, including a scoping literature review and theoretical analysis of policy theories found in literature, semi-structured interviews, observations, a survey, and secondary data analysis. Because the pilot projects were still in the process of implementing collaboration, overall evaluation took place within action research based on developmental evaluation according to Øvretveit (1998). The rationale for applying action research as a research method was twofold. First, studying collaboration is a complex process, implying that the type of research question is exploratory, rather than testing a hypothesis. Second, the case studies were being developed at the same time as the research was being conducted; although this provided the opportunity to explore and guide the implementation, we had to use methods that can be applied simultaneously. Thus, for purposes of generalisation, action research was the most appropriate method as it allows explorative research of cases in development, and also for support.

Below we reflect on some of the methodologies used for our studies and for the measurement of outcomes.
Action research

Action research provides the possibility to: 1) make the process of implementation visible, 2) focus on details and the implementation approach as a whole, 3) measure intermediate results, and 4) support and guide the implementation process (Øvretveit 1998, Lewin 1995, Funnel & Rogers 2011, Rossi et al. 1999, W.K. Kellogg Foundation 2004, Creswell 2013). Nevertheless, despite the opportunities offered, both the pilot project coordinators and the researchers were confronted with difficulties in carrying out action research.

The pilot project coordinators felt supported by the research. For example, at times, the dialogue sessions (Chapters 5 and 7) were very welcome and allowed to reflect on developments and on the relationship with the envisaged end result of the pilot projects. Amid the everyday hustle and bustle, the pilot project coordinators experienced this process of reflection as a welcome aid. The fact that the researchers were able to clarify the perspectives of the various parties involved (who sometimes used the same terms in different ways) was also perceived as being supportive. Based on the literature, the researchers were able to provide new insights that served to clarify the concepts, particularly concerning the envisaged end result, i.e. the integral thinking and acting of professionals. Additionally, the organisations involved in the project appreciated the fact that the researchers were, as it were, an ‘independent’ party. Also, the study was used (in agreement with researchers and pilot project coordinators) to manage the organisations (e.g. as a ‘big stick’; or by distributing a questionnaire). Finally, the papers that have been (and will be) published, support the professionals involved in the pilot projects with regard to the ongoing debate in the Netherlands about how to best organise care to meet patients’ needs in deprived neighbourhoods.

Nevertheless, three difficulties are worth mentioning because there is a considerable chance that these types of problems will also arise in other action research (Bensing et al. 2003). First, tension sometimes arose due to differences in the time frames of the pilot project coordinators and those of the researchers. The researchers needed a clear/comprehensive definition of the problem and of the programme theory. This takes time to consider this properly and, if not all data are available, even more time might be needed to collect additional data. However, in
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the pilot projects, a further clarification of the definition of the problem occasionally caused irritation among the pilot project coordinators, as they considered this to be no longer relevant at this stage of a project that was developing at high speed (Chapter 5). Second, researchers are cautious about making firm statements because they first want to collect and weigh all the evidence, whereas the pilot project coordinators sometimes needed ‘quick statements’ to support urgent policy decisions. Finally, there was some discrepancy between the information in the published papers and the daily actuality of the pilot projects, because it generally takes a relatively long time for papers to be published.

Measuring outcomes

In measuring the outcomes of ‘possibly changed way of the working of professionals’ and ‘possibly changed healthcare utilisation pattern of the patients’ some difficulties were encountered. First developing a measurement tool to measure professionals’ way of working was difficult, because the concept had not yet been crystalised (Chapter 7). In order to stay close to the developments, we consulted the experts involved with the case studies (Chapter 6) and developed one single questionnaire for all types of professionals working in deprived neighbourhoods. However, the quantitative findings were difficult to interpret because it was not clear whether the differences over time, or the differences between intervention neighbourhood and control neighbourhoods, were due to the intervention itself or due to differences between the professions. For example, the GPs might score differently on (one of) the three areas of expertise (population health orientation, generalism and coaching) than the nurses. Also, although the (absence of) changes in expertise may reflect the distribution of respondents across professional groups, the numbers in each group were too small to test in stratified analyses. Despite all this, this study is a first attempt at developing a tool to measure professionals’ attitudes in population health orientation, generalism and coaching. These first steps may serve further development of new measurement tools to evaluate professionals’ renewed expertise. Second, in our exploratory study, difficulty was encountered in measuring the outcome of possible change in the utilisation patterns of patients. Ideally, use should be made of existing databases, with data
on both health and social care utilisation reflecting the integrality of health and social care. Unfortunately, no such database exists (Struijs et al. 2015), as the data and information reflect the fragmented (financial) structures. Although we had the advantage of having access to the Agis Health Database (allowing secondary analyses of utilisation patterns in Utrecht Overvecht and comparison of this with two control neighbourhoods) this only provided information on utilisation patterns for general practice and hospital care, and not for public health and social care.

**Reflecting on promising elements found in the pilot projects to improve health in deprived neighbourhoods**

“GP's in poor areas are prevented from maximising what they could do by failure of provision of the resource that would give the deprived 'an average chance of health’” (Main & Main 2012, p. 293). This quote is in line with the findings in this thesis: that the complexity of problems in combination with the way patients deal with their own problems, and the difficulty of having a fruitful relationship with patients, make it difficult for professionals to provide what the patients need (Chapter 3). Nevertheless, do our findings reveal promising elements in the pilot projects that might compensate for the lower chance of good health in deprived neighbourhoods? The answer is: yes. Two elements proved to be promising: 1) the ‘collaborative response’ and 2) improved possibilities for taking public health measures, in close collaboration with primary care and social care.

**The collaborative response**

The response given by professionals in Overvecht to patients’ health needs consisted of applying a holistic approach, activating and coaching patients, and population health orientation. Also, when different professionals were involved with one patient, the response of these professionals showed consistency as they all aimed at treating the root causes through activating and coaching patients, were sensitive to the realities of the patient's everyday life, and communicated with each other about this (professional-to-professional communication). This consistency was reached because professionals collaborated to develop this response and sha-
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red a mission to bring coherence in their activities. This *collaboration*, facilitated by the projects’ management, also led to the professionals knowing each other, which was supportive of ‘good stewardship’ and useful in maintaining the patient’s trust in the professional’s relationship with them (Chapter 3). We coined the term ‘collaborative response’ to designate this approach, as it encapsulates the response that professionals give that was developed through collaboration, and is maintained when all professionals consistently give the same response.

The collaborative response is a promising element because it might: 1) help to embed services promoting health and healthy behaviour, 2) help overcome difficulties in providing patient-centred care or a ‘whole-person approach’, and 3) help to support patient self-management in deprived neighbourhoods.

1. The collaborative response might help to embed services promoting health and healthy behaviour:

Within the collaborative response, if a patient seeks help, a professional is equipped to: i) unravel the problems the patient presents, ii) understand the patient’s (social) context, iii) activate the patient to take his/her part of the responsibility in dealing with the problems, iv) know what other professionals are able to supply, v) decide with the patient what steps to take to treat the causes rather than the symptoms, and vi) guide the patient in taking these steps that fit the patient’s life. In the collaborative response, professionals take the responsibility to ensure that patients make use of health-promoting services (e.g. exercise), or deal with psychological problems by guiding them to these services. Other health-promoting services, such as coaching patients with healthy behaviour, is also seen as part of the professional’s daily way of working. The shift of focus from illness and cure to health and healthy behaviour, is a *mind shift* that became part of the implementation of collaboration in Utrecht Overvecht in 2006, and resonates with the advice (dating from 2010) issued by the Council for Health and Society established by the Dutch government.
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2. The collaborative response might help overcome difficulties in providing patient-centred care or a ‘whole-person approach’:

There are difficulties in applying patient-centred care (Jani et al. 2012, Starfield 2011) and a ‘whole-person approach’ (O’Brien et al. 2011) to patients with multimorbidity and to patients living in deprived neighbourhoods. Jani et al. (2012) reported that patient-centred care “… may be difficult to achieve in deprived areas because of (...) higher need due to multimorbidity and the resultant time pressures on GPs”. In the study of O’Brien et al. (2011) the GPs mention the ‘dangers’ of identifying problems that they cannot solve if they start applying a ‘whole person’ approach in a deprived neighbourhood. Starfield (2011) points out that patient-centred care generally centres around the management of diseases, and views comorbidity as a number of chronic diseases, while in her view “… good primary care is not the sum of care for individual diseases” and “… focus on specific chronic illnesses is unlikely to lead to improved health, particularly in populations that have high morbidity burdens overall”. Nevertheless, the collaborative response seems promising in that it appears to be able to tackle (some of) these difficulties. The pilot project facilitated more time for the professionals to do their work. It also enhanced the GPs’ possibilities to help patients with problems that the GPs cannot solve, by involving other professionals. Also, within the collaborative response, professionals try to oversee all problems in a patient’s life and the possible interrelatedness, and focus on treating the causes.

3. The collaborative response might help to support patient self-management in deprived neighbourhoods:

The ability for self-management is also questioned when it comes to applying it in a deprived neighbourhood. It is known that patients in deprived neighbourhoods have difficulty in taking responsibility for their own health and well-being (e.g. Goldman & Smith 2002, Vissenberg et al. 2016). Earlier studies also found that activating or coaching patients in self-management supports better health outcomes and better patient experiences (Hibbard & Greene 2013, Bodenheimer et al 2002, Vissenberg thesis 2017). We found that coaching and activating patients was part of the tools that were
developed and used in the pilot project (Chapters 3 and 7). Our professionals gave enough time to the patient to sort out the various problems, helped the patient decide what to do next, and coached them themselves or guided the patient to another professional when needed; in this way the collaborative response could be applied and also support patient self-management in deprived neighbourhoods.

*Improved possibilities for taking public health measures, in close collaboration with primary and social care*

The second promising element is the improved possibilities for taking public health measures, in close cooperation with primary and social care. One possibility that was made use of was in line with the ‘Improvement of the health of the population’ policy theory type: Within the pilot project in Utrecht, public health measures (e.g. preventing vitamin D deficiency) were applied by the GPs to vulnerable groups of patients, such as elderly and migrants. In ‘Project Vitamin D’, but also in other projects such as ‘Project Relax in Overvecht’, public health and primary care (and social care) worked together.

Moreover, in both pilot projects, the professionals were encouraged to adopt a population health orientation. One of the activities of the pilot projects to achieve adoption of a population health orientation, was for pilot project leaders and professionals to analyse together the local demographic and epidemiological data on the use of care/support, thereby defining the problem. A possibility for taking public health measures in close cooperation with primary and social care, is that public health takes stock of the ideas of the primary and social care professionals regarding the underlying causes of this defined problem. For example, a psychologist would explain how some of his/her patients endure considerable stress because of the procedures at the Social Welfare department. These procedures are often too difficult for these patients to deal with by themselves, because they lack the capacity to read (more) complicated letters and/or the social skills to ask for help. Or a social worker would explain how some people ask for their support to find an appropriate house to rent, because the information on renting houses is too difficult for these people to find and/or they do not understand the procedures required to be able to rent a house. By collecting such varied information, close
collaboration has the potential to provide more insight into the problems that need ‘fixing’ outside the realm of health care.

To our knowledge, the professionals did not automatically share their findings with the municipal department of Public Health. We did observe that, when professionals felt able and supported to change the patient’s situation for the better, because the pilot project facilitated this change, they had extensive views on what could work (Chapter 3). However, with regard to public health matters, healthcare professionals may not have experienced this possibility, i.e. they seem unaware/less aware that the municipal department of Public Health could use their input.

Prevention and health top the health policy agenda in many countries (WHO 2016, Berwick 2008, thesis Peters 2016). Our findings show that, in the collection of information to tackle problems outside the realm of health care, collaboration between healthcare professionals and the municipal department of Public Health does not take place without specific effort.

Reflecting on promising elements emerging from the pilot projects, useful for professionals working in deprived neighbourhoods

Here we reflect on the findings of the pilots to see which elements can be considered promising for professionals, in the sense that they might improve the conditions in which they work. Delivering health care in a deprived neighbourhood is tough. GPs experience more stress and frustration when working in deprived neighbourhoods (Popay et al. 2007A, Mercer et al. 2007, O’Brien et al. 2011). Pedersen & Vested even found a higher propensity of burn-out amongst GPs of ‘deprived patients’ (2014). One GP illustrates this in Chapter 7, when saying that she and other GPs “… feel this in their body”. Also, other health and social care professionals (as described in Chapter 3) encountered many difficulties when working with patients in deprived neighbourhoods. Do the pilot projects have the potential to improve working conditions in deprived neighbourhoods for health and social care professionals? The answer seems to be ‘yes’, for three main reasons.

First (as described in Chapter 7) the collaborative response enables professionals to activate patients, to give (or guide) them appropriate care, and work according to a shared mission that brings coherence to their activities at the neighbourhood level. In the words of a GP from Overvecht: “… and that’s so very
nice!! - that’s what makes professionals so happy!!”. Two studies support this reasoning: Mercer et al. (2007) state that more time during consultation has a ‘positive impact on stress and morale’ and Popay et al. (2007) see possibilities in improving referral options, giving GPs more time and help to ‘make their work more satisfying’. In our projects, more time with patients and improved referral options were both part of the collaborative response (Chapters 5, 7 and 8).

Second, working with more satisfaction could alleviate stress, but might also provide the extra ‘breathing space’ to re-energise in order to put in the extra effort needed when working in a deprived neighbourhood. The findings in Chapter 3 show that some professionals put in extra time and effort (such as giving patients a ride so that they can go and exercise, building a fruitful relationship, and making extra telephone calls or writing letters) because this is probably needed when some patients cannot manage by themselves. A Dutch newspaper recently reported another example of such extra efforts: 1 in 5 GPs save up left-over medicine to give to patients who are poor and would otherwise not take the medicine (Algemeen Dagblad, January 23rd 2017: p. 1 and p. 7). Putting in extra time and effort is in line with, for example, O’Brien et al. (2010), Sambale & Mandeville (2011) and Popay (2007a), all of whom underline the need for more effort/resources in deprived neighbourhoods because patients there are in need, as opposed to patients in more affluent neighbourhoods who more likely have ‘the personal, social, and material resources which meant they were capable of looking after themselves without extra input’ and whose problems are more ‘tackable’ (O’Brien et al. 2010). If professionals are able to provide more adequate care and support through the collaborative response, thereby making their work more satisfying, then putting in the extra effort might be less troubling.

Third, in the pilots, the collaborative response might have fuelled an interdisciplinary learning curve among the professionals, allowing them to see the larger picture. Through the initial multidisciplinary discussions, professionals exchange their views and expertise which helps them to better understand the root causes of multimorbidity in deprived neighbourhoods.

Reflecting on the question ‘What next?’
The studies in this thesis helped to get a better understanding of the health needs
of patients in deprived neighbourhoods and the difficulties that professionals encounter in the related healthcare delivery. Basically, at the moment, professionals and the healthcare system are not adapted to patients with multiple problems who experience difficulties with managing their own health. Further, this thesis concretised how and why collaboration between primary care, public health and social care could meet this problem in healthcare delivery in deprived neighborhoods. In fact, collaboration appeared to serve as a ‘vehicle’ to bring professionals together to develop competencies for generalism, coaching, and population health orientation, as well as the communication and collaboration skills necessary to employ them. Applying these competencies and working from the shared perspective that all professionals in the neighbourhood should apply these competencies, provides a collaborative response to the health needs of patients in deprived neighbourhoods.

In the final section, we reflect on the implications emerging from the lessons learned from our studies for practice, education, policy and research.

**Practice**

The data collection for this project ran until 2013. Meanwhile, new programmes have been and are being developed in the Netherlands to achieve more collaboration between primary care, public health and social care. For example, the Dutch Ministry of Health designated nine regional innovation initiatives as ‘pioneer sites’ in which “healthcare providers, insurers and often stakeholders like municipalities and representatives of citizens/patients are working jointly” to achieve better health, and improved quality of care and cost control (referred to as Triple Aim) (Drewes et al. 2015). Another example is the aim of the National Institute for Public health and the Environment (RIVM) and the Dutch Society for General Practitioners (NHG) in the project ‘Prevention in the neighbourhood’ (‘Preventie in de Buurt’) for more prevention by GPs in the neighbourhood. They focus on supporting public health and primary care to collaborate with professionals from other domains (https://www.loketgezondleven.nl/over-ons/programmas-rivm-centrum-gezond-leven/preventie-de-eerstelijnszorg). Also, the incentive pro-
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Gramme ‘Healthy in...’ (stimuleringsprogramma ‘Gezond in...’) was initiated by the Ministry of Health, Welfare and Sport. This programme is implemented by Platform 31 and Pharos, the Dutch Center of expertise on health disparities. They support 164 Dutch municipalities in decreasing health inequalities. One of the trajectories for this is advising municipalities to create ‘synergy circuits’, e.g. synergistic cooperation between primary care, public health and social care and other policy areas, and with other partners (https://www.gezondin.nu/thema/synergie-circuits). Another example, is the programme ‘Everything is health’ (‘Alles is gezondheid’), which aims to support a social movement towards healthier living. None of these programmes stands alone, but all fit into a wider social and political movement in Dutch health care.

At this moment, developing new ways of working in deprived neighbourhoods to better fit the health needs, is still in the pioneering stage. The findings from this thesis and from the related programmes do not yet provide sufficient insight to scale-up to all deprived neighbourhoods. Additional research is needed which should support the programmes and fill the gaps in knowledge. Evaluation, possibly within action research, and programmes and pioneering initiatives in the field can be strong allies. The initial findings provide some connecting factors, such as the promising elements described in this thesis, the mind shift from illness and cure to health and healthy behaviour (RVZ 2010), ‘positive health’ a recent definition of health by Huber et al. (2011), and the recent advice given by the National Health Care Institute to the Dutch government. It is not without reason that the pilot project in Utrecht Overvecht is mentioned as an important example.

Policy

In the Netherlands, in 2015 an advisory report was issued by the National Health Care Institute for the Dutch government, and was received by both the Minister of Health, Welfare and Sport and the Minister of Education, Culture and Science. The advice, ‘Naar nieuwe zorg en zorgberoepen: de contouren’ (Kaljouw & Van Vliet 2015), makes a plea to use patients’ needs as the starting point for rethinking the expertise of professionals and the organisation of health care. In 2016 the advice was followed with a proposal for the ‘Education-continuum for health care’
based on the advisory report (Van Vliet et al. 2016) ‘Anders kijken, anders leren, anders doen’. In the proposal, the committee places permanent education/training of both health and social care professionals at centre stage, as well as working in an interdisciplinary way to offer ‘care arrangements’ that fit the diversity of needs of patients. The committee offers clear perspectives on health, stimulating a focus not only on health care, but also on prevention. The committee strongly advises the government to support people to live a healthy life by means of education, employment, income and the social/physical environment, all supporting healthy behaviour. The findings emerging from this thesis support both the initial advice and the proposal.

Education

The mismatch found between the health needs and care, emphasises the importance to equip future professionals in their education. During their education, future GPs, as well as social workers, nurses, physiotherapist and other health and social care professionals, could be prepared to respond to complexity. Education in this direction could include practical tools such as the ‘teach back method’ (Roberts et al. 2012) and the 4Domain-model developed in Utrecht Overvecht (http://www.stichtingvolte.nl). Cultural competence (thesis Seeleman 2014) and competence to communicate with people with different levels of health literacy (Fransen et al. 2011), as well as the competence needed to treat multimorbidity (Plochg et al. 2009, Plochg et al. in press) could be part of this education. In addition, being able to work with professionals from other disciplines could be dealt with, as is also encouraged by the WHO in the ‘Framework for action on interprofessional education and collaborative practice’ (WHO, 2010).

Research

Some important questions need addressing before a collaborative response can become more mainstream, and close collaboration between primary care, public health and social care can be introduced as an additional way to gain insight into the problems that need ‘fixing’ outside the realm of health care. Based on our
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findings, a good starting point would be to further investigate Utrecht Overvecht, because various investments have already been made there to initiate a collaborative response. Also, a recent theoretical argumentation was given for one of the key tools developed in the pilot project (4Domeinen-model, also described in Chapter 7 of this thesis). In this theoretical argumentation, Leemrijse et al. underline that working with this tool (and collaborating, attuning care, and building fruitful relationships with patients) in theory could lead to improved health care in the neighbourhood and decreased hospital care (Leemrijse et al. 2016). It is important to know whether support is still needed in Utrecht Overvecht to maintain a collaborative response, including use of the tools that were developed. Also, when professionals still apply a collaborative response, what is needed to maintain a collaborative response among the professionals? An article by one of the GPs involved in Utrecht Overvecht published in a Dutch journal for GPs (Medisch Contact) made a plea for more time and resources (Smits et al. 2017). This might indicate that the investments made during the pilot project were insufficient. Further research could then focus on the effects on patients, job satisfaction of professionals and, eventually, on healthcare costs.

Nolte and McKee (2008) emphasise the need for evaluation and monitoring of new care models to better respond to the increased burden of complex chronic disease. Struijs et al. underline the importance of more knowledge on governance in ‘population centred services that improve population health’, on involving the population, on payment models and on methodological issues (Struijs et al. 2015). Those initiatives that are active now, and others that are starting to improve health in deprived neighbourhoods through collaboration between primary care, public health and social care, should receive all the support required to achieve their goals, accompanied by related research to support the need for monitoring and evaluation.
Conclusion

To conclude, the work presented in this dissertation focused on one possible strategy to improve healthcare delivery in deprived neighbourhoods, i.e. collaboration between primary care, public health and social care. In a case study, this collaboration led to a collaborative response to the health needs of patients in a deprived neighbourhood: public health, primary and social care professionals apply generalism, coaching and population health orientation, using collaboration and communicating skills, and with a shared mission bringing coherence to their activities underlying this approach.

Two promising elements of this strategy sufficed. The first is that the collaborative response might help to: i) embed health promoting services, ii) overcome difficulties in providing patient-centred care or a ‘whole-person approach’, and iii) support patient self-management.

The second promising element is the improved possibilities for taking public health measures, in close collaboration with primary and social care. Public health could use these insights to take action. Within the pilot projects, a structure was built that allows professionals to share the findings that emerge from what they experience when working with patients, because the department of Public Health took on a supportive and facilitating role. The professionals learned to look with a ‘population health perspective’ and could probably detect causes of problems in the neighbourhood and share this information with the public health department. The fact that this possibility embedded within collaboration was not self-evident in the pilot projects, gives reason to believe that specific efforts are required for this purpose.

This thesis aims to contribute to a better understanding of how a fit between health needs in deprived neighbourhoods and the healthcare system could be improved. Pioneering is necessary, supported by appropriate evaluation research. The time seems ripe, especially since the pilot projects do not stand alone but are part of a wider socio-political movement in Dutch health care.

All this calls for strengthening of care in which the health needs of patients, health and healthy behaviour are central, and also fit with the competencies of the professionals, all embedded in a facilitating and supportive structure.
References


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http://www.stichtingvolte.nl


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Wijk Overvecht. Nivel


In need of a collaborative response


