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Chapter 1

Introduction

Health care delivery in all countries can be improved. This firm conclusion is based on findings that show persistent discrepancies between perceived demands and needs on the one hand and the organisation, governance and actual performance of health care on the other. There are various views on how to bridge the gaps and governance strategies have been focusing on approaches such as planning, self-regulation and regulated competition. Although the policy rhetoric's flourish, the evidence behind these strategies in achieving improved population health is weak.

The title of this thesis, 'Building a Tower of Babel in Health care?', refers to the notion that there is no universal remedy at hand to improve health care delivery although there seems to be a common goal. As a metaphor, the title stands for the prospect of improving the organisation and governance of health care delivery and the deemed failure in doing so. Confusing languages inhibit politicians, policy makers, financiers, managers, professionals and patients to take joined action and to really bridge the gaps between the demand and need for and the supply of health care. The question mark is crucial as it puts the metaphor into perspective and makes a research topic of it. Hence, this thesis explores, in theory and in practice, how to reconcile the coexisting languages of health care actors to achieve better health care. The strategic vision of 'community-based integrated care' will be put forward as an Esperanto that serves this purpose.

In this introductory chapter, 'community-based integrated care' is introduced and positioned in relation to other visions on improving health care. The first subsection sketches the issue of health care performance using notions from systems theory. The second
subsection discusses ‘need’ and ‘demand’ in relation to the organisation of health care. The third subsection considers how the strategic vision of ‘community-based integrated care’ fits in with prevailing governance practices. The closing subsection sketches the research questions and outline of the thesis.

Health care performance

Many hold that the performance in health care could be better. This is the dominant view among policymakers and academics worldwide, which has been put forward in various international and national reports as well as in scientific writings [1-3]. The need for improving health care is substantiated by evidence that demonstrates widespread shortcomings such as poor quality of care, practice variations, persisting preventable medical errors and injuries, inexplicable differences in costs, health inequalities, lack of accountability, and fragmentation of care [4-10]. Against this background it is not surprising that health care performance and improvement have drawn major attention.

As a result of this attention, a large variety of strategies, instruments and tools have been developed that differ in purpose, perspective and scope. Nevertheless, their underlying theories and problem definitions seem to originate from a few core approaches that have evolved overtime. One of these is the ground-breaking framework of Donabedian who characterized the system of health care delivery in terms of ‘structure, process and outcome’ [11]. In his framework, performance is the resultant of the triad between these three concepts. Another approach is the use of health targets in health policy as introduced under the label of ‘management by objectives’ and further developed by the World Health Organisation (WHO) [12,13]. Performance in this regard is the attainment of health targets that are set in advance to structure and rationalise health policy issues by focusing on outcome, strategy, productivity, marketing and innovation. In a ‘systems’ approach, performance has to do with how well the interdependent elements, which constitute a system, interact to achieve its common purpose [14]. In a health care system, popula-
tion health provides an operationalisation of purpose -i.e. health targets. This implies that instead of isolating smaller and smaller parts of the health care system, 'systems thinking' works by expanding its view to take into account the wider system's interactions in relation to its overall health effects on the population at large. Although population health as the purpose of a health (care) system is a normative notion in itself, it is as a principle widely underscored in (inter)national policy documents [1,12,13].

'Systems thinking' predominantly underlies recent analyses and strategies to improve health care performance albeit often implicitly. This has to do with the upsurge of economic and managerial agendas over the last decades by health care policy makers [15,16]. With these agendas, defining health care in terms of a 'market' came along. In economic theory, the functioning of a market is analysed by investigating how well the supply of services or goods matches the demand of consumers [17]. From this perspective, the flawed performance in health care is attributed to a growing discrepancy between supply and demand. Providers are insufficiently able to deliver care services that meet consumer demands. The impetus for this discrepancy are common trends such as the ageing of populations, the increase of chronic and intermittent diseases, the rapid technological and scientific advancements, and the need to curb public expenditures. The accumulated impact of these trends in most industrialised countries is that the organisation of health care is insufficiently able to keep pace with the growing and changing demands [1-3,18]. Thinking in terms of supply and demand leads towards the straightforward solution that health care can be improved by making its organisation and development more demand-driven. However, the concept of demand has multiple meanings and is interpreted in different ways. Consequently, the issue arises what interpretation or conceptualisation of demand should be elevated as the leading principle in health care.
Demands and needs in relation to the organisation of health care

The concept of ‘demand’ in relation to ‘supply’ is essentially about the question how to make health care providers and/or financiers responsive to the wishes and preferences of consumers, whether a patient, insured or the public. Hirschman (1970) distinguished two options [19]. The first option is called exit and is key to economist thinking and analysis. The basic idea is that consumers should be given a choice among competing care providers and/or financiers combined with the financial incentive to purchase those services that offer the best value. If the performance falls short, they will become dissatisfied and purchase their services elsewhere. This mechanism would provide care providers and/or financiers with the stimulus to get their act together and perform better.

The other option is voice that means protest, political pressure and complaints. Consumers express their dissatisfaction or wishes directly to the care provider or indirectly to others whilst attempting to influence the service delivered for the better. There are numerous ways consumers can do this, both collectively and individually. For example they can state their views when asked, become active in politics or participate in decision making processes. Full voice would essentially mean patient or citizens’ control. However, it may also be consultation through patient councils or organisations only. Voice as defined by Hirschman is an abstract concept that underlies other concepts studied from multiple disciplines and perspectives. One of these is the empowerment concept. Individuals and their communities should be engaged in learning processes in which they create and share knowledge in order to control, change and improve the quality of their own lives and societies -i.e. to learn expressing their voice and influence responsive organisations. Through empowerment, individuals not only manage and adapt to change but also contribute to/generate changes in their lives and environments [20]. In health care, empowerment is used for health promotion purposes (i.e. improving health behaviour) as well as for involving residents in health policy making thereby increasing the responsive-
ness of the system to the values and believes of the community.

As health is not merely an individual good but also a collective one, the demand for health care is more than the sum of health care seeking behaviours of individuals (exit) or expressed wishes, preferences and complaints (voice) only. There are situations where those in need of care cannot demand care, as they are unknown, unable or unwilling. The discipline of public health, defined as the collective action for sustained population-wide health improvement [21], holds that societies have, or should have, considerable interest in sustaining and improving population health. For example societies have an interest to control communicable diseases, to have mental health care services, and to stimulate health as it co-produces wealth [22]. Therefore, it is argued that the supply of health care should match population health ‘needs’ (i.e. as objectively measured by observing the occurrence of diseases and limitations in a population) rather than the ‘demands’ of individual patients.

Whether the supply of health care should match population health needs or demands through exit or through voice, is an important debate, though normative in nature. In the end, the choice depends on one’s position concerning the issues of solidarity, the welfare state, and how one defines the ultimate purpose of health care. Still, many sign up to the standpoint that health care should not only contribute to, but even maximise population health. Why should we have a health care system otherwise? The strategic vision of ‘community-based integrated care’ is built upon the same position. It promotes a consistent public health orientation in health care policy making, which implies that population health needs should be leading. Moreover, ‘community-based’ in this regard also means that the community level is taken as the entry point for matching health care services to the health care needs as well as for involving, or even empowering, the community residents in their own health care. A sense of ownership and involvement of the community is crucial for improving population health. So, the strategic vision of community-based integrated care also builds on principals and tools from the ‘empowerment movement’ and thus demand expressed through voice.
Elevating population health needs as the leading principle has consequences for the organisation of health care supply, which is represented by another key element of ‘community-based integrated care’. ‘Integrated care’ refers to the critical transformation of the supply of health care services that should be made in order to maximise population health in the 4th stage of epidemiological transition. Health needs have changed considerably, as illustrated by the growing number of patients with chronic, intermittent and complex diseases who need care from multiple care providers working across different settings. As the current supply is too patchy, health care services have to be integrated [10,23,24]. It can be defined as the bringing together of inputs, delivery, management and organisation of services as a means of improving quality, access, user satisfaction and efficiency [25]. As such, ‘integrated care’ is a managerial concept that draws on theories from the management sciences.

‘Community-based integrated care’ thus represents a strategic vision that encompasses various elements derived from economic theory (bridging supply and demand), public health (population health needs and beliefs expressed through mechanisms of voice and empowerment), and management theory (organisation of integrated delivery systems). The next subsection introduces how the strategic vision of ‘community-based integrated care’ is embedded in prevailing governance models.

**Prevailing governance models**

The practical problem is that health care will not automatically reorganise itself via ‘community-based integrated care’ towards improved population health. This calls for interventions that facilitate the desired reorganisation to occur. Under the label of governance, these interventions are developed and enacted. The term refers to decision-making processes in public administration or within organizations. Its main functions are formulating strategic policy direction, generation of intelligence, exerting influence through regulation and ensuring accountability [26]. It takes place at different levels (national, regional, local) and can encompass the health sys-
tem as a whole (i.e. 'Stewardship') or the health care sector only.

Notwithstanding large differences across countries, national governments are currently preoccupied with developing and implementing 'market style' governance models [27-29]. The critical question is how the strategic vision of 'community-based integrated care' fits in with these. It is noticed that the embodiment of the key elements of 'community-based integrated care' is not self-evident. For example, studies have shown that population health considerations are not central in the reforms [30-33]. There are also doubts that providing public information on health care performance to consumers suffices to make the system more responsive to the preferences, beliefs and wishes of patients [34,35]. And, the profitability of integrated services in a context where care providers have to compete is questioned [36]. Moreover, Freidson (2001) argues that whatever governance model is chosen, it never will exist in its purest form but rather be a mixture of three ideal types of governance [37]. Due to the preoccupation with 'market-style' models, many health care actors seem to overlook this notion and ignore the influence and value of the governance through 'governmental planning' and 'professional self-regulation'. Despite that, past experiences with planning and self-regulation have their limitations in embedding the key principles of 'community-based integrated care' as well [38-40].

Thus, the key elements of the strategic vision of 'community-based integrated care' are not systematically embedded in the existing governance practices. Against this background, it is relevant to study in more detail the potential of 'community-based integrated care' to function as a strategic vision to improve the performance in health care. This calls for a more exploratory or inductive approach that studies the vision in theory and in practice, and from a broader 'systems' approach that combines and synthesises existing knowledge and theories. This thesis aims at providing such an exploratory study.
Central questions and outline of the study

The following two research questions are central to this thesis:

1) What is ‘community-based integrated care’ and how can it theoretically bridge the gap between population health needs and health care delivery? (conceptual question)

2) How is the strategic vision of ‘community-based integrated care’ embedded in the organisation and governance of health care delivery in Amsterdam Southeast? (empirical question)

The conceptual research question will be addressed in the first part of the thesis (Chapters 2+3). Chapter 2 theoretically evaluates the limited effectiveness of quality improvement activities in health care from a broader ‘systems thinking’ perspective that takes a population health orientation as the starting point. The aim is 1) to provide an outline of these activities and their underlying rationales; 2) to elaborate on the reasons why their effectiveness has been so limited; and 3) to infer a fertile approach that can synergistically embed all quality improvement efforts within healthcare systems - i.e. ‘community-based integrated care’. The practicability of the inferred approach is illustrated by relevant developments in the Academic Medical Centre/University of Amsterdam.

Chapter 3 theoretically explores the tensions between doctors and managers. This is relevant because ‘integrated care’ as a key element of ‘community-based integrated care’ originates from management science. From the literature, it is well known that the implementation of managerial policies often fails as they run counter to the logic of professionalism [41,42]. For this reason, the chapter provides a theoretical underpinning of the tensions that helps us to better understand and anticipate the practicability of, in this chapter, ‘clinical governance* activities. The thinking is framed by a theoretical perspective that combines the insights from sociologists’ theories on

* ‘Clinical Governance’ is a British policy concept introduced in 1998 by the NHS Executive. It is defined as a framework through which NHS organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care by creating an environment in which clinical excellence in clinical care will flourish [44].
'professionalism' and administrative scientists' theories on 'management science'. It provides new meaning to existing knowledge and developed quality improvement strategies as well as the agenda for a constructive dialogue.

The second part of the thesis presents the case study that has been conducted to address the empirical research question (chapters 4-7). The case study is built upon a series of four purposeful chosen stud-

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Figure 1.1 Potential scope of studied collaborations

ies in the South-eastern Amsterdam district. This region accounts for approximately 85,000 residents of whom 7,000 (8%) are older than 65, and 64% belong to an ethnic minority [43]. A variety of health care providers are located and/or active in the area, do collaborate and deliver a broad spectrum of services to community residents: 1 Academic Medical Centre, 1 nursing home, 4 residential homes, 1 public home-care agency, 1 public health agency, 1 social care agency, 5 primary care centres and 1 institution for psychiatric care. Each study takes another angle in order to obtain a kaleidoscopic view of the embodiment of the strategic vision of 'community-based integrated care' in the daily practices of health care delivery in Amsterdam Southeast. This is achieved by studying most of the aforementioned organisations at the policy or at the micro level.

The following four angles were chosen: 1) the governance practices of the municipality of Amsterdam and Agis, the care insurer with the largest market share in Amsterdam; 2) the shared governance practices of care providers through a 30 year old community health
partnership, called the Zizo; 3) collaborative initiatives of the Academic Medical Centre / University of Amsterdam in 2003/2004; 4) the intermediate care model between the Academic Medical Centre and the Henriëtte Roland Holsthuys, a residential home. It was examined whether or not the strategic vision of 'community-based integrated care' could be recognised. This implies that the scope of the studied collaborations could turn out to be 'com-

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<td><strong>Chapter 2</strong> To theoretically explore the reasons for the limited successes of existing strategies to rationalise and improve health care delivery and to infer a practical approach that can synergistically embed these strategies in health care</td>
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<td><strong>Chapter 3</strong> To theoretically explore the tensions between doctors and managers and to infer practical solutions that might ease them</td>
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<td><strong>Chapter 4</strong> To explore the scope of community-based integrated care in the governance practices of the municipality of Amsterdam and Agis, the major care insurer in the region</td>
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<td><strong>Chapter 5</strong> To retrospectively describe and explore the development of the Zizo partnership and its collaborative activities in relation to its context</td>
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<td><strong>Chapter 6</strong> To identify, describe and characterise all collaborative initiatives of the AMC with local care providers in 2003</td>
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<td><strong>Chapter 7</strong> To evaluate the functioning of an intermediate care model between the AMC and a local residential home</td>
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Chapter 4 kicks off with the exploration of the health system governance practices of the municipality of Amsterdam and Agis. The aim of this study is to explore whether the notion of 'community-based integrated care' is reflected in their practices. In other words, do both leading organisations direct the local health system

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<td>A 'systems thinking' perspective</td>
<td>Theoretical interpretative study based on literature</td>
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<td>A twofold perspective combining theories on professionalism and on management science</td>
<td>Theoretical interpretative study based on literature</td>
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<td>A 'community-based integrated care' perspective</td>
<td>Exploratory study based on qualitative methods</td>
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<td>A 'community-based integrated care' perspective combined with a 'network theory'</td>
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<td>A 'community-based integrated care' perspective</td>
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<td>A 'systems thinking' perspective supplemented by theories on implementation and quality systems</td>
<td>Process evaluation based on qualitative and quantitative methods</td>
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[17]
towards the health needs of the Amsterdam community and stimulate collaborative arrangements to adequately meet them. The study is based on a qualitative design consisting of document analyses, semi-structured interviews and a concise literature study.

Chapter 5 continues by retrospectively examining how local health care providers in Amsterdam Southeast collaborated for more than 30 years in interaction with the changes in Dutch healthcare. The aim is to explore whether the notion of 'community-based integrated care' was manifest in the activities of the partnership and whether it sustained over time. The study design features semi-structured interviews, document analysis and a literature study.

Chapter 6 features a descriptive evaluation of collaborative initiatives between the AMC and local health care providers. The aim is to systematically identify, describe and characterise these initiatives. The AMC plays an important role in the community, since it has explicitly adapted a 'community-based integrated care' strategy to secure and fulfil its academic core functions in patient care, science and medical education [45]. Data were primarily collected through structured face-to-face interviews.

Chapter 7 focuses on the functioning of the intermediate care model between the AMC and a local residential home, the Henriëtte Roland Holstuis. Representatives of both partners expressed concerns about how the model was functioning, and needed information to make informed decisions on how to improve the quality of care. The aim was to quantitatively and qualitatively explore whether the patient population admitted to the model was in accordance with the targeted population and how the quality of care was ensured.

Overall, the thesis is divided into a theoretical and an empirical part encompassing 6 studies in total. Table 1.1 provides a concise outline. The final chapter 8 summarises the findings, discusses the methodological limitations, and draws some implications for scientists, policy makers, financiers, managers, and professionals with special reference to the Amsterdam Southeast situation.
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