Chapter 8

Discussion

In this closing chapter, the potential of 'community-based integrated care' to function as a strategic vision for health care improvement towards population health will be discussed on the basis of the findings presented in the previous chapters. In the first subsection, the final conclusions of each separate chapter will be restated and related to the two central research questions. Successively, the methodological aspects of the overall thesis are considered. The two final sections provide an interpretation of the findings and draw implications for the key players in health care, with special reference to the Amsterdam Southeast area.

Main findings

The thesis was split up into a theoretical and an empirical part. The objective of the former was to theoretically explore the strategic vision of 'community-based integrated care' (What is it?). The objective of the latter was to empirically explore how the strategic vision of 'community-based integrated care' is embedded in health care delivery in the south-eastern district of Amsterdam (How does it work?).

The theoretical part has been worked out in two chapters. Chapter 2 describes the strategic vision of 'community-based integrated care'. It was reasoned that the limited successes to rationalise and improve the performance in health care stems from a lack of coherence among the various strategies and instruments employed. It was also argued that these should be embedded more synergistically in health care. The strategic vision of 'community-based integrated care' was put forward to achieve this goal. On the basis of community information on health needs and beliefs, targets can be set at the local or community level. When these targets are shared
between relevant decision makers, the various efforts to improve the performance in health care can be better reconciled. Each decision-maker can adapt the vision of ‘community-based integrated care’ without changing the nature and dynamics of their efforts and underlying rationales. In other words, decision making processes in health care are directed towards the same goals without prescribing the content of the processes itself. In this way, the strategic vision of ‘community-based integrated care’ can theoretically contribute to a better performance in health care.

In the consecutive chapter 3, the tensional relationship between doctors and managers was explored, as it is commonly known that these can frustrate the uptake of managerial policies, and thus the strategic vision of ‘community-based integrated care’. The theoretical analysis, based on a framework that combines theories on ‘professionalism’ and ‘management science’, learned that the tensions between doctors and managers stem from intrinsic differences in the way (medical) labour is organized and divided. As these cannot be reconciled, the only solution to ease the tensions would be initiating a constructive dialogue. A twofold agenda was recommended for this dialogue: 1) to develop a shared vision on how to divide and coordinate medical work; 2) to discuss the values, norms and goals underlying patient care from the patients point of view, both on the individual and the group level. As such, the findings provided a theoretical underpinning of the dialogue between doctors and managers, which is necessary to ease unproductive tensions. In the context of this thesis, the findings provide two insights. First, creating ‘integrated care’ arrangements is challenging as it runs counter to the logic of professionally divided labour. In other words, professionals will frustrate the uptake of ‘community-based integrated care’. Second, the recommended agenda for the dialogue reflects the key elements of ‘community-based integrated care’ and illustrates why this strategic vision might be fertile in improving the performance in health care.

The empirical research objective has been addressed in a series of four studies in Amsterdam Southeast. The findings of each sepa-
rate study were reported in chapters 4 to 7. Chapter 4 explored whether the strategic vision of 'community-based integrated care' could be recognised in the governance practices of the municipality of Amsterdam and Agis, the major care insurer in Amsterdam. Findings showed that the municipality holds such a strategic vision but with a limited scope. Agis, however, runs major financial risks when adapting such a strategic vision. Consequently, both leading actors are cautious in targeting health care delivery towards the Amsterdam population health needs, and in enforcing 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. The resulting vacuum in health care governance seems to be created by inadequate devolvement of responsibilities to municipalities and care insurers as well as by an imperfect calibration of an appropriate incentive structure. Shared governance is therefore opportunistically emerging in selected fields where interests converge and where there is a significant volume of care to be purchased. This implies that some care gaps in Amsterdam will be resolved and others will not.

In chapter 5, we explored whether the 30 year old community health partnership in Amsterdam Southeast had initiated, developed and operated collaborative activities from of a 'community-based integrated care' vision. Based on semi-structured interviews and documents, we found that the partnership itself was sustainable and successful overtime. However, the partnership lost its initial innovative nature and narrowed down its strategic focus towards elderly care. Furthermore, the realised collaborative projects, although enforcing integrated care, lost their community-based character. This seemed to be influenced by the incremental introduction of regulated competition in Dutch health care that leads towards a divergence of interests and thus willingness to collaborate. This casts doubts on realising ‘community-based integrated care’ through health partnership working in a more competitive environment.

Chapter 6 presented the results of a multiple case study of collaborative initiatives of the Academic Medical Centre / University
of Amsterdam. This university hospital has adapted a 'community-based integrated care' vision as articulated in its Academic Population policy. The results indicated that a considerable number of 27 collaborative initiatives have emerged in 2003/2004. Still, the initiatives are loosely 'community-based' and hardly focused on the full integration of care services. This suggests that the community linkages of the Academic Medical Centre in Amsterdam could be further developed. The critical factor for success will be gaining the full support of the clinical departments for the strategy, as their short-term interests are challenged as theoretically explained in chapter 3. Furthermore, it is advisable to monitor the progress towards 'community-based integrated care' on the overall hospital level.

The findings of the last study were presented in chapter 7. The conducted process evaluation showed that setting up intermediate care in a residential home for patients released from the AMC was less straightforward than originally perceived by management. Due to a heterogeneous patient population, a relatively unqualified staff and an impeded implementation process, the model did not function as anticipated. The evaluation implicitly underscores the value of the 'community-based integrated care' vision. It could have been possible to provide valuable information both to substantiate the relevance of the intermediate care model at the outset, and to better work out the intermediate care model in practice.

**Methodological considerations**

In the earlier chapters the specific limitations of the theoretical evaluations and the enacted series of four empirical studies have been considered in detail. This subsection provides some general reflections on the research methods used and the validity of the overall findings.

The split into a theoretical and an empirical part was motivated by the present practice of health care performance and improvement. The two theoretical interpretative studies were done, because there is a greater need for critical reflection on, and synthesis of current
knowledge and theories on health care improvement than focusing on one specific aspect from one theoretical perspective. The current body of knowledge and theories is large, though splintered across the various disciplines such as the public health, health policy and management sciences, health economics, and medical sociology. So, the idea behind the theoretical part was to put the knowledge from different disciplines together and elaborate on potential improvement strategies from there. This is in line with the overall nature of health services research as an overarching discipline incorporating the knowledge, theories and methods from different disciplines [1-3].

The empirical part of the thesis was justified by the theoretical one. The case study in the South-eastern Amsterdam district was initiated to explore how the strategic vision of ‘community-based integrated care’ withstands in practice. Therefore, a series of four exploratory studies was executed. The focus was on exploratory research, as it was too early to derive workable hypotheses and to test them. The studies were situated in one geographical area -i.e. the district of Amsterdam Southeast. This was reasonable given the community orientation inherent to the notion of ‘community-based integrated care’. Furthermore, it provided the advantage of studying different phenomena in the same context. The studies were purposeful selected in order to include all key players that are commonly identified as the central actors that make up a health care system -i.e. patients, care providers (professionals and institutions), financiers, policy makers. In this thesis a study involving the patients is lacking. There was a fifth case study planned in collaboration with the Round Table, a community organisation of elderly in Amsterdam Southeast, that would have incorporated the patient perspective [4]. The objective was to explore what visions, opinions and assumptions elders hold concerning their own role in navigating health care delivery. Unfortunately, the study failed as the Round Table was ended due to internal turmoil and could neither be bypassed nor replaced. Apart from the patient perspective, one could also argue that an empirical study on the professional
perspective is lacking. However, this lack is filled by the theoretical exploration in chapter 3, which draws on earlier empirical work and other research conducted within the department of social medicine of the AMC [5–7].

The research relationships with relevant persons in the field were established as a result of the ‘academic population’ policy of the AMC. This policy encouraged the department of Social Medicine to direct parts of its research activities towards the systematic evaluation of collaborative activities among health care actors in Amsterdam Southeast [8,9]. As a consequence, research capacity was made available for the four studies. The deputy director of integrated care in the AMC was a natural partner in this process. From a practical perspective, the four studies were set up to meet the information needs of the municipality of Amsterdam, Agis and the Zizo-partnership in making strategic choices for the (near) future; of the AMC in getting a systematic overview of its collaborative initiatives; and of the responsible managers in resolving the perceived problems in the functioning of the intermediate care model. The relationships with the key participants throughout the study period were productive and fruitful. It was never a problem to get people involved and willing to participate in one of the studies. In order to maintain the relationships, the participants were regularly informed on the progress of the research and asked for their input.

The methods used in the studies were predominantly based on qualitative inquiry, notwithstanding the additional use of quantitative approaches in two studies. This qualitative strategy was best suited to get an ‘in depth’ understanding of how the strategic vision of ‘community-based integrated care’ is held and why. The mixed methods were warranted as they broadened the scope of the studies which was necessary to get a full picture (see chapters 6 & 7). So, the thesis included qualitative data collected through semi-structured interviews, documents analyses, and incidentally non-participative observations, as well as quantitative data collected through registration forms, validated and non-validated questionnaires filled out during face-to-face interviews.

178
The analyses of the qualitative data throughout the thesis was quite similar. Basically, the 'systems thinking' perspective implied that the analyses were focused on understanding how the strategic behaviours and interactions of the studied institutions and individuals influence the 'system', of which they are part, in achieving its purposes. The data were analysed against a skeletal frameworks or theoretical perspectives that were roughly developed beforehand and if necessary adjusted during the analyses. These skeletons provided direction, but left enough freedom and flexibility for exploration [10,11]. The strategic vision of 'community-based integrated care' was used as the principal skeleton. However, other theories were also used such as business theories on strategic management and networks (chapter 4 + 5) as well as theories on quality systems and implementation (chapter 7). Procedurally, one researcher took the lead in analysing the data whilst assisted and monitored by the other members of the research teams. The transcripts of interviews and documents were coded, and then summarised in memo's.

In qualitative inquiry researchers try to control and enhance the internal validity by ruling out threats during or afterwards the study [12]. Two specific validity threats needed attention during the studies: researcher bias and reactivity.* On the occurrence of researcher bias was regularly reflected by the principal researcher. Essential in this regard was that the explored settings, institutions, and interviewed people represented a wide array of perspectives, rationales, disciplines, and opinions. It prevented the researcher for 'going native' and thus for over-identification with the studied cases and interviewed respondents. Researcher bias could also happen by staying too close to the skeletal framework and imposing it on the perspective of the settings and people studied. However, key to the strategic vision of 'community-based integrated care' is that it

* Researcher bias occurs when the selection of data fit the researcher's existing theory or preconceptions and the selection of the data 'stand out' to the researcher. Reactivity is the influence of the researcher on the setting and individuals studied [13].
draws on notions from various perspectives and theories and even promotes a flexible and open mind to these (see chapter 2). This implies that the risk of imposing the theoretical framework of ‘community-based integrated care’ on the collected data was minimised given the very nature of the framework. Nonetheless, researcher bias was curtailed by applying different quality procedures (i.e. member check’s with several respondents, critical peer review by senior researchers not directly involved in the thesis and experts in the field), which we used to stimulate reflexivity.

Reactivity of the studied settings and people interviewed was monitored and if necessary encountered. Generally, respondents were keen on being interviewed and to participate in the studies, and to be open and critical. This had partly to do with the confidentiality created by the research. It was expressed by respondents that they had confidence in the study and in the individuals in the research team. Foremost, it was noticeable that the people working in the context of Amsterdam Southeast know and trust each other well. They have a long history of collaborating and built an open culture overtime. Despite that, research tools were used to verify and monitor the reactivity and resulting threats for the validity. First, the purposeful sampling of respondents was helpful in identifying respondents who were reluctant to be open. It was very noticeable when respondents were not. Their narratives contrasted too much with the ones of others. Out of more than 75 interviews, this occurred three times. Second, data collected from other sources or methods of inquiry were used to justify specific statements and themes (triangulation). This quality procedure was continuously applied throughout the analyses.

The external validity or transportability is limited in the sense that the findings cannot be easily generalised beyond the studied settings. For example, the process evaluation of the intermediate care unit (chapter 7) delivered an overall explanation of what mechanisms and factors might have influenced the functioning of the unit. These findings are primarily context specific. This limitation was anticipated and inherent to the chosen exploratory research designs
applied in this thesis taking the setting of Amsterdam Southeast as a case study for studying how the strategic vision of 'community-based integrated care' is embedded in daily practice. The principal aim was to provide illuminating ideas, new insights and a deeper understanding of the studied phenomena.

*Interpretation of the findings*

Critics may see 'community-based integrated care' as a fuzzy concept that adds nothing new to the existing body of knowledge on improving health care delivery. The concept of 'community-based care' originates from the WHO declaration of Alma Ata 1978, while the concept of 'integrated care' emerged at the end of the 1980's [14,15]. However, in this thesis both concepts are not used in their original senses as 'blueprints' or organisational formats sketching the ideal organisation of health care. Rather, their combination is elevated as a strategic vision that redirects all coexisting rationalisation and improvement agenda's in health care towards the same endpoints without prescribing how those endpoints should be achieved.

Its promise lies in the recognition that the various approaches and their underlying rationales to improve the organisation, governance, and ultimately performance in health care have legitimacy and need to be acknowledged. Therefore, the only way forward is balancing them, not imposing one over the other. The unproductiveness of one rationale dominating the others is a recurrent phenomenon in the history of health policy and illustrated by the three governance models that have been in place the last decades. In the 1970's, authors such as Illich and Mc Keown criticised the downsides of self-regulation by the medical profession [16,17]. In the 1980's, the disadvantages of governmental planning and regulation aimed at cost containment became visible [18,19]. Nowadays, there is a preoccupation with governing health care under a market ethos. However, one can predict that this latter governance model will have its downsides too. This is illustrated by the mounting evidence challenging the key assumption that people will behave as ratio-
nal consumers seeking performance information to purchase health plans and/or health care services [20,21].

In the theoretical section of this thesis, it is argued that the fundamental differences among the different approaches and their underlying rationales in health care can neither be removed, nor ignored. Hence, it will be more fruitful to take this incompatibility as the start for developing new strategies in stead of the problem to be resolved. 'Community-based integrated care' is elevated as a strategic vision that can provide direction in balancing the different rationales in health care and make their coexistence more productive. The basic idea is built upon two rules: 1) Clear endpoints must be defined on the basis of population health needs and beliefs, and consistently used as the leading principle to organise and govern health care. 2) Actors in health care must get the freedom to follow their own logics in meeting those endpoints. In theory, this could be an effective approach to realise more joined and consistent action towards a better performing health care system. Note that this leads to heterogeneity. Health care will be organised and governed in multiple ways through markets, governmental regulation and professional institutions.

However, a theoretically sound vision does not guarantee practicability. 'Community-based integrated care' might be useful for policy purposes, because it unifies and brings people together. But in daily practice, it cannot undo the fundamental differences between the actors involved and the incentive structures within which they operate. The two aforementioned rules are not easily followed, as illustrated by the Amsterdam Southeast case study. The case study shows that local care providers, the municipality and major sickness fund do successfully collaborate. Though, integrative activities are not principally initiated and developed from a systematic community health orientation that maximises the health of the Amsterdam South-eastern citizenry. The studied health care actors in this thesis collaborate only in fields were they have mutual interests. This is not surprising, as it is commonly known that health care is a business where individuals earn their living, make a career and gain prestige;
where institutions want to secure their future viability; and where politicians and policy makers have an interest to curb public expenditures. These concurrent and often conflicting objectives hinder key stakeholders to sign up to programmes that have clear objectives to maximise population health. Lewis et al. (2000) put it as follows:

'Rearranging health care rearranges resources and incomes; in a finite world this creates winners and losers, and one can expect prospective losers to oppose change that may be laudable on wider grounds. If health policy diminishes the favour of more social interventions and programs, the health care constituency—a substantial force in all developed countries—will consider itself under siege and will predictably create or highlight alarmist scenarios designed to create support and nostalgia for the status quo.' [22]

Apart from 'nostalgia for the status quo', the findings also pinpoint serious flaws in the design of health care delivery in Amsterdam Southeast and the Dutch system more generally. First, the link between public health data and production data was missing. A variety of intelligence was available, though splintered across the various actors and often not specific enough. This is illustrated in the case study showing the inadequate functioning of the intermediate care model (see chapter 7). At the outset, a systematic insight in the needs and demands of AMC inpatients who ought to be admitted to the model was lacking. In the literature, this issue has also been raised and discussed. Performance frameworks are currently promoted and developed within which the link is embedded to visualise the contributions of health care to population health [23,24].

A second flaw was in the allocation of responsibilities and tasks. The signalled vacuum in the governance of the local health system in Amsterdam (chapter 4) relate to an imperfect devolvement of governance functions. The municipality and Agis are made responsible for different populations, which intrinsically complicates the occurrence of shared governance practices that direct the entire health system towards maximising population health. The problem is of international relevance, which is increasingly recognised [25,26].
This attention is warranted, since there are more options to allocate responsibilities and tasks across multiple health care settings. This is illustrated by the care providers in Amsterdam Southeast who have a longstanding innovative tradition, but are less willing to collaborate and innovate under the pressure of competition. So, there is a growing need for strategic direction from governing agents. The last flaw in the health system design that seems to undermine the uptake of ‘community-based integrated care’ in health care concerns the incentive structures. In The Netherlands, these are insufficiently aligned to the goal of maximising population health. The municipality, Agis as well as the care providers are not directly rewarded on the basis of population health outcome measures. This topic is currently high on the international policy agenda. Under the label of ‘pay-for-performance’ efforts are put in the development and implementation of outcome measures and rewarding systems that trigger care providers to maximise their contributions to population health [27-29].

Another practical doubt concerns the degree of freedom that actors should get to meet the defined endpoints. When should one actor start or stop to impose one rationale over the other? This is essentially a grey area where the boundaries of each of the coexisting rationales cannot be clearly determined. Hence, the actors themselves should communicate, negotiate and find out in practice where the boundaries lie. This can only work when all actors have a clear view on the strengths and weaknesses of their own perspectives, and have some comprehension of the other ones.

Thus, the implementation of the strategic vision is not a self-fulfilling prophecy. From the literature, it might be expected that it takes years before the vision is common knowledge, if taken up by health care actors at all [30,31]. Though, the uptake of the strategic vision does not require new institutions, organisations or bureaucracy. Rather, it can be rolled out as a matrix over the existing health care system, which overcomes a variety of implementation barriers. Foremost, the point will be reached that improving the systems of care will not suffice. In the context of constrained resources, choices
must be made concerning what services need to be made publicly available. To make these choices rationally, requires the adoption of strategic visions such as ‘community-based integrated care’ that evaluate the health care system in relation to its purposes. From this perspective, it is not illusive that decision makers adopt the strategic vision of ‘community-based integrated care’ to make choices. The ‘academic population’ policy of the AMC (chapter 6) and the performance framework of the Dutch ministry of Health, Welfare and Sports might be indicative in this respect [32].

This brings us back to the promise of the vision. Although practical issues can be raised, the strategic vision is a must for two reasons. First, the practical doubts essentially relate to the complexity of health care in daily practice. Health care was and will always be the product of all actors, their activities and their interactions taken together. In this light, the vision can also be seen and used as a diagnostic instrument to better understand the dynamics and problems in health care. It makes one, whether a patient, a professional, a manager, a financier, a policy maker, a politician or a scientist, at least aware of the strengths and weakness of his/her own perspective and that of others. Second, it is unrealistic to expect that the design and execution of a perfectly rational health care system is possible. However, it is also naive not to recognize the fragmentation and inconsistencies in the numerous efforts to improve the performance in health care. ‘Community-based integrated care’ may serve as strategic vision that unifies and redirects these efforts towards the goal of population health.

**Implications**

This section discusses the implications of ‘community-based integrated care’ as a strategic vision for the various health care actors, specifically for those residing in Amsterdam Southeast. The overall implication is that all actors still have to do homework and should get their act together.
IMPLICATIONS FOR SCIENTISTS The findings of this thesis have several scientific implications. First, as the findings are theoretical and exploratory in nature, there is a need to further substantiate them and test them more thoroughly. For example, can it be rejected that the identified mechanism explaining the functioning of the intermediate care model also clarifies the functioning of models elsewhere? Another, more general, aspect concerns the practicability of 'community-based integrated care'. How can the strategic vision diffuse among health care actors and will it really lead towards an improved performance in health care? These questions are complex and challenging, which brings us to the second implication. In order to appropriately address them, research designs should have a broader scope, which as our studies illustrate, is at the expense of rigour. However, creative designs are being promoted that try to balance rigour and validity by combining quantitative and qualitative approaches (i.e. mixed methods), purpose-collected and coincidental data, and multidisciplinary research perspectives [33-35]. These evaluative approaches provide a good foundation for advancing the evidence base for improving performance in health care.

The subsequent inference is that researchers must broaden their conceptual frameworks to include multiple rationales, perspectives and theories. This requires working in multidisciplinary research teams. Foremost, health services research needs to be more firmly established as a discipline in the scientific community. Health services research can function as an overarching discipline to disclose and bridge the various disciplinary bounded bodies of knowledge concerning pertinent topics relate to improving the performance in health care. Thus, the scientific community must practice what it preaches. The promotion of integrated care alike, the scientific knowledge production needs to be of an integrated nature as well.

IMPLICATIONS FOR THE MUNICIPALITY OF AMSTERDAM, THE GOVERNMENT The implications for the municipality of Amsterdam relate to the policy concept 'stewardship'. Good stewardship requires that (local) government makes explicit health pol-
icy, which includes defining a strategic vision for the future, outlining the priorities, exerting influence, generating intelligence and share knowledge [36]. In this light, the formulated local health policy of the municipality of Amsterdam is a good start, and basically the way to go. However, the scope of the enacted policies needs to be much broader and more explicit. The municipality must not be reluctant in seizing upon its responsibilities and try to influence all four sectors in Dutch health care (see chapter 4). It is crucial that the municipality develops a strategic vision (i.e. community-based integrated care) on how the local health system of Amsterdam should contribute to and maximise population health of the citizenry. Besides, the forthcoming Social Support Act (WMO) as well as the Health Insurance Act indirectly or directly demand more input from Dutch municipalities in this respect. So, there is a (growing) legitimacy for municipal health and health care policies.

These policies ideally encompass several areas. First and foremost, the municipality should set the local priorities on the basis of population health needs. This can only be done when the municipality generates and integrates all intelligence that is needed to make informed decisions. More importantly, local politicians and policy makers should be willing to set those priorities. This is often problematic because many priorities are or should be set at the national level (e.g. coverage of the basic insurance, funding of care services). However, the absence of priority setting by the (local) government stresses the relationships in the field where physicians and managers together need to set the priorities. The second area is the continuation of the collaboration with Agis and further develop their shared governance practice. It is very important that both take joined action to systematically and consistently direct the entire system. Though, the collaborative is only sustainable in the long run when the described vacuum in the governance is filled. Third, the municipality must build consensus among key stakeholders in order to let them sign up to the goals set. Thereby, influence should be intelligently exerted by using multiple governance models. Last, the aforementioned generation and integration of community in-
telligence (public health data + production data) should not only serve the information needs of the municipality, but the needs of all stakeholders. In that respect it will be important to see to what extent the municipality can enforce community building around health themes whilst the philosophy of the new health insurance market is rather exit based than voice based.

**IMPLICATIONS FOR AGIS, THE CARE INSURER/Financier**

The findings suggest that Agis cannot govern health care in Amsterdam on the basis of a 'community-based integrated care' vision. The practical problem is that the competitive advantages of such an approach are absent, at least in the short term. This finding is important, as it challenges the basic idea underlying the new Health Insurance Act. From January 2006, Dutch care insurers must compete for their insured, which would give them the incentive to strategically purchase those health care services that satisfy (potential) clients the most. In this way, strategic purchasing would increase performance in health care. However, the position of Agis shows that this is not self-evident. The findings sketch the mechanism that threatens to manoeuvre Agis, and the other care insurers, into a ‘cost play’ instead of a competition on the quality of the purchasing function within which quality and population health considerations play a role. Notwithstanding the efforts Agis puts into quality issues (e.g. through the collection of data on consumer experiences [37]), the prime incentive will be on efficiency, which will affect the nature of their negotiations with care providers. It can be expected that care insurers become less willing to respect and acknowledge other rationales in health care, which might ultimately be at the expense of the performance in health care as argued in this thesis.

To avoid this gloomy scenario, Agis could in the first place be prudent in imposing its rationale over the one of the care providers. This can be realised by giving a certain degree of freedom in the contractual mechanisms and payment systems through which health care is purchased. The advantages of more satisfied care providers might outweigh the extra costs. For example, care providers
will advise patients and their families to buy Agis health plans, which potentially increases the number of insured. Given the uncertainties concerning the ability and willingness of the public to make rational health plan choices, it might even be a better differentiation strategy for Agis to get competitive advantages (quality as a marketing strategy). In the second place, the key to good strategic purchasing is linking the contracting of care providers to a good planning. This involves assessing the insured population health needs, formulating policies and priorities, and specifying the models of care that should be provided in light of the resources available [38]. In other words, care insurers have to invest in building regional networks, in mutual trust, in generating community intelligence, and thus to adapt a local/regional orientation rather than bargaining the lowest price by playing out the care providers against each other. Although a local/regional orientation is not the same as a public health orientation (see chapter 4), it will bring Agis closer to stimulate care providers to contribute to population health. The final requirements in this respect are preventing ‘free riding’ of competing care insurers and a more firm evidence base for more ‘upstream’ care models (i.e. health promotion, disease prevention). Both requirements will create so called ‘business cases’ for population health considerations, as returns on investment will then be more certain and thus profitable.

**Implications for the Zizo, the care managers** The findings learn that the future for the Zizo-partnership is uncertain. This is primarily influenced by the changing policy context and the resulting vacuum in the governance. To a certain degree, the Zizo-partnership was able to fill this vacuum itself, which is shown by the development and implementation of successful collaborative care models for the frail elderly and the chronically ill. So, one could believe that partnership working is a valuable vehicle to stimulate joined action among competing care providers. However, the findings also learn that the (past) successes of the Zizo-partnership can be attributed to the longstanding history of the partnership, the mutual trust, and the willingness to collaborate as well as the sup-
port of the leading governing bodies in Amsterdam. Furthermore, the prospect of more competition, the upscaling of member institutions, and the currently indistinct support of the same governing bodies is gradually hollowing out the partnership which is illustrated by the loss of its community-based and innovative character. In this light, the expectations of health care partnerships must be tempered.

Nonetheless, the Zizo-partnership has potential for the future. The forthcoming Health Insurance Act, the Social Support Act, and the modernisation of AWBZ provide new opportunities for collaboration. It is not illusive that the municipality and Agis will decide to purchase innovative health care services through the Zizo-partnership. For them, it might be an efficient and effective strategy to purchase care programmes that better meet population health needs of the Amsterdam Southeast citizenry. The Zizo-partnership could anticipate and influence its future viability in several ways. First, the partnership could start to integrate available public health data with the management information gathered for monitoring its collaborative activities and use this information to initiate and develop new innovative projects. Second, it is important to adapt a more rational and evidence-based management of collaborative care arrangements. As clear cut information is often lacking, managers run the risk of being persuaded by political willingness rather than by ‘evidence’. Third, the Zizo-partnership could stress and communicate its unique nature and potential to its stakeholders. The findings show how crucial assets such as know-how, mutual trust, and infrastructure have been built over a period of more than 30 years and that it is worthwhile to be maintained. Last, the partnership could broaden its scope by allowing other care organisations to participate in the partnership.

IMPLICATIONS FOR THE CARE PROFESSIONALS Self-regulation of care professionals should be guided in the direction of newly divided medical labour. Professionals must get their act together in designing, managing, coordinating and providing coherent medi-
...cal care trajectories for individual patients. They are the only ones in the health care business who have the expertise, knowledge and know-how to do this on the basis of medical considerations. The key problem, however, is that the professionals have lost the capability to do this job well. The (sub)-specialisation has resulted in ‘silos’ of expertise that are ill-suited to treat the patients of the 21st century who suffer from more diverse, complex, chronic and intermittent diseases and limitations. In this regard medical professionals can insufficiently fulfil their responsibility. As shown by the analysis in the third chapter, multidisciplinary teamwork is one solution to this problem. Still, this is not a solution that is practicably full proof. Multidisciplinary teamwork’s effectiveness will greatly depend on how the participating professionals deal with ‘turf-battles’ that are inherent to the logic of professionally divided labour. Similarly, concepts such as the ‘soft-bureaucracy’ or ‘management participation’ will run to this critical problem. Therefore, the best solution would be a new division of medical labour within which the medical expertise is professionalized that is necessary to overview and coordinate present-day care trajectories for individual patients. Exemplifying in this regard would be general practice and specialties such as geriatrics. This latter solution requires a fundamental rethinking of medical curricula. In practice, this change is emerging, but at a very slow pace.

Apart from reorganising medical labour, professionals should continue and improve their communication with the other stakeholders in health care. Thereby, it is important to stick to the agenda as proposed in chapter 3. Professionals should do the job for which they are trained. It is not good to draw them into management as it decreases the effective time that they can spent on their patients. However, this requires that professionals can rely on and trust other stakeholders in health care to acknowledge their professional values and norms.

Both the ‘what’ and ‘how’ questions on the strategic vision of ‘community-based integrated care’ were addressed in this thesis. It was explored, in theory and in practice, whether this vision can be
fertile in improving the performance in health care. Starting point is that the limited success to rationalise and improve the performance in health care stems from a lack of coherence among the various approaches employed. The vision aims at overcoming the inconsistencies by aligning the approaches and make their coexistence more productive. This can be done by defining clear endpoints on the basis of population health needs and beliefs and then give health care actors the freedom to use their own approaches and underlying rationales to meet those endpoints. In theory, this could be an effective approach to improve the performance in health care.

In practice, the strategic vision of 'community-based integrated care' seems useful to unify and bring people together, but it cannot undo the fundamental differences between the actors involved and the incentive structures within which they operate. This is shown by the findings. In Amsterdam Southeast, the municipality, Agis and local care providers do successfully collaborate. However, their integrative activities are not principally initiated and developed from a systematic community health orientation that maximises the health of the Amsterdam South-eastern citizenry. The actors primarily collaborate in fields were they have mutual interests.

This brings us back to the metaphor of a Tower of Babel in health care. Can the strategic vision of 'community-based integrated care' function as an Esperanto that prevents the deemed failure of improving the performance in health care, the building of a Tower of Babel alike? The thesis' findings show that the theoretical basis is the same. The strategic vision of 'community-based integrated care' intents to facilitate the communication between people who speak different native languages without imposing one language upon the other. The only 'grammatical rule' is that actors discuss and agree upon the health care goals to be striven for -i.e. maximising population health. In practice, the big challenge is to get people in health care not only to speak this Esperanto, but also to remain persistent and consistent in the resulting building actions.

192
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