Plochg, T.

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Chapter 4

Local health systems in the 21st century: who cares?
An exploratory study on health system governance in Amsterdam

Abstract

Background: There is a growing awareness that there should be a public health perspective to health system governance. Its intrinsic population health orientation provides the ultimate ground for determining the health needs and governing collaborative care arrangements within which these needs can be met. Notwithstanding differences across countries, population health concerns are not central to European health reforms. Governments currently withdraw leaving governance roles to care providers and/or financiers. Thereby, incentives that trigger the uptake of a public health perspective are often ignored.

Methods: In this study we addressed this issue in the city of Amsterdam. Using a qualitative study design, we explored whether there is a public health perspective to the governance practices of the municipality and the major sickness fund in Amsterdam. And if so, what the scope of this perspective is. And if not, why not.

Results: Findings indicate that the municipality has a public health perspective to local health system governance, but its scope is limit-
ed. The municipality facilitates rather than governs health care provision in Amsterdam. Furthermore, the sickness fund runs major financial risks when adapting a public health perspective. It covers an insured population that partly overlaps the Amsterdam population. Returns on investments in population health are therefore uncertain, as competitors would also profit from the sickness fund’s investments.

Conclusion: the local health system in Amsterdam is not consistently aligned to the health needs of the Amsterdam population. The Amsterdam case is not unique and general consequences for local health system governance are discussed.

Introduction

The ‘performance crisis’ in healthcare invoked the World Health Organisation (WHO) to reemphasise the potential of public health in directing health systems [1]. This renewed interest is also articulated in the ‘new public health’ agenda [2-4]. Public health should be broadly defined as the ‘collective action for sustained population-wide health improvement’ [5]. Derived from this definition, leading the entire health system and ensuring collaborative action are designated public health functions. The former is aligning the policies and services within a health system to the needs, beliefs and values of the entire population it is considered to serve. The latter ensures collaborative arrangements across sectors in which these needs can be met. Both functions should be incorporated in governance practices [6-8]. It would foster more rational, effective, efficient, responsive and equitable health systems—at least in theory. Governance 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 [9]. It takes place at different levels (national, regional, local) and can encompass the health system as a whole (i.e. ‘Stewardship’) or the healthcare sector only [1,10].
Notwithstanding a growing awareness of the importance of a public health perspective as put forward by the 'new public health', this is not obvious in European governance practices. National governments currently take up a supervisory role and deregulate in order to facilitate entrepreneurial behaviour [11,12]. Care providers and/or financiers such as primary care trusts in England or sickness funds in Germany and The Netherlands are considered to purchase health and healthcare services [13-16]. The question is whether these non-governmental actors will do this from a public health perspective and whether the scope of their practices would be broad enough [17]. If not, European reforms may fail to realign health systems to the needs of their populations. The relevance of this issue can be illustrated by the current situation in The Netherlands.

The Dutch health system is designed into four sectors (see figure 4.1), which are regulated and financed through a mixture of private and public insurance schemes, and municipal budgets [18,19]. Consequently, no single actor is responsible for aligning the health system towards population health and initiate collaborative arrangements. Municipalities have the statutory responsibility to govern the public health and social care sector. Sickness funds are responsible for governing the acute and long-term care sectors (i.e. healthcare). Unless municipalities and sickness funds collaborate, there is no guarantee that Dutch local health systems are coherently governed from a public health perspective.

We explored the situation in the city of Amsterdam where the municipality and Agis (the sickness fund with the largest market share) govern the local health system. We interpreted whether a public health perspective is reflected in their practices. The following research questions have been addressed: 1) Is there a public health perspective to the local health system governance practices of the municipality of Amsterdam and Agis? 2) If so, what is the scope of this public health perspective? 3) If not, why not?

The Amsterdam context is interesting in this regard. The city has the oldest and one of the largest Municipal Health Services of the Netherlands. Since its foundation in 1901, this service has planned,
The four sectors in the Dutch health system

<table>
<thead>
<tr>
<th>Public Health</th>
<th>Acute Care</th>
<th>Long-term Care</th>
<th>Social Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Governed by Municipalities</td>
<td>Governed by Sickness funds</td>
<td>Governed by Sickness funds</td>
<td>Governed by Municipalities</td>
</tr>
<tr>
<td>Provided by Municipal Public Health offices</td>
<td>Provided by Private professionals and institutions</td>
<td>Provided by Private professionals and institutions</td>
<td>Provided by Municipalities</td>
</tr>
<tr>
<td>Financed through Municipal budgets and 'AWBZ'</td>
<td>Financed through 'ZFW' and private health insurance</td>
<td>Financed through 'AWBZ'</td>
<td>Financed through Municipal budgets</td>
</tr>
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</table>

LEGISLATION

supported and provided local health(care) services as a delegate of the Amsterdam city council [20]. Furthermore, Agis and its predecessors traditionally had a community orientation and were engaged in governing healthcare in Amsterdam [21]. Foremost, the system is increasingly under pressure. This is fairly due to the large, diverse and complex health needs of the Amsterdam population [22]. Another pressure comes from the high degree of urbanisation, which brings along a large number of providers in a dense area. Consequently, it is difficult to organise a continuum of service delivery. This is compounded by the foreseen shortages in the professional workforce [23,24]. So, the urge to redirect the health system of Amsterdam is high. As such, the embodiment of both public health functions seems warranted, but also fertile given the history and tradition of both organisations.

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Methods

Data collection
An exploratory, qualitative study was considered appropriate because the intent was to interpret the perspectives of the municipality and Agis. As the former is a public organisation, we could easily retrieve data from municipal documents and by attending public debates. The documents were downloaded from Internet sites (i.e. the City Council, the Municipal Health Service and the Societal Development Service in Amsterdam) and collected via public officials. Selected documents included official policy reports, working documents, research and discussion papers, and minutes of conferences (appendix 4.1). Public debates on local health policy were held in the light of the 2002 city council elections and on the local health policy plan released in December 2003. These debates were attended by citizens, professionals, executives of Agis, public officials and local politicians. We observed these debates and made notes of relevant notions. In addition, we obtained the minutes that were made of these debates.

To obtain a deeper insight in the perspective of Agis, we conducted semi-structured interviews with 10 executives of Agis selected 'purposively' for their position in the organisation (appendix 4.2). In 2003 two interviewers interviewed them at their places of work using an interview guide, which was developed around the research questions (appendix 4.3). During the interviews, the guide was used in an informal and flexible way to prevent the interviewers from imposing their own preconceptions. The interviews took approximately one and half hour each, were recorded and later transcribed.

Data analysis
The data were analysed against the concept of 'community-based integrated care' [8]. We used this concept to operationalise the aforementioned public health perspective. It falls apart into 'community-based care' and 'integrated care'. The former term was defined as a health system that is governed on the basis of community
health needs and is responsive to the beliefs, preferences and societal values of residents who can participate in the policy making processes. The latter term generally means bringing together inputs, delivery, management and organization of services related to diagnosis, treatment, care, rehabilitation and health promotion. [6]. We narrowed this definition down to the consistent exercise of authority to ensure collaborative action across the four health care sectors. With these definitions in mind, one researcher coded the transcripts and documents.

To validate the analysis, we used different strategies. First, we tried to verify crucial findings in all three data sources. Second, we solicited feedback from the three key respondents of Agis and one senior official of the Municipal Health Service. Third, the research team monitored the data collection, analysis and emerging findings (peer review). Last, the emerging findings were contrasted with the literature.

Results

The perspective of the municipality
The municipal perspective was on facilitating rather than on governing health care provision. The municipality held a public health perspective, but did not use it to really govern the health system. The starting point is that a community orientation was intrinsic to the municipality. A municipality is by definition responsible for a geographically defined community [25]. Logically, the collection and use of community information in policy making was visible throughout the documents. Policies were prioritised and developed on the basis of community information. This was illustrated in the Healthy Living in Healthy Amsterdam memorandum:

'Two basic choices are made in the memorandum. First of all, that the state of health of the Amsterdam population is the basis for setting priorities, policy proposals and interventions. And, in the second place, that the course of people's lives is to be the focus.' [a]

This community orientation enabled the determination of care gaps between the four sectors. In various documents, incoherence in
the supply of services was highlighted as a major issue. Exemplifying was the need for coherence between housing, long-term care and social care. Owing to the deinstitutionalisation of elderly services, the need for tailored elderly services at home is increasing. As responsibilities for planning, organising, financing, and providing these services are divided over numerous actors, the need for coordination is high [b-d]. Similar problems were also recognised in other fields such as youth care, emergency mental health care, and support facilities for vulnerable groups [e-i].

Still, the municipality was cautious in governing health care and resolve the identified problems. This was motivated by the lack of power, means and resources. This was also observed during the public debates. Local politicians explicitly rejected a more leading role for the municipality in healthcare. Consequently, municipal activities strongly reflected the municipal statutory duties in healthcare.

'Municipalities have a limited influence on care; municipalities have no powers over the parties in the care sector. (...) Responsibility for the range of options, quality and funding of health facilities does, after all, rest with the care insurer, while the care providers are responsible for the implementation. In the sense of indirect facilitation the municipality can assert its influence by assuming a director’s role.' [a].

However, three types of activities could be identified that seize upon municipal responsibilities and aim at creating more coherence in healthcare governance. First, the municipality was bringing together relevant actors (e.g. providers, sickness funds, housing associations, district authorities). Various collaborations could be identified. Most of them were focused on specific fields such as elderly care and acute psychiatric care [b,d,g]. One collaborative had a more general focus. The municipality, Agis and the province of North-Holland have signed a letter-of-intent with the aim to intensify the collaboration and mutual alignment [j].

Second, the municipality planned to integrate community information needed for a consistent governance of healthcare services [a,s]. A monitoring system was set up to explore emerging gaps in the supply of health services. Thereby, a specific focus was on moni-
toring shortages in the professional workforce and on elderly care needs [t]. Even so, relevant community health information would be made available and accessible in such a way that providers, financiers and users can better align their plans, demands and needs.

Third, initiatives were focused on the municipal organisation itself. In Amsterdam, the municipality is organised into one central authority and 14 district authorities. Managing this organisation meant making agreements on centralising or decentralising financial, regulatory, planning and/or executive responsibilities. These agreements were made as past experiences had learned that the collaboration between central and district authorities could be improved [r]. Therefore, it was officially recorded in the management agreement 2002-2006 how central and district authorities should collaborate and on what selected fields [o]. It was decided to decentralise the financing and planning of parental-child Centres (youth care) and elderly care, and to centralise all responsibilities for support structures for drugs addicts, the homeless and psychiatric patients. By doing this the municipality aimed at a more consistent and coherent municipal involvement.

*The perspective of Agis*

Central in the respondents' rationale was that Agis' perspective is relative to the strategies of competitors. Competing sickness funds have to distinguish from each other to attract insured. Sickness funds can do this by following a 'cost-leadership' or a 'differentiation' strategy. In the former, a sickness fund sets out to offer the lowest premium. In the latter, a sickness fund seeks to be unique along some dimensions widely valued by the insured [26]. Only the 'differentiation' strategy will lead to strategic purchasing sickness funds. The funds opting for a 'cost leadership strategy' have as a consequence no interest in governing healthcare. Following this rationale, respondents believed that Agis has no alternative than to differentiate and to become a proactive purchaser of healthcare in Amsterdam. They gave two arguments. First, the insured population was too expensive as it consumes more care than those of com-
petitors. Respondents attributed this to the large number of insured residing in three large cities.

'We have to recognise that our business is established in one of the most expensive regions of The Netherlands. We are seated in three large cities: Amersfoort, Utrecht and Amsterdam. (...) So, if we are going to compete on premium, we will not make it.' (respondent 4)

People living in urbanised areas commonly consume more care than people living in rural areas [27]. This seems to be caused by an over-demand rather than an over-need. This raised the question whether Agis could reduce over-demand of its insured population by improving its purchasing function. The Dutch government enforces this approach but the respondents were pessimistic.

'See the difficulties we have to close down a small hospital in Amsterdam. We did not get the means. (...) We have done everything to downsize the supply of healthcare in Amsterdam, but it did not work. We do not have control. (respondent 6)

This issue touches on the debate in the literature concerning the system of risk adjustment formulae set to redistribute premiums [28,29]. The respondents argued that these formulae should contain a comprehensive measure of 'degree of urbanisation', while it would compensate Agis for its expensive population. So far, the Dutch government has not changed the formulae leaving Agis with insufficient revenues.

Second, several competitors are part of large alliances that sell other financial products such as life and income insurances, and banking services. These alliances represent enormous capital and economic power, which gives them the competitive advantage to compensate losses over a longer period. [30] The limited economic reserves due to the high cost structure of Agis (i.e. extra costs resulting from merging three sickness funds, investments in information technology) would not allow such a strategy.

'We do not want to be the most expensive sickness fund. We want to be an average sickness fund. (...) But this implies that we have to curb our expenditures. We have limited economic reserves relative to our competitors. This means that we cannot compensate. Competitors can
carry on longer and postpone passing on premium increases by eating into their capital. Furthermore, it is very difficult for us to influence our cost-structure. (respondent 2)

For both reasons, Agis had to raise the flat-rate contribution boosting the premium one of the highest in the Netherlands [31]. This restricts Agis’ opportunities to follow a cost-leadership strategy explaining its initial willingness to differentiate.

However, respondents doubted the practicability of a differentiation strategy. They emphasised the irrationality of a public health perspective and pinpointed two problems. First, Agis had no interest in targeting healthcare to the needs of the Amsterdam population. Agis has been responsible for another population.

‘We do not represent public interests! We represent our customers. As we are market leader in several regions in The Netherlands with some other insurers, people start confusing our market leadership with representing public interests.’ (respondent 1)

Second, Agis was oriented towards reimbursing healthcare costs made by groups of individuals rather than maintaining the health of its insured. This individual health orientation was best illustrated by the reluctance to purchase individual preventive services. Respondents considered the business case for health promotion rather weak. The returns on investment in contracting these services are too uncertain.

‘Prevention is problematic as the evidence base is rather weak and insured can change every year of sickness fund. Then, you risk investing five years in prevention and after the sixth year the client leaves for another sickness fund.’ (respondent 1)

Nevertheless, the substantial market share of Agis in Amsterdam and the felt need to compete on differentiation require a regional orientation. Respondents considered such an orientation crucial for organising a successful purchasing function. Agis needs to build and maintain relationships with local providers and professionals as well as to know the Amsterdam culture and circumstances.

‘The supply of health services has to respond to the demands of patients. Not the other way around. This implies that you need to have
regional expertise and knowledge on how the local health system is working and addresses those demands. (...) Our statement is that in the regions where you have many insured, you have to develop regional expertise and know how.' (respondent 4)

This quote suggests that Agis would initiate and ensure collaborative arrangements across sectors, at least for their insured residing in Amsterdam. All respondents were affirmative, but also explained that the current context inhibits the uptake. The respondents identified four major stumbling blocks. First, there is limited room for discretion in purchasing health services, as there is a scarcity in the supply of health services. Second, adequate information is marginally available in order to identify best practices. Third, respondents considered cultural change among providers and professionals crucial, as they must accept, support, and even facilitate differentiating sickness funds. Professionals have to comply with value based contracts as well as multiple benefit packages of patients. Fourth, the current context does not prevent free riding competitors who may profit from Agis' investments in healthcare provision in Amsterdam. So, respondents consider strategic purchasing currently impossible.

Discussion

To overcome the 'performance crises' of European health systems, governance practices should incorporate two core public health functions: targeting the system towards population health and ensuring collaborative action across sectors [5,8]. It is a continuous challenge to elevate both designated public health functions in policy considerations [32]. Notwithstanding considerable differences in the exact implementation of health policies and the context in which reforms take place (e.g. Bismarck or Beveridge), there is a converging trend among European governments towards introducing market-mechanisms and devolving health system governance responsibilities to non-governmental agents. Still, this planned market approach does not dismiss governments from their public accountability [11]. It is
doubted whether governments are fully aware of that. Their focus seems to be mostly on cost control rather than on population health considerations [33,34].

The explorative findings of this study support this notion. In the city of Amsterdam, there seems to exist a vacuum in the governance of the local health system, including healthcare. The municipality holds a public health perspective, but its scope is limited. Agis, the major sickness funds in Amsterdam, runs major financial risks when adapting a public health perspective. Consequently, both leading actors are cautious in targeting the system towards the Amsterdam population health needs and enforce collaborative action across sectors in which those needs can be met. This is not an ideological problem but primarily a practical one, as both actors are willing but unable.

Owing to the exploratory nature, the data sources used and its contextual imperative, the transportability of the findings is limited. Moreover, we just explored the governance practice of one sickness fund in Amsterdam, thereby ignoring the practices of others. However, the vacuum in health system governance is noticed and reported elsewhere in The Netherlands and in other European countries [17,35]. This suggests that the findings have a broader scope than just Amsterdam. They provide some general notions concerning the incorporation of a public health perspective in health system governance practices.

First, the principal challenge is to fill the vacuum in governance. It is recognised that this can only be done by bringing together governments, financiers and providers in formal structures with clear lines of responsibilities and tasks. Health systems increasingly have to be governed through networks rather than bureaucratic hierarchies [11,25]. In Amsterdam this sort of shared governance is recognised. For example, successful collaboration has emerged to ensure an integrated delivery of acute psychiatric care and to integrate housing, long-term and social care. However, shared governance has its limitations. Collaboration only emerges in selected field where interests converge and where a significant volume of
care must be purchased. This implies that some care gaps will be resolved and others not. Owing to the dynamics in the Dutch system, it is unclear what fields will be selected. The impression is that the municipality and the sickness fund stay stick to their responsibilities and duties, thereby decreasing the opportunities for coherent governance of the local health system in Amsterdam. This is influenced by the uncertainties concerning the forthcoming Health Insurance Act and the Social Support Act [36,37]. Both devolve responsibilities to sickness funds and municipalities, but their practical implications are unclear. Second, incentives structures should be made more supportive. Governmental bodies, financiers and providers should be triggered to contribute to the ultimate goal of population health. Therefore, population outcome measures should be developed and rewarded for [38-41]. Finally, elevating a public health perspective in health system governance only succeeds when public health experts are engaged and determined to influence governance practices. This is a comprehensive challenge because the existing public health workforce is not well prepared for this task [5,32].

The aforementioned notions are based on the assumption that regulated competition will dominate health system governance the coming decade. The point of no return seems to have passed in many European health system reforms implying that the 'windows of opportunity' for a fundamental discussion on this topic are limited. Still, it is important to pragmatically discuss this issue once again. There are services that can be perfectly provided in a competitive environment (i.e. those services for which there is a clear-cut business case). But, there are also services lacking such a business case (e.g. emergency care, prevention, chronic care) and should therefore not be left to the market. This is primarily a political choice that politicians and policymakers should be willing to make. If not, filling the vacuum in health system governance will heavily rely on the willingness and vision of the actors involved. When the system does not engage them, nobody will care for health systems in the 21st century.
References

17. McKee M, Delnoij DMJ, Brand H. 'Prevention and public health in social


34. Wendt C, Thompson T. Social austerity versus structural reform in


Appendix 4.1 Selected documents


D. Urban steering committee Housing, Long-term and social care. Minutes of the conferences of 2,7,14 September 2004. [in Dutch]


H. Municipal Health Service. Year report social & mental health care
O. Management agreement central city and districts 2002-2006.
Q. Roorda J. Strategies of municipal health services (GGD’en) concerning public health: how strengthen the municipal health services and public health services? 2004.

Appendix 4.2 Respondents of Agis

Respondent 1 Member of the Board of Directors
2 Head Strategic Management Staff Department
3 Consultant Innovation Purchasing / R&D
4 Regional Account manager Amsterdam
5 Head Purchasing Long-term Care
6 Head R&D
7 Head Marketing
8 Head Client Service
9 Medical Consultant
10 Head Purchasing Acute (curative) Care
Appendix 4.3 Topic list interviews key executives Agis

General objectives
— To explore the perceptions of Agis key executives concerning strategic purchasing.
— To explore the perceptions of Agis key executives concerning the Dutch health system reforms.

Introduction
— Introduce researchers and study; confidentiality; research procedure

1. Personal characteristics and background
   — Sure name, sexe, function
   — Background, work experience, education

2. What does strategic purchasing mean to you?
   — What instruments do you want to use?
   — Feedback process and performance indicators (benchmarking)
   — Availability of steering information
   — Expected benefits
   — What type financial incentives?
   — What type of contracts?
   — What sort of production agreements do you expect to make?
   — Can Agis easily meet its obligations to the health care providers?
   — How do you balance the tension between quality of care and cost control?

3. How do you perceive a governing role of Agis in the city of Amsterdam?
   — Is Agis willing to govern health care and to strategically purchase health care? (motivation)
   — What perspectives on this theme are visible within Agis?
   — How would other actors perceive a stronger governance role of Agis?
   — Is such a role feasible?

4. To what extent can Agis assure strategic purchasing of health care in Amsterdam?
   — Organising the strategic purchasing function
   — Strategic mission (public health perspective; competition strategy)
   — Internal organisation of Agis (link between divisions; IT)

5. What do you expect from the Dutch health system reforms?
   — Are the health reforms necessary in order to take up a governance role in health care?