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Citation for published version (APA):
Summary

Many hold that performance in health care can be improved. Various gaps exist between perceived demands and needs on the one hand and the organisation, governance and actual performance of health care on the other. However, the state-of-the-art on health care improvement indicates that improvement activities and strategies have too limited success so far. This thesis addresses this issue from a broader ‘systems thinking’ perspective and therefore contributes to the literature on health care improvement. It has been built upon the supposition that there is no universal remedy at hand to improve health care delivery and therefore examines the content and practicability of the strategic vision of ‘community-based integrated care’. This vision can be applied to realise more joined and consistent action (‘integrated’) towards a better performing health care system that maximises population health (‘community-based’).

Chapter 1 provides a general introduction to the strategic vision of ‘community-based integrated care’. It introduces and positions the vision in relation to other visions on health care improvement; it sketches the different concepts and theories on which the vision draws; and discusses how the vision is embedded in prevailing governance practices. It then outlines the relevance of the two research questions that 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? (What is it?)
2) How is the strategic vision of ‘community-based integrated care’ embedded in the organisation and governance of health care delivery in Amsterdam Southeast? (How does it work?)

Following both questions, the thesis is split up into a theoretical and an empirical part. The former deals with the meaning, content and conceptualisation of the strategic vision of ‘community-based integrated care’. The latter deals with issues related to the practicability and actual use of the strategic vision in daily practice.
In chapter 2, we introduce and outline the strategic vision of ‘community-based integrated care’. Starting point is the notion that the limited successes to rationalise and improve the performance in health care stem from a lack of coherence among the various strategies and instruments employed. We argue that these can and should be embedded more synergistically in health care by adopting the strategic vision of ‘community-based integrated care’. On the basis of community information on health needs and beliefs, targets can be set at the local or community level. If relevant decision makers on all levels of the health care system share those targets, the various efforts to improve the performance in health care can be better reconciled. The decision-makers (re)direct their improvement efforts towards the same goals without the pressure to change the nature and the underlying rationales of them. In this way, the strategic vision of ‘community-based integrated care’ theoretically orchestrates synergy between the various efforts and thus more success in improving the performance in health care.

Chapter 3 provides an exploration of the tensional relationship between doctors and managers. It is commonly known that these tensions 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’, learns that the tensional relationship is inherent to the different ways doctors and managers organise and divide (medical) labour. The only solution is to ease the tension as these differences cannot be reconciled. We therefore recommend a constructive dialogue that addresses a twofold agenda. Doctors and managers should: 1) develop a shared vision on how to divide and coordinate medical work; and 2) discuss the values, norms and goals underlying patient care from the patients point of view, both on the individual and the group level. In the context of this thesis, the findings provide two valuable insights. First, to develop ‘integrated care’ arrangements (i.e. to orchestrate synergy among the various improvement efforts) is challenging as it runs counter to the logic of professionally divided labour. Second,
the twofold agenda 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.

Chapter 4 explores whether there is a 'community-based integrated care' perspective to the governance practices of the municipality of Amsterdam and Agis, the major care insurer in Amsterdam. Findings show that the municipality holds such a perspective but with a limited scope. Agis runs major financial risks when adapting such a perspective. 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 devolution 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 not.

In chapter 5, we explore whether the 30 year old community health partnership in Amsterdam Southeast had initiated, developed and operated collaborative activities from a 'community-based integrated care' perspective. Based on a single case study, 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 seems to be influenced by the incremental introduction of regulated competition in Dutch health care. So, the findings cast doubts on the ability of health partnerships to apply the strategic vision of 'community-based integrated care' in a more competitive environment. The care providers only collaborate in those areas where they had mutual interests.

Chapter 6 presents the results of a multiple case study of collab-
orative initiatives of the Academic Medical Centre / University of Amsterdam. This university hospital has adapted a community-based integrated care strategy in 1996. The results indicate that a considerable number of 27 collaborative initiatives have emerged. Still, these 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. Furthermore, it is better to monitor the progress towards ‘community-based integrated care’ on the overall hospital level than at the level of the collaborative initiatives.

The findings of the last empirical study are presented in chapter 7. The conducted process evaluation shows that setting up an 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 strategic vision of ‘community-based integrated care’. It would have provided information to better assess the relevance of the intermediate care model at the outset, and to better work out the intermediate care model in practice.

In the final chapter 8, the potential of ‘community-based integrated care’ to function as a strategic vision for health care improvement towards population health is discussed on the basis of the findings presented in the previous chapters. The discussion reveals the several key messages that together make up the central inference of this thesis:

1) The fundamental differences among the various strategies and instruments to rationalise and improve the organisation, governance and actual performance in health care can neither be removed, nor ignored. Hence, it is more fruitful to take the incompatibility as the start for developing new strategies in stead of the problem to be resolved.
2) 'Community-based integrated care' can theoretically function as a strategic vision that provides direction in balancing the different rationales in health care and make their coexistence more productive. The basic idea is built upon two rules. First, 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. Second, actors in health care must get the freedom to follow their own logics in meeting those endpoints.

3) In practice, the strategic vision of 'community-based integrated care' seems useful to unify and bring people together. As notified earlier, the vision cannot undo the fundamental differences between the actors involved and change their vested interests. Therefore, health system redesign is warranted to facilitate the embodiment of 'community-based integrated care' as a strategic vision in health care.

4) For two reasons, the prospects of 'community-based integrated care' as a strategic vision in health care are good. First, implementation 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 barriers. Second, the point will be reached that improving the systems of care will not suffice. In the context of constrained resources, choices must be made in health care. 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.

5) The uptake of 'community-based integrated care' as a strategic vision in health care is a must. The vision can be 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. Moreover, the vision may serve to unify and redirect the numerous efforts to improve the performance in health care towards the goal of population health.

The title 'Building a Tower of Babel in Health Care? Theory and
Practice of ‘Community-based Integrated Care’ is a metaphor for the central inference of this thesis. It questions whether the strategic vision of ‘community-based integrated care’ can function as an Esperanto that prevents the deemed failure of improving the performance in health care towards the goal of population health, 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.