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Intersectoral Collaboration in Primary Care: Implicit Barriers and Lessons from the Cuban System

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Table of Contents

Summary

Health differences in the Netherlands are large. These differences are caused by a diverse set of determinants, such as physical and social environment, income, work, education and lifestyle. Successfully combating health inequities requires an approach in which the care for different health determinants is integrated. Combining forces, GPs and municipal governments could reduce health inequities. Yet, several reports and policy documents, as well as empirical experience have identified that collaboration between GPs and the remains challenging in the Dutch context. The Cuban Primary care system is a good practice example for successful intersectoral collaboration. This study aimed to identify implicit barriers for collaboration between GPs and the municipality in the Netherlands, and uncover lessons to be learned from the Cuban system.

This study has been conducted using the Grounded Theory Method. The execution of this study was two fold: a divers group of GPs and municipal policymakers in the Netherlands were questioned through semi-structured interviews, member checks and a focus group. In Cuba, a participant observation study, including informal interviewing was conducted in several primary healthcare facilities.

We identified implicit barriers for collaboration, including task interpretation of GPs, segmented structures and financing, and a GP culture of autonomy and independence. The single system, common goal, and community participation of the Cuban primary care system contributed to successful collaboration. We concluded that the possibilities to collaborate are shaped by ideological, structural and cultural factors of the primary health care system. These all impact one another as well. Therefore, we propose that ideological, structural and cultural changes can contribute to a better intersectoral collaboration.

Background

Health differences

Health differences in the Netherlands are large. For example, men with a low income die 5 years earlier, and live 16 17,8 years less in self-reported good health. (1) Also ethnic minorities and migrants in Europe have a poorer self-perceived health as compared to the general population. (2, 3) These differences are caused by a diverse set of determinants such as physical and social environment, income, work, education and lifestyle, that affect one another and influence the health of a person. In turn, disease may negatively impact these factors. For example, health problems, as well as debt are some of the most important factors limiting participation to the workforce. (4) In turn, unemployment and social isolation is a risk factor for several mental and physical health problems. (5,6) Despite efforts from the state to reduce health differences in the Netherlands, the effects so far have been limited. (7) Policies aiming at improving general public health do not account for the complex set of determinants affecting health in people in a low social economic situation, and are thus less successful for them. Successfully combating health inequities requires an approach in which the care for different health determinants is integrated. An *integrative primary healthcare* (integrale eerstelijns zorg) in which different actors in the social and healthcare domain collaborate to address physical and mental health, as well as socio-economic and environmental problems- has been widely propagated as a means to reduce health differences. (8, 9, 10, 11)

General Practitioners in Integrative Care

An integrated approach can take place around an individual patient or on a public health level. (12) Primary care in the Netherlands is relatively low threshold. As patients are inscribed at a General Practitioners (GP) practice, there is often a long standing relationship between GPs and their patients. Patients often visit their GP with physical complaints related to complex social-economic problems. (13) Because of this, GPs have an unique broad overview of the health and wellbeing of both the individual and the neighborhood they work in. Moreover, they have a need for an integrated approach to adequately help their patients. (13) For this reason, primary care professionals can play an essential role in bridging the gap between individual treatment of disease and population health as they are at the interface of personal and community health. (14)

In addition in the Netherlands GPs have an important role referring people to other specialists, both in the medical and in the social domain. In many cases these specialists can only be accessed through referral by a GP. In this way they also have 'a gatekeeping' function.

Local government's role in diminishing health differences

Diminishing health differences is about tackling the social and environmental determinants of health. Local governments (in the Netherlands the municipal governments) play a key role in this, as they are responsible for many aspects that determine health. (15) Dutch municipalities have tasks that can contribute in creating the conditions for healthy living, such as spatial design, including housing, green spots, facilities and mobility. In addition they offer assistances to their population that concern health determinants, such as social work and debt 'assistance'. (16)

Being responsible for all these disciplines that affect health, they can have a coordinating or facilitating function in intersectoral collaboration for health The WHO-Europe

summarized the role of local governments as follows: *'Local governments are key deliverers of health and health equity. […] They create the preconditions for healthier living and intersectoral action. '* (17)

Combining forces -of low threshold access at the interface of individual and population health of the GPs and the ability of the municipal government to coordinate and shape determinants of health in different sectors- together they could reduce health inequities.

The Dutch context

Two current developments should be considered in the study of collaboration between GP's and local government in the Netherlands: the decentralization of certain health services to local government, and the alarming increase of GP's work pressure. (12, 18, 19)

Due to national changes in government policy elderly people live longer independently at own homes instead of at specialized facilities. (20) This has brought more, complex care to the GP practices. In addition GP's have taken over certain care and procedures traditionally done in hospitals. These factors have contributed to an increase of workload. (19) A 2018 study commissioned by the national GP association (19) reviled that two thirds of the Dutch GP's indicate their work load and pressure are too high, and that this negatively affect the quality of patient care and causes risks for the patient. (19) This reality should be acknowledged as GP's should not be burdened with extra time-consuming tasks. Moreover, 12% of the GP's indicated the high work load caused them to 'always or often' not ask questions to uncover the actual reason for the patients visit. (19) This evidently may prevent them from obtaining an integral view of their patients problems. At the same time good intersectoral collaboration, allowing for appropriate referral to, and effective communication with government services, could help to improve the workload experienced by GP's.

In 2015 local governments became responsible for care that was previously coordinated at the national or provincial level. ('wet maatschappelijke ondersteuning' and 'jeugdzorg') These changes came alongside significant budget cuts. (12) Now GP's refer patients to health care services provided or coordinated and financed by the local government. This causes them to be more directly involved with one another. Yet, several reports and policy documents, as well as empirical experience have identified that collaboration for integrative primary care remains challenging in the Dutch context. (12, 21, 22)

Barriers for collaboration

Due to the recent policy changes and the growing awareness of the need for intersectoral collaboration different stakeholder organizations have published reports and studies on intersectoral collaboration in the Dutch primary care sector. (22, 23) These have provided insight into the challenges in realizing integrative care.

A practical guide for better collaboration between GP's and local government formulated hands-on recommendations. These were based on evidently informed insights specific to GP's and local governments collaboration. They addressed topics such as how to get started, means of communication, and how to get insight into local policy. This guide mainly refers to practical and structural barriers, such as lack of time, coordination and expertise, fragmentation of responsibilities and privacy laws. However, research in intersectoral collaboration has shown that, in addition to these structural factors, more

fundamental and implicit elements are at the basis of what makes collaboration difficult. Elements such as vision, self-reflection, mutual respect, sense of duty and involvement, and expectations about roles, have been identified to play an important role. (24, 25)

Indeed, one study identified the need of a paradigm shift from 'care and disease to health and behavior', and people centered care. Moreover they recognized organizational and financing structures as key barriers. Lastly they formulated the insight that initiative and change come from 'bottom up'. (23)

A different publication on the integration care and socioeconomic support identified several important 'questions' of intersectoral collaboration. (22) Namely interrelation between policy, management and practice; the challenge of conflicting tasks; being open for change; knowing the limits of your own profession; investing time in setting up collaboration; and getting to know each other on a personal level. Though this publication speaks of integrative care specifically from the viewpoint of social work, these questions could be considered in the collaboration with GPs as well.

Paradigm of collaboration

Collaboration is a complex and multi-faceted process. For this study a paradigm developed by Twijnstra Gudde was used. Though this paradigm is based on collaboration between two equal, possibly competing organizations, and is not specific to intersectoral collaboration it provides a framework in which to arrange the many aspects affecting collaboration. As visible in **figure 1** it highlights 5 main aspects of collaboration, namely process; organization; relationship; interests; and ambition. (26)

As in the study above, and confirmed by informal empirical observations, barriers in collaboration between GPs and local government are often ascribed to 'process' and 'organization' related factors. However, as mentioned above, more implicit elements in the domain of 'ambition', 'interests' and 'relationship' often play an important role. A (public) gap of knowledge still exists in the identification and analysis of obstacles that hinder collaboration between GPs and local government. Most evidently implicit factors in the domains of ambitions, interests and interpersonal relationships remain unexplored.

This paper presents a systematic qualitative study on collaboration between GPs and local government for community oriented integrated care in the Netherlands. Moreover it draws lessons from the Cuban care system for the implementation of integrated community oriented approach in primary care.

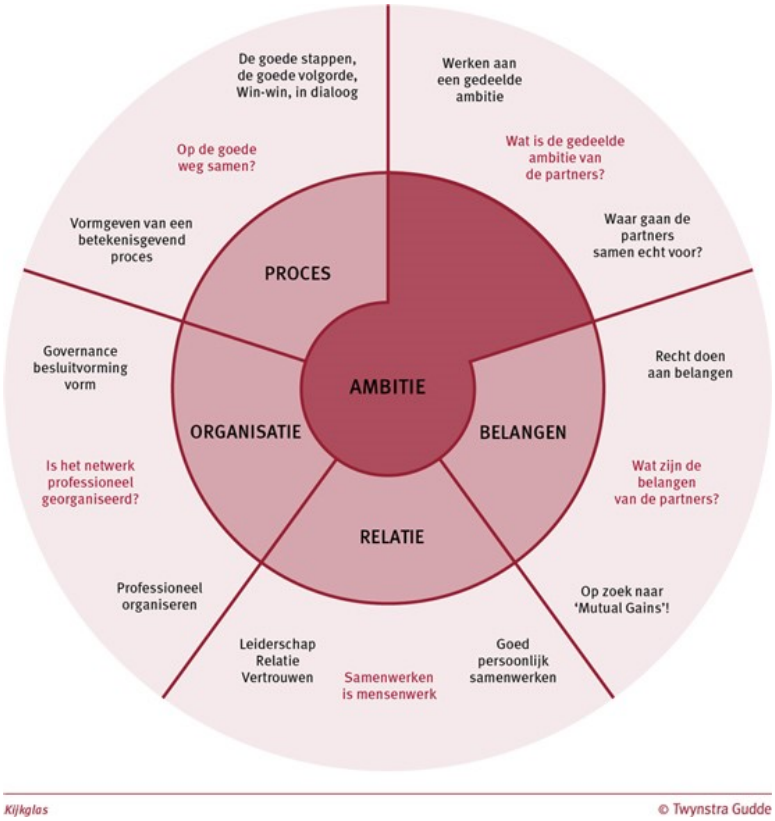

Figure 1: Paradigm for collaboration
Translation (per segment):
Ambition: Work towards a shared ambition; What is the shared ambition of the partners?; What do the partners really want to work for together?|
Interests: Do justice to interests; What are the interests of the partners?; Look for mutual gains|
Relation: Good, personal collaboration; Working together is 'human work'; Leadership, Relation, Trust|
Organization: Professional organizing; Is the network professionally organized?; Governance structures for decision making
Process: Shaping a meaningful process together; Are we on the right path together?; Good steps, right order, win-win, dialog.

The Cuban example

One remarkable 'good practice example' of *integrative primary care* is the Cuban healthcare system.

From 1959 onwards there has been a strong political determination to organize healthcare in an accessible and equitable manner, and improving the populations' health. Primary health care is the cornerstone of this system. Primary care is organized in a community-oriented fashion, and is integrated with other sectors that affect health. In this way it is able to address health determinants, as well as health problems of the population. (27)

All 11 million inhabitants of Cuba correspond to a *consultorio,* - a neighborhood health clinic consisting of a team of a GP and family-nurse. One *consultorio* is responsible for up

to 1500 people. It addition to attending to people with health problems, the GP and family-nurse teams see all of their population one or more times a year, depending on their health status. (28) (Group 1-4, **See Box 1**) In this way the whole Cuban population is in view and under the care of the primary health care system. Once a year the *consultorio* makes an analysis of the health situation of their population (*análisis de la situación de salud)* in which they evaluate the health, risk factors and health determinants of their population and area. Based on the analysis an action plan is formed to address these. In addition, the GP and family-nurse often live in the same neighborhood as in which they manage the *consultorio.* (28) This allows them to have a better understanding about the realities of the neighborhood that affect the health of the population.

Box 1: Continuous Assessment and Risk Evaluation System

Group I: Apparently healthy individuals	Seen at least once a year
Group II: At-risk individuals who may develop health problems due to risk exposure at home or work	Seen at least twice a year
Group III: Ill individuals, including those with chronic, communicable or non-communicable diseases Group	Seen at least three times a year
IV: Disabled or otherwise incapacitated (temporarily or permanently) individuals suffering from disruption of their motor, functional, sensory or mental capacities	Seen at least twice a year

Source: Cory, C. (2017) Cuba's Family Doctor-and-Nurse Teams: A Day in the Life, *MEDICC Review* Vol 19, No 1

15 to 20 *consultorios* form a 'health area', that corresponds to a 'neighborhood in-patient clinic'. These are also based in the community and offer diagnostic procedures, laboratory testing, and more specialized consultations. (29) Once a month a 'basic working group' gets together in the in-patient clinic. This group consists of all of the GPs and nurses of the 15-20 *consultorios*, the in-patients clinic's specialists in internal medicine, gynaecology/obstetry, and pediatrics, as well as the clinics dentist, psychologist, social worker, epidemiologist and the statistics expert. Here they discuss cases that require an interdisciplinary approach, as well as general concerns of their population's health. The epidemiologists carry out an analysis of the neighborhood twice a year, identifying the physical, environmental and social health risks. (30)

Subsequently, different sectors of the local government come together with health care professionals, as well as with groups from civil society to address health risks. (31, 32)
The local health analysis are grouped together at different governmental levels and inform local and national decisions on public health. In addition national epidemiologic institute (INHEM) carries out public health investigation on topics not addressed at the level of the *consultorios* and inn-patient clinics. An example of this are the tens of 'national programs' issued by the ministry of public health with protocols for the management and especially the prevention of high prevalence diseases.

This community oriented, integrative primary care approach has lead to an equitable and highly accessible public health system. (12) As a consequence Cuba has a remarkably healthy population, as reflected in the high life expectancy, which was at 78,45 years at birth in 2016. (33) The infant mortality rate of 4,3 per 1000 life births in Cuba is considered low. (33) (In comparison the average infant mortality rate for countries in Latin America and the Caribbean was at 16.2 in 2016 and the life expectancy at birth was 74,70 years.) (33, 34) In the Netherlands these numbers are were 3,6 in 1000 and at 81,5 years respectively. (35, 36)

Furthermore, an epidemiologic shift has taken place in Cuba since the implementation of the community oriented integrative primary care system. The raise in life expectancy and a lower birthrate (from 4,01 in 1950 to 1,45 in 2015) has led to an aged population, with 19,8% of the population being over 60 years old. (37) Infectious diseases - associated with vital primary deficiencies such as nutrition, water, housing- were gradually replaced by chronic and degenerative diseases, injuries, and mental disorders. (38) These amore associated with *'genetic factors and vital secondary deficiencies such as personal or environmental safety, emotional support, and opportunities for full realization of individual potential'.* (38) Now heart disease, malignant tumors and cerebral-vascular diseases are the three principal causes of death in Cuba. (39)

Thus despite being an impoverished and developing country, the health indicators and disease profiles in Cuba are comparable to those in developing countries. This is especially remarkable considering the per capita spending on healthcare in Cuba is less than half of the Dutch health expenditure per capita. (40) The health care expenditure as a percentage of the GDP are similar, 11.1 % and 10.9 % in Cuba and the Netherlands respectively. (41, 42) (This reflects amongst others the health care workers salaries and the government production of pharmaceuticals.) For these reasons better understanding of the Cuban experiences in collaboration for community oriented integrated primary care can provide insights useful for the Dutch situation.

Research Questions

The above has lead us to the following research questions:

1.How do GPs and municipal governments in the Netherlands view their own and each other's roles, and what implicit obstacles hinder their collaboration?

2.What lessons can be learned from the Cuban primary care system about collaboration in the community between government, healthcare, and social care professionals?

3.What conditions have to be met in order to achieve this collaboration?

Materials and Methods

Grounded Theory Method

This study has been conducted using the Grounded Theory Method. This method contains the systematic generation of a theory from data throughout the whole research process. As aspects of a theory evolve it may become apparent that the research questions or methodology need to be adapted to better answer the emerging questions. As data was collected repeating ideas emerged and were given a descriptive code: a tag describing the key point of a piece of data. Different codes were grouped together into 'categories'. Subsequently categories were integrated into a theoretical model, describing in which way categories are linked with one another. A constant comparative method was used testing the theoretical model on new data. In addition negative case analysis was preformed, looking for instances in which the developing theory did not apply to adapt the theory accordingly. As more data was gathered the theoretical model was adapted, untill data saturation. This method allows the theory to account for the full complexity of the data. The Grounded Theory Method therefore is a suitable method for exploratory research aiming to understand complex processes.

To answer research question 1 semi-structured interviews were preformed, followed by small-scale local focus groups. Lastly a member check was carried out, in which respondents were able to comment on the findings of thisstudy. In this way triangulation of the data was managed.

Participant recruitment

Recruitment of GPs and civil servants from the local government involved in community oriented care took place by purposeful sampling striving for variation regarding age, gender, neighborhood characteristics, location, experience in community oriented care and employment type. A description of the respondents is in **Table 1** under **Results**. GP's of the Diversity and Global Health working group of the Dutch GPs society (NHG) were invited to participate. Contacts out of the professional network of Prof. Maria van den Muijsenbergh were approached subsequently to achieve diversity, specifically in employment type. Civil Servants were recruited using the contacts of the program Wijkgericht werken of the Radboudumc division Primary and community care and of Pharos program Gezond In. Recruitment went on until theoretical data saturation was reached.

Semi-structured interviews

Semi-structured interviews with GPs and civil servant were carried out. The topic list and questions for the interviews was based on literature and expert opinions from GPs and researchers within the program Wijkgericht werken Radboudumc division Primary and community care and Pharos program Gezond In. The initial topic list underwent several minor changes during the interview stage, based on the usability of the responses given in answering the research question. Moreover questions were added as new topics of interest emerged out of previous interviews. In addition some topics were omitted in certain interviews due to time constraints or because they were not applicable to the specific case. (See **attachment** I)

Focus groups

It was initially aimed to carry out a focus group consisting of GPs and civil servant from diverse municipalities. However, as traveling to a central point prevented many people to participate it was decided to carry out small focus groups at different municipalities.

There was always at least one GP and one civil servant present. The focus groups were used to test the theories and ideas that emerged from the interviews in the Netherlands as well as from the participant observation study in Cuba. (See guide in **attachment III**)

Member check
After analysis of the interviews a member check was performed. The categories and theories identified from the interviews were send to the interviewees and they were asked to comment. (See **attachment IV**).

To answer research question two a participant observation study was carried out

Participant observation
Participant observation in the role of an 'observer participant' was carried out during four weeks at a Cuban 'consultorio del medico y enfermera de la familia', in Havana. Data collection consisted of detailed field notes and informal interviewing. In addition guided visits were made to a neighborhood inpatient clinic, a community center for mental health, a mother-and-child house, a community project to activate elderly people, a 'grandparents-home', and an educational institute for people with psychosocial disabilities, the house of the local federation of Cuban women (FCM) and the national epidemiological institute. In each of these places field notes and informal interviews were recorded. A description of the informants is in **Table 2** under **Results**.

Coding & analysis
The data (notes from the participator observation and transcripst from the interviews and focus groups) was coded, ensuring validity by double coding some of the data by the researcher and supervisor. Diverging conclusion were discussed until agreement was reached. A thematic analysis was performed. Subsequently the results were discussed by both researcher and supervisor until agreement was reached.

Results

1. How do GPs and municipal governments in the Netherlands view their own and each other's roles, and what implicit obstacles hinder their collaboration?

Table1: Respondents description

Respondent	Description
#1	GP with 2,5 years of working experience as a 'locum GP' (waarnemend huisarts) in two middle-large city. Some experience with collaboration
#2A	Policy advisor and project leader in social services, of a small town.
#2B	Newly appointed counselor for youth and Healthcare of a small town.
#3	Recently retired GP, who worked at a health center in a disadvantaged area of a large city. Has little experience in collaboration with the municipality.
#4	Policy maker at the department for health care, at a municipality that includes two villages. Has invested much time over a long period in collaboration, with mixed results.
#5	GP with 12 years of working experience, working in a health center in a middle-large city. Extensively involved in collaboration with the local municipality.
#6	GP working as a locum GP in two practices, both located in strongly disadvantaged neighborhoods. Little experience with collaboration with the municipality.
#7	GP with an independent practice in a large city. Has some experience with collaboration
#8	GP with an independent practice in a large city. Has little experience with collaboration
#9	Policy maker in a large city, with ample experience in collaboration with GPs
#10	Recently retired GP, with ample experience in collaboration with the municipality, in a large city.
#11	Team manager youth and education, including youth care, in a large city. Ample experience in collaboration with GPs.
#12	Policy maker at the department of 'wellbeing' of a middle-large city. Has experience in collaboration with GPs.
FG	Group consisting of one GP, and two policy makers at the department of 'healthcare and wellbeing' at a small town.

In Summary:

Collaboration between GPs and local government can concern individual care or developing policy or projects directed at a broader population. The structures for primary healthcare are segmented: GPs and the municipal government have different responsibilities and financing structures. Therefore they have different interests in collaboration. (**Figures 2 & 3)** This can function as an implicit barrier for collaboration. Other implicit barriers seem to be rooted in cultural aspects like the wish for independency among GPs a different use of language. Concordance in task

interpretation, knowing one another and believing that collaboration works are positive determinants for collaboration (**Figure 4**) .

Types of collaboration

First of all, there are different levels of collaboration between local government and GPs. 1) Collaboration in a project or around changing local policy. 2) Collaboration in providing care for individuals. The second has become more important ever since the 'transitions' gave local governments the responsibility of providing specific healthcare services to which GP refer their patients. (See **Box 4**) This has opened up the need, but also the opportunity for more close collaboration between the municipality and GPs. Where the policy makers of the municipality are perceived to be part of a distant bureaucracy, workers who carry out the practical work for the municipality are felt to stand closer to the GPs.

Because before there were neighborhood-teams [wijkteams] *the municipality felt like something that was really afar, something administrative. It felt like a cumbersome apparatus, that would say 'lets consult' and that would form all kinds of little groups, and more groups. That culture I am familiar with as well, and I think that is also the image may GPs have.* #5

The municipality is responsible for the neighborhood-teams and the Governmental Health Services [GGD] *and all that. But in the end you do it with the workers of those organizations. So we overlap on a policy lever, but also at a practical level, in the neighborhoods.* #10

GPs are often in a position in which they manage both the administrative and the practical application of their work. In contrast, in the municipality this is divided between the policy makers and the social workers that are employed by the municipality. For this study, we interviewed GPs and policy makers of the municipal government, as they are the ones who make the decisions that shape the possibilities and conditions for collaboration between GPs and social workers of the municipality.

Segmented responsibilities

GPs and policy makers were asked what they considered to be their tasks with respect to the wellbeing of their populations. There answers are summarized in **figure 2**. Generally these responsibilities did not overlap. There is thus a segmentation of responsibilities.

The municipal government feel responsible for public health, primary prevention and some care facilities. Now that youth mental health has also fallen under their responsibility they also have some 'cure' tasks. Moreover they put in place long term policies, and can play a coordinating role between different organizations that work.

First of al primary prevention, stimulating a healthy lifestyle. That is were it starts, and wellbeing of course. And since 2015 we also provide part of the care. Youth-care is a big part of that.

With the youth mental health care we now also have responsibility for some of the 'cure'. -FG

The tasks of the municipality are defined in the law for public health [wet publieke gezondheid]. […] And as a municipality we also care for out citizens in a very broad sense

of the word, in all kinds of domains. And there we preferably want to [..]prevent problems from happening in stead of solving them.. #4

We thing social support is very important, that is also a big part of our task. There we can prevent people from getting even more problems that they already have. And that they can be 'happier'. #2

In the end controlling the costs for us as municipal government is a very important task indeed. Because we can only spend the money once. #2

The task interpretations of GPs seemed to vary greatly between GPs. In general GPs see their task as a responsibility to individual patients and focus on cure and contributing their technical medical knowledge. Furthermore, they act primarily in reaction to what they are burdened with. Some GPs have, in addition to that, a broader task interpretation, in which they see working together in the social domain as part of their task.

If you as a GP are sort of to 'go-to point' for social problems, then they also come to you in times of crisis. Then you have to deal with everything, right at that moment, even though you also have other patients. And that can be very difficult. If you just say 'No, the neighborhood nurse [wijkverpleging] of the Neighborhood Team has to do that, then you can focus more on your patients, for the medical things, rather that those administrative things like housing and safety.' #6

First of al it is important to provide good care for the patients that are registered at your practice. And I think I am a doctor that in addition does a lot with prevention. […] Also because I have a lot of patients that have little education and a low social economic class, so they need more education of health and healthcare. So I try to provide that through information sessions in the neighborhood, organized by other organizations. Those I do as a volunteer. And for the general population, you should also be accessible to the whole neighborhood, that is also one of your responsibilities. #8

I think that in the future it will be inevitable for GPs to think more broadly. Which is also something that makes this trade fun and beautiful. Being part of a team of people that has a broad outlook, sharing information and making decisions together on what is best for the neighborhood. And I notice that other GPs are also seeing this. […] They don't think 'we are only going to provide strictly GP-care'. But that we have a broader task. #5

Sometimes these different tasks can contradict, causing friction.

The GPs are very focused on their patients. They want the best for them, and if their refer them they just say 'this help should just be arranged', whether it concerns medicines, therapy or being admitted. And we as municipality are more focused on broader aims, such as the WMO, focused on all our citizens. And we have a limitation of financial means. Up until today I don't feel GPs have a lot of understanding for our situation. #4

Generally, the responsibilities of GPs and the municipality towards people's health are segmented, yet the people it concerns are not. **(Figure 2)** This insight forms the basis of the motivation to collaborate. (As the policy makers of the municipalities that participated in this research all already demonstrated a willingness to collaborate or had collaborations established, the task interpretations described here focus primarily on the GPs.)

I thing GPs are actually responsible for the medical domain. But humans don't function that way. So I think you should also be interested in what is happening around the medical issue, and guide people to the right place for help. #6

It may seem that it is segmented like that (as in **figure A attachment III**)*, but for the people who come with a problem it is of course not divided that way. So we always try to think from the point of view of the people. When you do that you can't really go wrong. - FG*

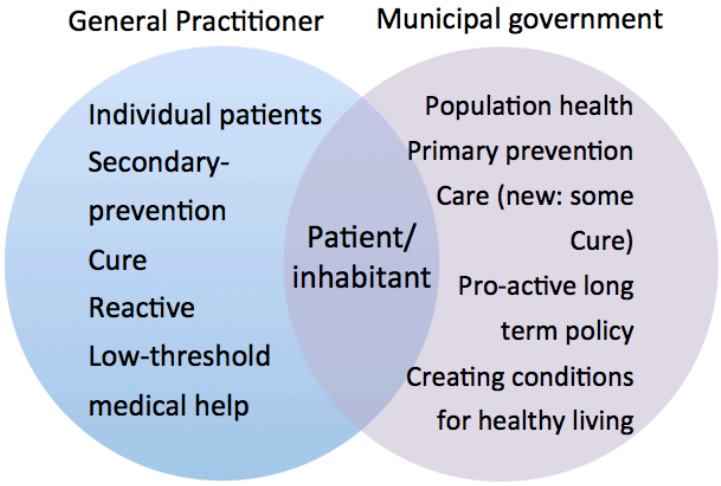

Figure 2: Primary care responsibilities of GPs and the municipality, according to the respondents.

The variation in the task interpretation of GPs was also noted by the municipality, and reflected their willingness to collaborate.

The willingness to collaborate wit us [municipality] varies a lot. Really a lot. One GP really wants to, but encounters all kinds of obstacles, and the other one doesn't want anything to do with it al all, that is an even bigger problem. #2

When a GP sees a patient, I understand perfectly well that they need to identify a problem, and find a solution in only 10-20 minutes. And that is very different from the way we work. Our Neighborhood Teams always try to have a very broad way of seeing a person. So those are party different visions, and different ways of working between GPs and the municipality. I can imagine, -or rather, I think- that these different ways of working make collaborating more difficult. […]But there are also cases in which we are successful, so that varies. There is a lot of diversity between the GPs. #9

Diverging and overlapping interests

The segmentation in responsibilities, also includes a segmentation in execution and funding. This causes GPs and the municipal government to have both overlapping and diverging interests when collaborating with one another.

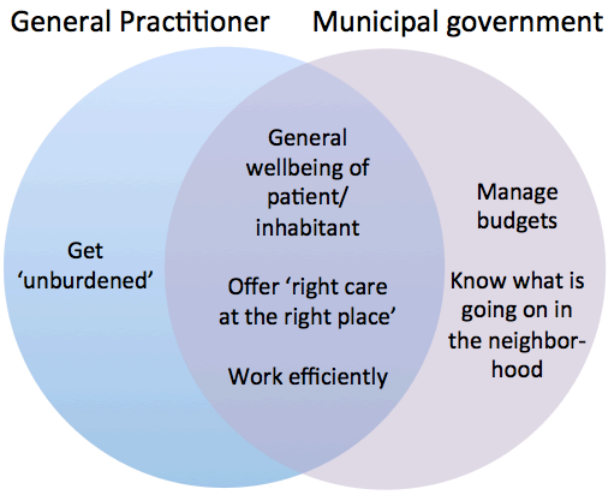

Figure 3: Overlapping and diverging interests of GPs and the municipality in collaboration

These differences in interests are noticed, and can be a cause of reluctance in perusing collaborations. GPs mentioned the financial interests of the municipality as a concern.

GPs look more at the patient, while they [municipality] *look if not too much money is spend on healthcare, because they got quite some cutbacks, and they don't have that much money.* […] *And GPs are also a bit scared of that when collaborating with the municipality. That thát is their underlying goal. That they don't want to collaborate to get better care, but rather to look after the money. I think that fear exists .#1*

We want the municipality to provide fair and fitting care, and not only 'sit on their money' as if guarding a treasure chest. #5

Conversely, the priority of the relation of GPs with their patients caused a local governor to question their decision making in referring patients to government services.

They know they always need to prioritize their relationship with the patient. So that makes it quite difficult for them to confront their patients, and say 'no' to them when they ask for something. […] I think it happens quite often that a GP does not say 'no' when they actually should. And as a result we have seen a huge rise in the referrals to the youth-care by the GPs in this municipality. #2

Yet when asked whether these different interest are ever explicitly discussed all respondents replied negatively. Under **Research Question 3** there is a further analysis of how this barrier of different interests can be overcome, creating win-win situations.

Knowing one another, and believing in collaboration

In addition to this task interpretation, the conviction that working together with the municipality will be beneficial is an essential determinant for successful collaboration.

One of the causes [of whether GPs want to collaborate] is whether they experience the method actually works. #8

Well, I think it helps when GPs notice they actually have something to gain form the

social domain. And that is a vicious circle you need to break. #9

It helps to facilitate collaboration when people know each other personally, and know what they have to offer.

For example in X place they organize a 'Neighborhood Safari' [Wijk Safari] once in a while. Where you go by different organizations from the municipality, such as the Leger des Heils and the Voedselbank and things like that. And then you know where it is and what kind of people work there. When you have seen them once, it makes them more real […] And it doesn't occur to you most of the times to refer a patient to a place you don't know, or only read about once. But when you have been there you can consider which patients it will suit. #1

Coming together every two months you get to know each other better. And net time you need to call them, you work together more easily. #10

Winning trust by working together pragmatically and bottom-up. And see what you have to offer each other as you get to know each other, and realize 'Oh, this is useful, when I refer to that place. And they also notify me of how they followed up.' That is the best way to do it. #9

However both these factors also depend on the extent of collaboration that is already in place. This is illustrated in **figure 4.** In this way both positive and negative spirals can maintain a certain situation. The key is to turn around the negative spiral. Further insights on how to achieve this are discussed under **Research Question 3.**

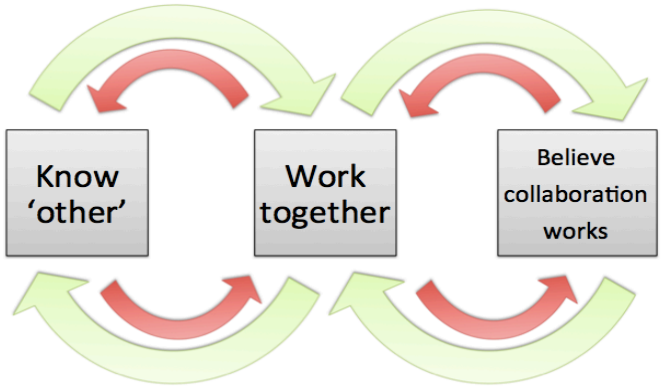

Figure 4: Working together, knowing each other, and believing collaboration works, can affect each other as both a positive or negative spiral.

Implicit barriers for collaboration

When asked about barriers for collaboration most GPs and municipal policy makers first mention practical barriers, such as lack of time, and funding and working with privacy laws. However, this study focused on implicit barriers that complicate collaboration, despite willingness and possibilities to collaborate. The structures of financing of the GPs and the municipality can form such a barrier.

Financing structures

An important factor is the segmentation of the financing structures. Just like the responsibilities within primary healthcare are segmented, so is the financing. This again

is complicated by the fact that the people they care for and the processes they go through are not segmented. For prevention and intersectoral collaboration many investments are made by the municipal government, but most financial benefits go to the health insurance companies.

Should we do more with prevention? […] We'd think it is quite a good idea, here at the health center. We thought 'shouldn't we have a prevention-worker?' But then, do we *need to pay for that as well? Because that doesn't 'pay for itself'. There is no profit model for prevention in the current financing system. #6*

I think that the way GPs are financed also forms a barrier. Because the insurance companies need to make separate 'payment indications' [betaal titel] to finance collaboration. The fact that it is all so tightly regulated does form an obstacle. […] In place X they did an experiment with financing based of the population. So not financing based on results or the amount of consultation the GP did. And that caused the GP to have more attention for wellbeing. That resulted in that boundary between the healthcare financed by the insurance companies and welfare got blurred. #9

[…] and there it becomes clear that many more people are send to the municipality to help them with their problems in the social domain that are at the basis of their health problems. But then it gets stuck because the municipality does not have enough money for al that. All the while it is getting cheaper for the insurance companies, because there are less referrals to medical specialists. […] So that also has to do but the budgets, and the segmentation of the budgets. Because healthcare is organized of a national level, but the social domain is done by the municipality. So they pay while the insurance companies win.. #10

To cope with this segmentation of financial structures, several municipal governments try to collaborate with health insurance companies to co-finance prevention programs for their population. However, especially for small scale municipalities it is difficult to establish such a contract with insurance companies.

We are a relatively small municipality, which is why insurance companies are not willing to even talk to us, they tell us 'not interested'. We are 'only a B municipality'. Yes, very strange. Too bad! #2

Profit motive

This segmentation of financial structures is further complicated by the market principles and 'profit motive' that influence the working of care providers. As described in the introduction, the municipal government is responsible for providing certain healthcare facilities, such as youth mental health. Care professionals are contracted and paid by the municipal government to provide this care for people in the municipality. The providers of this youth mental health are organized in for profit businesses. For this reason they have, in addition to providing good care, an interest in providing as many hours of care as possible, rather than efficiently using the resources of the municipal government where they are most needed. This has an important impact on so called 'patient stops' for youth mental health care. These 'patient-stops' are further discussed under **Research Question 3.**

And then you get this situation in which the budget is all spend by October or November. And everyone who is signed up afterwards they tell 'Sorry, you don't get help. You need to wait till next year.' […] And this happens because at the beginning of the year a

large part of the budget is spend on people who actually only need very little assistance. Because these healthcare providers, deliver so much care. #4

I think that independent care providers must have had massive turnovers in these last few years. They must have. – FG

Likewise, most of the GP's in the Netherlands are also self-employed. Their income depends on the revenue of their practice: the fee they receive per patient on their practice list and in addition the fee for each patient contact. The average incomes of GP practices is broken down in **Figure A** in **Attachment V**.

The practice receives the revenues by billing the care they provide to the health insurance companies. In most cases however time invested in collaboration with the municipal government can not be billed with the insurance company, and thus is financially not profitable for GPs. This forms a barrier for some GPs to invest time in collaborating with the municipality.

Well, it is a difficult thing to say, because in the end you do it for the patient, but well you also want an income as a GP, and there is definitely a financial incentive, because for every proceeding you do you get money. […] The same time you spend on collaboration with the municipality you could also spend doing for example chirurgical operations, that get you much more money. So you must feel that it is worth it. In terms of energy and time, but also financially. #1

I have no financial interest in the collaboration at all. It is even going against my own interest, because this does not get subsidized by the insurance company. –FG

Financing plays in as well. You can just do what you want, and you aren't really judged or cut back by weather you collaborate or not. That does play a role. #7

Culture of autonomy

Another barrier experienced was the dominant, (but not un-contested) culture of individualism and autonomy of the GPs.

There are also those who you never see, never hear. Those who think 'I have my own practice, it is my shop, and I decide. I don't need others for that'. #4

Language

Lastly it was hypothesized that differences in language use may form a barrier for collaboration. Use of professional jargon can increase the perceived distance between the two parties. A word use questionnaire (described in **Attachment II**) reviled there was indeed a different use and preference for words between GPs and municipal policy makers. This was visualized in **figures 5 & 6.** Especially the GPs disliked ('felt allergic') some words they thought to be typically used by the municipality, like 'client', 'pillars' and 'policy plan'. People from the municipality were in general less critical about the word list presented to them. (**Attachment II**) However, this was generally not explicitly experienced as a barrier for communication. The different use of words seems to reflect the different priorities of each party.

Use of language *was* experienced as a barrier when the same words were used, but a different meaning was attached.

At some point we had a meeting with GPs present. And during the conversation there were some misunderstandings around the word 'primary care' [eerstelijns]. So then we did a round where everybody gave their definition of primary care. And that resulted to be quite varying. #12

Figure 5: Word use of municipality policy makers, as determined through the questionnaire in **attachment II.** Translation of each word is also given in **attachment II.**

Figure 6: Word use of Genera Practitioners, as determined through the questionnaire in **attachment II.** Translation of each word is also given in attachment **II.**

2.What lessons can be learned from the Cuban primary care system about collaboration in the community between government, healthcare, and social care professionals?

The Cuban primary care system has a completely different focus and structure from the Dutch primary care system. Comparing the two, and the impact of their different organization on the possibilities for intersectoral collaboration would be a colossal task, and difficult to translate into actions for the Dutch context. However, studying a healthcare system that is fundamentally differently organized can provide new insights. It gives an idea of how the organizational structures, but also the culture and ideology that shape it, impacts how it functions.

Table 2: Informants description

Informant:	Description
DM	Teacher at the national school of public health, where he specialized in epidemiology and in health care management
NS	Nurse and teacher at the national school of public health.
DP	Psychiatrist and teacher at a local mental health clinic in Havana.
NM	Nurse at a Mother and Child house in Havana.
NC	Nurse at the neighborhood clinic with over 30 years of working experience in this neighborhood.
DC	Medico General Integral (GP) at the neighborhood clinic with 34 years of working experience, of which 20 years at this clinic. In addition she ran the breast cancer screening consultations at the local in-patient clinic
F1	Volunteer at the local Federation of Cuban Women (FMC).
F2	Volunteer at the local Federation of Cuban Women
SG	Social worker at a neighborhood 'House of the Grandparents' in Havana.
DE	Epidemiologist at the national institute of epidemiology, which does research for and advices the national government on public health matters. Before becoming an epidemiologist she worked as a Medico General Integral (GP) in an neighborhood of Havana.

In Summary:
Access to the management level of the Cuban primary care system turned out to be very hard. Therefore the results are based on the perspective of health care and social care professionals working in the community, and researchers in the field of public health.

Cuba unified the responsibilities, interests and finances of healthcare in a single care system. This follows from an ideology of health care as a right of all people and a responsibility of the government. This has also shaped the task interpretation of health care workers, giving them a naturally integral view on health care. In addition a culture of collaboration and solidarity allows for community participation, further contributing to an integral health care approach.

Accessibility and reliability of respondents
It became evident that access to people in administration positions in Cuba was very difficult to achieve in the context of this study. On one occasion it was arranged to have a meeting with an administrator of a neighborhood policlinic, but the meeting got cancelled with the argumentum the administrator thought it was not within the scope of

this research. It was not possible to set up any meeting with others in an administrative position. For these reasons, the results of the research carried out in Cuba focus primarily on health care workers in primary care, and their role in intersectoral collaboration, and not on the possible role of local government.

In addition it has to be noted that the reliability of the factual information that was given by some of the respondents was questionable. In some cases statements of different respondents directly contradicted one another. In other cases the information stated as facts were verifiably untrue. These questionable statements always portrayed the Cuban health care system in a favorable way. It was not possible to verify whether the respondents were aware of the faultiness of their statements. Access to information is limited due to restricted internet accessibility and state control of a means of all media. It was noted however that specifically respondents from the National School for Public Health seemed keen on transmitting a purely positive representation of the Cuban health care system. Three examples are given in **Box 2.** Building a relation of trust with informants, talking to a large diversity of people and fact checking, were important to achieve a reliable image of the Cuban primary care system.

*I do think we have had a problem with a top-down mentality of 'authority figures'. No-one would dare to say something about it. You and I can talk about this here [*at her home*] but at the institute I can not say these things.* –DE

Factors that shape intersectoral collaboration

Based on the interviews and participant observations in the primary health sector in Cuba, it can be concluded that an interaction between cultural, ideological and structural

Box 2: Unreliable statements

1) *'As you may have noticed, there is no problem with air pollution in Cuba. Because we are an island, the wind of the sea blows all the polluted air away.'* - DM

Walking around in Havana this statement is notably untrue. Later during my visit I attended a conference on health and transport, in which the air pollution in Havana and the impact on pulmonary diseases was explicitly discussed.

2) '*52% of the governments budget goes to heath care. 45% goes to education, and the rest goes to culture. '* -DM

Logically this statement seems unlikely, as it would leave no money for spending on any other government organizations, such as sanitation, national defense, transport, state owned corporations, etc.. According to the WHO the health care expenditure was 18,01% of the national budget. (31) Though this is relatively high, it does not come close to the stated 52%.

3) *'Cost effectiveness is no argument for administrators in deciding whether or not to introduce prevention programs. The value of a human life can not be counted in money. In fact, cost effectiveness is not even researched.*' –DM

Later a contradicting statement was made by another respondent.

'*A colleague of ours at the institute is an expert on cost- effectiveness analysis. […] This is becoming more and more important, because of the way it is going now the cost are getting difficult to cover.*' -DE

factors shape the well functioning intersectoral collaboration in Cuba. These factors do of course also affect one another, creating a complex network of interactions. The codes retrieved from the data, substantiating each of these factors, are described in **Box 3.** The following paragraphs will describe how these factors interact and affect the possibilities for collaboration.

Box 3
Codes: What factors shape intersectoral collaboration in Cuba's primary healthcare system?

Ideological factors:

- Health care, especially primary care and prevention are a **political priority**.
- There is a strong consciousness of **health as a 'right of the people'**.
- Focus **on communal wellbeing**, rather than only individual wellbeing.
- Sense of **common wellbeing goal** with care providers from different domains.

Structural factors:

- **Single, universal health care system**
- **Public system**
- **No profit motive**
- More **GPs per capita**
  - Thus more time per patient
- Established **structures for intersectoral collaboration**
- GP's and nurses are **part of the community** they attend.
- Established **structures community participation**
- Educated and **knowledgeable population**.
- **Diversity** of care providers.

Cultural factors:

- Informal, **low threshold** ambient of GP clinic
- Cultural **experience of time**
- **Group culture and solidarity**

Single, universal health care system
One of the difficulties identified in realizing collaboration in the Dutch context was the segmentation of both the responsibilities and the finances within healthcare. In Cuba a single health care system, all financed by the state, does not experience this segmentation.

The government set the ideology of health care as an unconditional right. It took responsibility for providing accessible healthcare to all its people free of charge. The government takes responsibility for health and wellbeing as a whole, and not just certain aspects. In addition no-one can profit individually, financially from providing care. In this context preventative measures, rather than curative interventions take the

main stage. This is realized through the organization of the primary care. GPs are not only responsible for patients that come to them with health issues, but for the wellbeing of their whole population.

Structures of intersectoral collaboration

The broader tasks of the GP creates an awareness of the determinants of health, which often lay outside the medical domain. For this reason Cuba's primary care system has established structures for intersectoral collaboration. In this way the care provided in different domains come together and are coordinated. An example of this is the care that is organized around pregnancies, as described in **Case 1,** the coordination of dengue outbreaks, or the meetings of the basic working groups (*grupos basico de trabajo*) at the neighborhood policlinic, as described in the introduction. These structures of collaboration bring the different care professionals together. It was notable that care professionals in different domains in the same neighborhood knew each other by name (and each others phone numbers by hart). This indicates their close contact. In this way GPs benefit from the additional knowledge and expertise of other care professionals, and patients are helped in a more integral way.

Case 1: pregnancy care

When a woman in Cuba gets pregnant she is expected to visit the GP within the first in the first 14 weeks of pregnancy for an uptake consultation. A general medical assessment is done, identifying possible risks of the pregnancy. She gets folic acid and iron supplements. And the woman, as well as the father of the child, is tested for HIV and syphilis. In addition the appointments with other healthcare professionals are coordinated.

After this the women is within 15 days seen by a **gynecologist**, a **psychologist**, a **social worker, dentist,** and a **nutritionist**. They all make an assessment and, where needed plan follow up meetings with the women.

Their assessments are written down into a file which the woman is supposed to carry with her during the whole pregnancy.

When the pregnancy is considered to be very high risk, the woman is admitted into a 'mother and child house' in her neighborhood. Here she is exempted from working, doing any physical labor, or the stress of the household. In addition nurses and a gynecologist are present for medical assistance.

During the whole process, the GP is informed by all the different care professionals, and is responsible for overseeing the case.

Common wellbeing goal

The integration of health care with social care was to such an extent that they were, by some not even considered to belong to a different domain. This for example became evident when a confusion of speech occurred when I talked about collaboration between social workers and GPs as an example of intersectoral collaboration.

'But social workers and GP work in the same sector. So this is not intersectoral

collaboration' - NS

The same was underlined by the sense of a common goal between all primary care professionals. On several occasions care workers mentioned something among the line of: '*In the end we all have the same goal, the patients wellbeing.*' - NM, SB, F1

Group culture

The attitude of teamwork was somewhat in contrast with the desire for autonomy and control some Dutch GPs mentioned, and which was found to be a barrier for collaboration. This was hypothesized to be related to the group-culture, and general sense of solidarity and mutual support that characterizes Cuba. The culture of solidarity within primary care for example became visible in the way care professionals would, in a natural an informally organized way, take over each others patients when, due to stress, illness or family issues, one of them could not attend to these patients.

Community focused vision

Similarly, healthcare professionals seemed to think about health and health related issues, less on an individual and more on the societal level. For example, after having done a check up of women of 43 year with hypertension in her third pregnancy, the GP commented the following:

'*I am worried. Pregnant at her age, with hypertension. This is a risky pregnancy. But well, the birth rate of this country needs to go up, so…'* - DC

The less individualistic focus also caused them to naturally see their patients surroundings as part of their health and wellbeing.

'The ones responsible for someone's health are, the person themselves, their family, their community, and the government.' -DM

F2: '*We have programs for young girls who dropped out of school, to learn a trade, like accountancy, hairdressing or computer science.'*

Dutch interviewer*: 'Oh, right. So they can become independent. Take care of themselves.'*

NC (at the same time): '*Oh, right. So they can contribute something to their community. '*

GPs per capita

Cuba knows a high number of GPs per capita. Indeed, nearly all doctors specialize as a general practitioner, before possibly continuing into a different speciality. This causes the practices to have less patients, allowing for more time to be dedicated to each person. The practice in which the participant observation was conducted had 2 full time working GPs, one of whom had a population of 732 people and one of 1060. This allowed the GPs to spend more time on each visit. Visits often took between 15 and 30 minutes and never seemed rushed. The GPs often asked after the patients' family wellbeing and their home situation.

No profit motive

Moreover, the salaries of all workers are set at a standard rate by the state. Therefore this does not influence how these workers prioritize their time, and there is no financial competition between health workers.

Participation leads to patient centered healthcare
Another lesson from the Cuban care system is the focus on community participation. When done well, this leads to a person centered approach, which takes into account the different domains that affect the persons wellbeing. An example of this are the educational materials that are developed by the local section of the Federation of Cuban Women (FMC) together with the local in-patient clinic. A folder on 'healthy families' gives advice to parents on themes, identified by the FMC to be of interest to their population. It includes food preparation and healthy diet, but also parenting advice about teenagers and the importance of blood pressure regulation.

Conditions for community participation are on the one end low threshold primary care system, practically, financially, socially as well as culturally, that allow the health care workers to have a close relationship with their population. On the other hand there are structures, such as the FMC, and societal factors that allow communities to voice health care concerns.

Low threshold
Low threshold accessibility is achieved by the fact that nearly all healthcare is completely free of charge and locally available. In addition it is low threshold in the sense that the GP and nurse know all their patients as well as their context personally. This allows for a familiar atmosphere in the clinic.

Part of the community
Often times GPs and nurses live in the same neighborhood as the communities they serve. This causes them to have a close relationship to the community, and a better understanding of the issues their patient population faces. They will for example know when there is a problem with the garbage retrieval, what the living conditions are in different areas and how the social cohesion of the community functions. In addition, being part of the community they will know more about the daily life's of their patients. For example, which children have trouble at school, what families have money issues, which people experience loneliness, and who is traveling abroad. This causes them to have a naturally integrative view of their patients and the problems they present themselves with at the clinic.

Walking with a family nurse around the neighborhood it is very evident she was a well known and respected member of the community. She was greeted by nearly everyone she passed, and often people would start a conversation with her. These informal conversations were at the same time used to assess how people were doing and to educate people about health related issues.

*'Who is this beautiful baby here?! You are getting so big! And who is letting you sit in this strong sun?! '*To the parents: '*How has he been? […] With the sun this strong it is really important to make sure he is in the shadow. '* -NC

The GP and nurses at the local clinics are involved with their community, even to an extent that in the Netherlands would be considered inappropriate, but in the Cuban context seems to communicate care and involvement.

'To be a good GP or nurse in primary care, you need to also be a bit of a gossiper. You need to know what is going on with people. And often neighbors or other people in the community can provide you with a lot of information.' -NC

Diversity of care providers
The diversity of the health care workers adds to the low threshold accessibility of the primary care. People from all different geographic areas, socio-cultural and ethnic backgrounds are trained as doctors and other health care workers. As a whole, this allows the system to be more culturally sensitive, being aware of for example local practices, and problems.

'We know what it is like to life in these [impoverished] conditions, so that helps us to understand what our patients are dealing with.' NC

'People from more rural areas are schooled to become doctors, so they can return to their communities. They know best what the realities and needs of those communities are.' –DM

Structures for community participation
All of the above contributes to a closer relation between GPs and the population. In addition there are explicit structures that are supposed to contribute to popular participation in primary care. Most importantly the Federation of Cuban Women (FMC). The FMC are organized in each neighborhood, and represent the interest of women. They form a two way bridge between the population and health workers. On the one end they help to educate and inform the population on health related issues. On the other end they can inform GPs about the goings on in the neighborhood or about specific people.

They organize for example vocational training for young women who, often due to pregnancy, dropped out of high school, they give information on how to prepare healthy food, breast feeding and they are responsible for educating and convincing mothers on vaccination of their children. In addition they are a point of contact for people for questions on for example childcare, family issues and sexual health.

In addition there are supposed to voice the needs of women and families in local government. However, due to the authoritarian, one-party state, and a lack of representative democracy, it can be questioned to which extent these bodies are truly able to independently articulate critical opinions from the population. For example when asked about questions around the legalization of same sex marriage, - which was a topic of public debate at the time of this study, due to proposed changes in the constitution- chief members of the FMC had an outspoken analysis and opinion. However, they did not voice this in the public debate.

'The party hasn't voiced a statement on it yet they are still in the process of collecting opinions in the population. So we can't really participate actively in the public debate yet.' -F2

Knowledgeable population
Lastly, due to completely freely accessible general education, as well as extensive health education campaigns, the Cuban population has a relatively high level of (health) literacy. The education, the high number of doctors per capita may add to this, as there is a doctor in nearly each family, who often educates their family on health issues.

The high level of knowledge about health and medicine was exemplified by the fact that in the 4 weeks of participant observation at the consultorio, only one patient did not

know the precise name of their medication. Health related issues were also often a topic of conversation with both peers and strangers. In this context it was noted that there was generally a greater consciousness about health and health related issues than in the Netherlands. It was not unusual for people, not working in the healthcare sector, to have knowledge about specific diseases and be able to interpret lab results. This knowledge allows people to participate actively in their own health care process, facilitating a patient centered approach.

3.What conditions have to be met in order to achieve this collaboration?

In summary:
The Dutch GPs and municipalities that were interviewed encounter diverging responsibilities and interests. In some cases they also found solutions to overcome these differences, creating win-win situations. Re-considering ideological, structural and cultural aspects of the Dutch primary care system can help to provide insight in how to overcome the barriers and achieve collaboration.

Creating a win-win situation: Time and information

Diverging interests of GPs and municipal governments were described under **Research Question 1.** However, when these interests are translated into practical actions, the differences between both parties *can* become smaller. In this way, in the practical implementation, the interests of both parties may overlap more than in theory. Thus, by collaborating they can create win-win situation.

GPs have an interest in being able to provide fitting care to patients with complex 'multi-domain' problems. These patients are not sustainably helped by merely intervening in the medical domain. Moreover, they tend to come back to the GP more often. As described in the introduction, high workload is an increasing issue for most GPs.

The added value is mostly for those vulnerable patients whom you as GP can't figure out how to help all on your own. […] Because those are the cases that often take the most time. And often it is not even 'GP-care'. It is money and relations and care. #5

However, the impact on collaboration resulting from this lack of time differs depending on the actions of the GP. Some GPs hope to alleviate their workload somewhat by being able to refer these patients to the municipality. The municipalities often state they can provide such alleviation of workload.

Lets be honest, we also expect the municipality to unburden us. #5

One time, when we got together with the coordination group, even we got started one of the GPs started to grouch saying: 'I am so annoyed with this! I have been busy all morning trying to get this child in need to a boarding home. But I encounter all kinds of hurdles along the way. So complicated!'. The coordinator of the 'Plus-team' was sitting next to her and said: 'One phone call to us, and we would have taken over that case for you. And we'd have that fixed within 10 minutes. We know exactly what to do, and who to call.' #4

At the same time, the municipal government also have an interest in GPs referring people with problems in the social domain to them. GPs are in a position to detect problems at an earlier stage.

Because we as Neighborhood Teams and municipality are actually at the 'back end'.

We often see people when it is almost too late, when their risk be evicted for example. People come ask for help way too late, or they are referred to us by someone else. […] So for us the so called 'front field' is very important. Where the people are who can puck up on problems. Social networks, schools, but also GPs are part of it. #2

On the other end there are those GPs who dismiss the social domain as part of their responsibility as it would cause an even higher workload.

At the practice in place X for example we have a lot of elderly people, and we also have an assistant specifically for elderly care, who really helps with the whole social domain. But the GP of place Y has consciously chosen not to do that. She says, I don't what to have anything to do with housing of care ín my practice, the municipality has to pick up on that or the Neighborhood Teams. SO the practice in place X does offer a good service […] but it also puts a lot of pressure on you as GP. #6

Logically, when the GP does not want to attend to social problems in their practice, the municipal government also does not reap the benefits. Thus, the same situation and interest can lead to different actions and results. From these examples it follows that it is not merely availability of time itself, but rather the action that follows what determines the possibilities for collaboration. This is schematically shown in **tables 3 & 4.**

Situation	**Interest**	**Action**	**Effect on other party**
Lack of time →	*Less work load →*	*Refer complex cases with determinants in social domain to the municipal services →*	*Municipality gains insight in 'front field'.*

Table 3

OR

Situation	**Interest**	**Action**	**Effect on other party**
Lack of time →	*Less work load →*	*Take no action in the social domain →*	*Municipality has no direct collaboration with GP*

Table 4

In addition to this GPs have stated that when they experience time pressure, they are *less* likely to ask about determinants in the social domain that affect their patient. Yet, the less the social domain is taken care of, the more the patient will attend to the GP. Thus a negative spiral dynamic can occur.

Debt, conflicts, poverty, domestic violence, unemployment, those things make people ill. They have much more somatic complaints because of it. […] And I notice that those

people who have all these problems, they come to me much more often, with complaints of lower back pain, headaches, etc. #6

When you have financial worries, or a high time pressure, then you will eventually see that reflected in the patient care. Money is not the motivation to do or not something. But when you just need to do a certain amount of consults each hour, you might not bring up anything about the social domain, because you don't have the time for it. Which actually also comes down to not having the money for it. #6

Creating a win-win situation: Handling austerity policies

When it comes to the interests of the municipality a similar analysis can be applied. All municipalities have to deal with the nationally enforced austerity policies that came with the 'transitions' of care tasks the municipal responsibility. (**Box 4**)

We can only spend our money once. And the costs in the whole health care domain are rising explosively at this moment. […] And when we have no more money, we have no more money. So in end we are really looking for ways to control the costs. #2

However, the way this was done differed significantly. There are municipalities that try to stimulate GPs to detect and refer cases in for example youth mental health services as early as possible. In this way they try to prevent escalation of the problems, and through prevention, safe money of the more complex care. In this process, GP's are an asset, as they have generally a relationship of trust with their patients.

Well, one of our side-goals [for collaborating] is of course that we are responsible for the WMO. Which costs us a tremendous amount of money. Especially in the youth-care. So we say, what we can involve GPs from an early stage with these problems, maybe we manage to keep these problems more manageable. At the moment we wait too long, and the problems become larger and larger, the solutions also become more complex and expensive, which costs us even more money. #4

The municipality has several interest. They manage the budgets of youth care and the WMO. They want to do that effectively and efficiently, referring people to the right places. So they are also benefitted by the extra information the GPs have to offer. But also find problems on time, before they escalate. […] In part that is also a question of money. #5

Box 4

In 2015 some decentralizations in the social care domain took place, together know as the 'transitions'. These put care responsibilities, which had previously been coordinated on a national level, in the hands of municipal governments. This was done with the goal to provide more efficient and personalized care, and carry trough budget cuts. (12)

- All the 'youth care' (Jeugdhulp) including youth mental health has become the responsibility of the municipal government in both content, execution and funding. The budget cut applied specifically to the 'specialized' youth care, which takes in the more complex cases. (12)

- Municipal governments are now responsible for carrying out the new law for Social Support (Wet Maatschappelijke Ondersteuning, WMO). This means the municipality is responsible for organizing and funding the certain type of caregivers as well as devices to help people stay living at home as long as possible. (12)

I think we also have a credits with the people. When the GP tells you, you should go to the Neighborhood Team, people actually do it. #7

We notice that if the GP refers a patient to us, people actually come. 'The doctor says I had to come, so.. ' The doctor still has a lot of authority, people really listen to them. #2

There are also municipalities that try to reduce the costs by trying to prevent GPs from referring to the services they have to finance. Indeed it was considered that GPs should not be able to refer patients to child psychiatrists, who are paid for by the municipal government.

For the youth it is really clear, the municipality pays. We as GPs really fought for the right to be able to refer to youth care in the Netherlands. At the being they said 'No, that all has to go through the Neighborhood Team.' #7

GPs make about 60% of the referrals to youth care. And that is our budget. […] But they don't have a direct incentive, or responsibility towards us. So we need to show them it is eventually also their task and in their interest to refer less, and not go over our budgets. […] A lot of them already do a good job, and they don't refer their patients to us that often. #2

In addition to this some municipalities implemented a patient –stop once their budget for the year was done. This generally led to frustrations with the GPs as they could not refer their patients to the care they needed. This dynamic is schematically summarized in **tables 5 & 6**

So now the treat exists of what happened in Eindhoven as well. That the municipality sets a certain budget and says 'That's it. This is all the money we've got.' And by the time you reach October or November the money is all spend, and everyone who is referred to youth care after that is told 'Sorry, you don't get help, you have to wait till next year.' Well, that is really not nice. #4

The municipality has a contract with several child-psychiatrists. But that money is gone too fast. So that around this time of the year [end of October] people need to wait until the new year to be able to get the right help. I think that is not ok.' #7

Situation	**Interest**	**Action**	**Effect on other party**
National enforced austerity task →	*Spend less money →*	*Stimulate early referral as a preventative measure. Treating problems at an early stage is less costly. →*	*GPs patients are helped and large, complex problems may be prevented.*

Table 5

Situation	Interest	Action	Effect on other party
National enforced austerity task →	*Spend less money →*	*Implement a patient- stop, and advocate for* less *referrals.*	*GP's patients may not get helped. GP's are frustrated with municipal government.*

Table 6

In addition to these, some respondents reported a third approach. This was one of not focusing on the austerity goals, and even, on the short term, invest extra money into the health care services they are responsible for, to ensure no patient-stop will occur. This is described in **Case 2.**

Case 2: creating a common goal

In the municipality of a middle large city, it was decided not to adhere to the austerity measures in the first two years after the transition, but rather invest more money from their financial reserves. This was appreciated by the local GPs.

Of course you know they can not keep doing this. But I thought it was a very nice gesture. There were also places where they [the municipal government] said: 'Too bad, we are out of money.' What do you mean we are out of money? Place X did not say that. But after two years they did say: 'Hmm, we have spend a lot more money than we meant to. How come?'

Simultaneously a investigation was started into the referrals to youth mental health services by the GP's. When evaluated social workers was concluded that 40% of the referrals was unnecessary or could better attend to a different service. Faced with the hard numbers GPs were more willing to adapt their behavior.

If se all start to apply this healthcare will actually become cheaper. And the waiting times become shorter. So it is actually useful. [..] We thought 'We can do better'. Because doctors are also quite proud. We have a professional pride. So we though, shit, so we really preform worse that the rest of the Netherlands in this? So we were actually also willing to change something.

In this way a sense of a common goal, rather than conflicting interest was created

In place X the municipality did open up the path for collaboration. […] We want to make sure together *that we manage to make ends meet – ór we need to try to get more money from the national level. So now is has become a problem of 'us together', not only a problem of the municipality.*

Thus, the same starting point can lead to different outcomes. This tells that it is not necessarily the practical context itself, but rather how it is dealt with, which determines successful collaboration. Which path is chosen depends also on the barriers the people involved encounter or perceive. In **Research Question 1** it was identified that barriers for collaboration were caused by the segmented structures of organization, responsibilities and financing, leading to diverging interests. In addition, task interpretation, a culture of autonomy as well as language differences played a role.

At **Research Question 2** it was found that an interaction between cultural, ideological and structural factors shape the well functioning intersectoral collaboration in Cuba. These factors in their turn also affect one another, creating a complex network of interactions.

We propose that changes in each of these aspects can contribute to successful collaboration. As elaborated on in **Research Question 2** it would not be possible to directly translate the Cuban experience to the Dutch context. However, re-considering ideological, structural, and cultural realities of the Dutch primary care system can provide insight into how to overcome the barriers of intersectoral collaboration.

Structural factors: Segmentation vs. Person centered approach
In Cuba there is a system for community participation in primary care. The study with Dutch GPs and the municipality revealed that a segmentation in responsibilities can be overcome when a person centered approach is taken.

It may seem that it is segmented like that (as in **figure A attachment III**)*, but for the people who come with a problem it is of course not divided that way. So we always try to think from the point of view of the people. When you do that you can't really go wrong. - FG*

It is exactly this person-centered perspective in the organization of care that can be achieved through community participation.

Structural factors: Segmentation vs. unification
Cuba has a single (not-segmented) health care system. Different health care workers have divers expertise, but they consider themselves all to be working towards the same goal of patient wellbeing. In this context, they have established structures for collaboration, in which they often interact with one another. It was identified in the Dutch context that knowing one another personally helped in building successful collaboration. Established structures for collaboration, such as regular meetings, facilitate enormously in building intersectoral relationships.

Ideological factors: Task interpretation
The way the primary care system is structured may determine to a large extent how GPs see their own and others tasks. It was identified that the possibilities for collaboration depend a lot on the task interpretation of GP's. In the Netherlands the task interpretation of GPs vary a lot. Some do not want to collaborate with the social domain at all, where others see intersectoral as a necessary part of their job. In Cuba, the vision of health being something not only of the individual but also of their social and environmental surroundings, causes intersectoral collaboration to be so natural it is not questioned. Though responsibilities of GPs and the municipal government in the Netherlands are segmented, the people it concerns are not. This insight forms the basis of the motivation to collaborate.

Ideological factors: For profit motive

The for profit motive of some services of the Dutch primary care system undermines the dedication to collaboration. Independent of their personal motivation, it is only logical GP's and for example youth psychiatrists take cost into account when deciding how to invest their time, as their livelihood depends on it. The ideology of the market principles applied to primary care providers creates this situation. In the Cuban context, all health care are employed by the state, with a fixed salary. This allows them to spend their work hours as they see most beneficial for the health of their population.

Cultural factors: Group culture vs. autonomy

The group-culture as well as a culture of solidarity in Cuba facilitated the collaboration. This was in strong contrast to the individualistic culture, and the wish for autonomy of the Dutch GP's.

Discussion and conclusion

In a recently published interview the Dutch minister for public health stated that fundamental changes to the current health care system are needed. Based on conversations with stakeholders he stated: '*The health care system needs less 'market' and more collaboration. […] Collaboration does not happen out of nowhere, but it should be build-in inn the way we organize the health care.*' (43) This would mean a welcome break with the previous policy of the national government of opening the health care sector further to the market, spreading a profit driven ideology.

This study subscribes to this insight while it reconsiders the fundamentals of the Dutch health care system, -based on the question of intersectoral collaboration. It hopes to contribute to finding new balances in the structures, ideology and culture of the Dutch primary care system that will allow for better intersectoral collaboration, eventually canceling out health differences.

The study adds to previous publications that provided practical tools to improve collaboration, (12, 22) by uncovering implicit barriers for collaboration. In addition, this study is in line with previous research that states that a paradigm shift is needed to achieve better intersectoral collaboration. (23) The contrast with the Cuban health care system reveals with more clarity the paradigm that the Dutch primary care system functions within now and how it affects collaboration.

The goal of strengthening the intersectoral collaboration is to reduce health inequities. The recent Astana declaration, published by the WHO member states, stated that: *'We find it ethically, politically, socially and economically unacceptable that inequity in health and disparities in health outcomes persist.'* (44*)* However, a recent government publication reviled that health differences in the Netherlands remain large. Efforts to reduce these differences in the last 35 years have been largely unsuccessful. (7) This indicates the urgency to reduce health inequities but also the complexity of this problem, and the need to reconsider approaches.

The Astana Declaration also underlined the need to strengthen primary care, the intersectoral approach to health. In addition it echoed one of the conclusion of this study, highlighting the role of community participation in realizing intersectoral approach. (44)

Strengths and limitations

The strength of this study is the multi-angle approach, bringing in a new perspective from the Cuban experience.

However, this study also knows a few weaknesses. As described in **Research Question 2,** transparency into government-regulated processes in Cuba was an issue. As a result it was aimed to not base the findings on factual statements of the informants, but rather on their personal experiences and the observations made

In addition participant observation studies always are subjective. It was especially noted that, coming from a different culture and health care system, it was difficult to judge what of the observed behavior was considered normal in the Cuban health care system, and what was in fact exceptional. In addition to the at times propagandistic communication described under **Research Question 2**, this can have influenced the data collection and interpretation. A weakness of this study is therefore the fact the

participant observation in Cuba was only done in one GP clinic, and all visits of primary care facilities were done under the direct supervision of a teacher from the National School for Public Health.

For this study, we interviewed GPs and policy makers of the municipal government, as they are the ones who make the decisions that shape the possibilities and conditions for collaboration between GPs and social workers of the municipality. Understanding the experiences of the social workers employed by the municipality as well, may give further insight into how collaboration can be successfully implemented

All of the municipalities interviewed were either already engaged in, or actively trying to establish collaboration. The municipalities approached were contacts from the Pharos institute for health differences. Thus a selection bias is in place, towards municipalities that pursue collaboration. In addition, in the study in Cuba, local government could not be included. In the results it is noticeable that there is a focus on the GP's perspective, and their role in shaping collaboration.

Focusing more on the possibilities of local governments to overcome barriers, and interviewing municipal governments with more divers attitudes towards collaboration, may provide further insights. However, we have no indication to think that willingness to collaborate is often an issue at the municipal level.

Recommendations: and considerations

Based on this study a few short-term practical recommendations are formulated, as well as some considerations.

First of all, it is suggested to municipal governments to start small, when setting up new collaborations with GPs. As there is a great diversity in willingness of GP to collaborate it is logical to start whit the smaller group of motivated GPs. The outcomes of that collaboration can then be used to familiarizing a larger group of the possibilities of and convincing them of effectiveness of collaborating. In this way the negative spirals visualized in **figure 4** can be turned around.

It has been found that both GPs and municipalities are aware they have different interests in collaborating, yet this is not openly discussed. Explicitly talking with one another about the different interest each party has in the collaboration may help to increase the trust and think of win-win situations.

Education of GPs how to take a person centered integrative approach , how to treat a person in their social and environmental context, and how to collaborate with different disciplines, would help to ensure a future generation of GPs that is able to carry through the necessary changes for successful intersectoral collaboration. This calls for inter-professional learning. (45)

Offering accreditation points for GP's to participate in intersectoral meetings, such as network events (refereerbijeenkomst) or workshops on collaboration, can give them an extra motivation to participate.

Lastly, a few dilemmas need to be discussed. Certain aspects that make the Cuban health care system successful in intersectoral collaboration can become problematic when exaggerated, especially when applied to the Dutch cultural context. Thus a balance must

be found that fits the local context and culture, while still allowing for the needed changes.

An example is the focus on public health and the society as a whole, rather than the individual. This should not take away the focus, and objective evaluation of an individual when they attend the care of a GP for their individual problem. The example of the GP considering the countries birth rate when evaluating a pregnant woman signaled this risk could exist in Cuba.

Likewise the personal relationships between the health care professionals and their population is an tremendous asset in the integral approach to health care. However, the habits that shape this relationship, such as 'gossiping' and unsolicited advice, may be considered inappropriate in the current Dutch context. Indeed it may lead to loss of (the intention to) objectivity.

The single health care system and the common wellbeing goal allow for efficient collaboration. However, it comes with the risk of a top-down mentality, with loss of spontaneity and initiative. An earlier study concluded that the most promising changes come from bottom-up ideas, which came from creative and spontaneous initiatives on the ground. (23) Thus it is important to maintain a balance and leave space for such bottom-up initiatives.

Conclusion

Collaboration between GPs and local government can concern individual care or developing policy or projects directed at a broader population. This study found that the possibilities to collaborate are shaped by ideological, structural and cultural factors of the primary health care system. These all impact one another as well. Therefore, we propose that ideological, structural and cultural changes can contribute to a better intersectoral collaboration. This is visible in **figure 7.**

This will not only enhance the wellbeing of the population, but also can help to diminish workload of GPs.

In the ideological domain, GPs should see their task of patient care in a broad perspective, seeing the patients in their social and environmental context. In addition, the for profit model of part of the primary care system currently forms a barrier for collaboration.

The structure is shaped by the ideology, but structural changes could also facilitate the ideological changes needed. A single system, in which the responsibilities of care and the finances for care, are not segmented, will help change the task interpretation and the financial motives of GPs. Structures for community participation can also help to bring about this patient centered perspective. Setting up structures for intersectoral meet ups could help different actors to get to know each other and will facilitate collaboration.

In the cultural domain we need to move from GPs that want to stay independent and autonomous to GPs that see themselves as team players within the primary care. In addition an unifying use of language can contribute.

Moreover it was found that GPs and municipal governments at times have different interests in collaboration. Despite the awareness of different interests of the GP and the municipal government, this was not explicitly discussed in any of the cases researched.

Talking with one another about these interests can take away distrust, and may help to create win-win situations.

Figure 7: Structural, Cultural and ideological factors affect the implementation for intersectoral collaboration.

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ATTACHMENT I

Topic list interviews

Achtergrond	• Kunt u de wijk/ gemeente waarin u werkt kort schetsen? • In welke verbanden werkt u samen met de gemeente/ huisartsen?
Visie	• Er wordt tegenwoordig veel gesproken over samenwerking tussen gemeente / wijk organisaties en huisarts. Wat is de meerwaarde van zulke samenwerking voor uw werk? • Wat is uiteindelijk het doel/ de doelen van die samenwerking? • Denkt u dat de GEM/ HA dat zelfde doel heeft? → Waar liggen hun prioriteiten? Komt dit overeen? • Wat is de taak van (uzelf) huisartsen/ gemeente ten aanzien van de gezondheid van burgers? → bijv. Is een huisarts er alleen voor eigen patiënten die met klacht komen? Ook voor patiënten in de praktijk zonder klachten? (preventie) Ook voor wijkbewoners in het algemeen? • Het is naar voren gekomen dat de visie en taakopvatting van huisartsen sterk verschilt van persoon tot persoon. Waar zou dat aan liggen?*
Motivatie	• Wat motiveert u *persoonlijk* om deze samenwerkingen aan te gaan?
Beleving	• Hoe ervaart u de samenwerking tussen huisartsen en gemeente? • Wat zijn belangrijkste barrières en wat helpt bij de samenwerking?
Rolverwachting	• HA: Wat verwacht u van de gemeente ten aanzien van gezondheidzorg /// ten aanzien van huisartsen? • GEM: Wat verwacht u van huisartsen ten aanzien van de gezondheidszorg /// ten aanzien van u? • Hoe denkt u dat de gemeente/ huisarts zelf hun taken ziet? (Waar liggen hun prioriteiten?) Komt dit overeen? →Hoe speelt dit zich uit in de praktijk? → Wat helpt om dan toch op één lijn te komen? • Andere huisartsen hebben aangegeven dat er soms een wantrouwen is vanuit huisartsen naar de gemeenten, omdat zij het idee hebben dat de gemeente met een bezuinigings agenda aan tafel zit, en dat tegen het belang van de patient in gaat. Herkent u dit?*
Onderling	• Vindt u dat de gemeente ambtenaren/ huisartsen met wie u

vertrouwen **	samenwerkt goed werk leveren? → Concreet: wat heeft u aan de GEM/HA binnen de samenwerking. → Gevoel dat taken toevertrouwd kunnen worden? Waar komt dat door?
Communicatie	• Hoe ervaart u de communicatie met huisartsen / mensen van de gemeente? • Ervaart u wel eens 'cultuur verschillen' in de samenwerking met huisartsen/ ambtenaren? Kunt u dat beschrijven? → Merkt u bijvoorbeeld dat er een verschil is in taalgebruik? Gebruikt u: burgers of patiënten? Integraal? Gezondheidsbevordering? Positieve gezondheid? Beleidsplan? *** • Wat is de impact daarvan op de samenwerking?
	Samenvatten barrières
Reflexiviteit **	• Hoe gaat u om met de barrières die u ondervindt in de samenwerking? Kunt u gezamenlijk evalueren/ hoe gaat dat?
Overig	• Heeft u nog aanvullingen? / Zijn er nog dingen die niet aan bod zijn gekomen die van belang zijn in de samenwerking tussen huisarts en gemeenten?

* These questions were added later as part of the comparative method.

** These questions required an already establisched collaboration. In the cases that there was not any form of collaboration established these questions were ommited.

*** The prliminary list was established based on expert input from a reseacher from Pharos. Each respondent (GP and civil servant) were asked to add words to the list that in their experiance caused tension in communication. See **Attachment II.**

ATTACHMENT II

Participants were given this list of words in Dutch and asked to indicate for each of the following words if 1) know and or/ use the word 2) don't know/ don't use the word 3) know the word but dislike the use ('welke woorden bent u echt allergisch voor'). In addition they were asked to add words they identified as jargon to the list.

Burgers / Citizens

Patiënten / Patients

Client / Client

Inwoner / Inhabitant

Gezondheidsbevordering / Health promotion

Positieve gezondheid / Positive health

Diagnose / Diagnosis

Ziekte / Disease

Zorg bieden / Provide care

Behandeling / Treatment

Zorgketen / 'Chain of care'

Primaire preventie / Primary prevention

Leefstijl / Lifestyle

Integraal / Integral

Wijkgericht / Community Oriented

Beleidsplan / Policy plan

Transitie / Transition

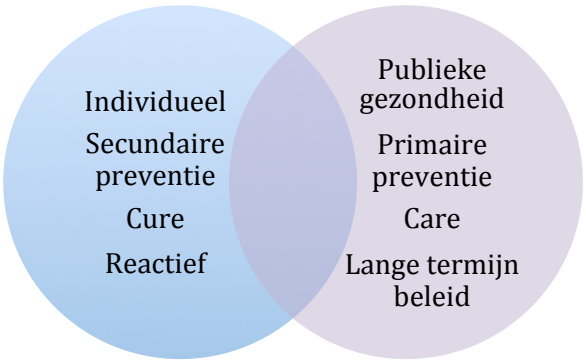
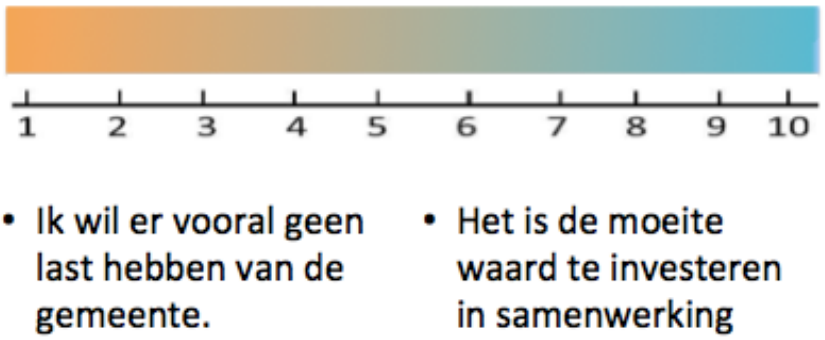
Pijlers / Pillars

Transformatie / Transformation

Bezuiniging / Cutback

ATTACHMENT III

Topic list for focus group.

Algemeen	Op wat voor manier vindt er in deze gemeente samenwerking met huisartsen plaats?
Discussie vragen:	
Verantwoordelijkheden	 Stelling: Huisartsen en de gemeente hebben verschillende verantwoordelijkheden naar patiënten / inwoners. De verantwoordelijkheid van de huisarts richt zich op het individu, focust op 'cure' en secundaire preventie, en is reactief. De gemeente is verantwoordelijk voor publieke gezondheid, gericht op lange termijn en heeft primaire preventie en 'care' taken. - Eens/ oneens? Waarom?
Belangen	Welk belang heeft u bij de samenwerking? Zet op volgorde belangrijk naar onbelangrijk. - A- Goede zorg leveren - B- Plezier/ voldoening - C- Financieel belang - D- Wettelijke verplichting voldoen - E- Efficiënter werken - F- Anders: ……. Wisten jullie dit van elkaar? Verschilt het veel tussen huisartsen en gemeente? Zo ja, maakt dat uit?
Houding huisarts	 De bereidheid van huisartsen om samen te werken verschilt erg per huisarts.

	Herkent u dit? HA: Waar plaatst zichzelf? Waar komt dit door? Maakt het type dienstverband uit? GEM: Waar plaatst u de gemiddelde huisarts in deze gemeente? Hoe gaat u mee om?
Politiek sentiment	Wat is de rol van het politieke sentiment op hoe huisartsen en gemeenten samenwerken?
Taalgebruik	Woordenlijst opdracht, en discussie. (Zie **ATTACHMENT II**)

ATTACHMENT IV

Code list send to respondents for the member check, with in red the codes that were commented on. Below the replies that were received from the member check.

CODES

Aard samenwerking

- Samen beleid maken
- Projectmatige samenwerking
- Samenwerking rond patiënt

Doel

- Efficiëntie
- Preventie
- Kosten besparen
- Kwaliteit patiëntenzorg
  - *Juiste plek*
  - *Passende Zorg*
- Inzicht voorveld voor Gem
  - *Achterliggende oorzaak aanpakken*
- Ontzorgen HA

Barrieres

Practische Barieres

- Meerdere buurtteams per praktijk
- Privacy
- Geen duidelijke takenverdeling
- Bureaucratie
- Inefficiëntie
- Tijd investering/ HA overbelast
- Financiële prikkel HA
  - *Tijd is geld*
- Verschil in taalgebruik

Impliciete Barrieres

- Wantrouwen om bezuinigen
- Weerstand verandering
- HA wil soms autonomie en regie
- Onbekend met mogelijkheden

Determinanten

- Financiële prikkel
- Werkverband
  - *Bestuurlijk betrokken*
  - *Waarnemend*

Zorggroep
'Georganiseerde' huisartsen
Noodzaak zien
Geloven dat het werkt
Aantonen nut
Pilot kost tijd
HA nemen meer aan van een collega
Elkaar kennen
Investering loont
Structureel overleg
Fysiek aanwezig
Terugkoppeling
Enthousiaste partners
Rol verzekeraars
Moeilijk voor kleine gemeentes
Scholing-Opleiding
Algemeen- politiek sentiment

Taak gemeente

Fysieke en sociale omgeving gezond en leuk leven
Wettelijke Plicht
Preventie
Welzijn
Bezuinigen
Faciliteren interdisciplinair samenwerken
Ontzorgen HA

Taak huisarts

Technische medische kennis
Doorverwijzen
Poortwachter
De-medicaliseren
Laagdrempelig aanspreekpunt
Vertrouwensband
Eventueel preventie (in samenwerking)
Eventueel welzijn
Samenspelen eerstelijns
Signaleren
Rond individu
Wijk
Standpunt innemen

Replies:

- *En bij privacy hoort denk ik ook specifiek beroepsgeheim.*
- *En bij onbekendheid met mogelijkheden hoort denk ik specifiek ICT mogelijkheden.* #1

Enkele opmerkingen met name bij taak gemeente:

- *Bij wettelijke plicht kun je de naam van de wet aangeven die de opdracht bij de gemeente legt: Wet Publieke Gezondheid*
- *Daarbij ligt de nadruk inderdaad op preventie en welzijn maar toch ook op het voorzien in zorg en bevorderen van gezondheid.*
- *Het is geen "taak" van de gemeente om te bezuinigen. Noodgedwongen moet dat soms wel gedaan worden. Verder is het geen taak van de gemeente om de HA te ontzorgen maar het is wel een manier om te realiseren dat de zorg voor onze burgers beter wordt dus daar waar we de HA het werk makkelijker kunnen maken, behulpzaam zijn of werk uit handen nemen levert dat een positieve bijdrage aan een goede gezondheidszorg.* #4

Voor mij herkenbaar en zeer compleet overzicht – dank!
Ik hou het voor mezelf ook even paraat als mooie "kapstok" bij gesprekken over dit thema #5

Ik heb geen aanvullende dingen. Of er dingen zijn waar ik het niet mee eens ben? Dat vind ik lastig om te zeggen, sommige dingen staan schuingedrukt met nog wat dingen eronder, en mijn mening is niet de mening van de rest van de huisartsen dus en die horen er ook in. #6

Ik denk dat je lijst een goed beeld geeft van wat we hebben besproken, # 12

ATTACHMENT V

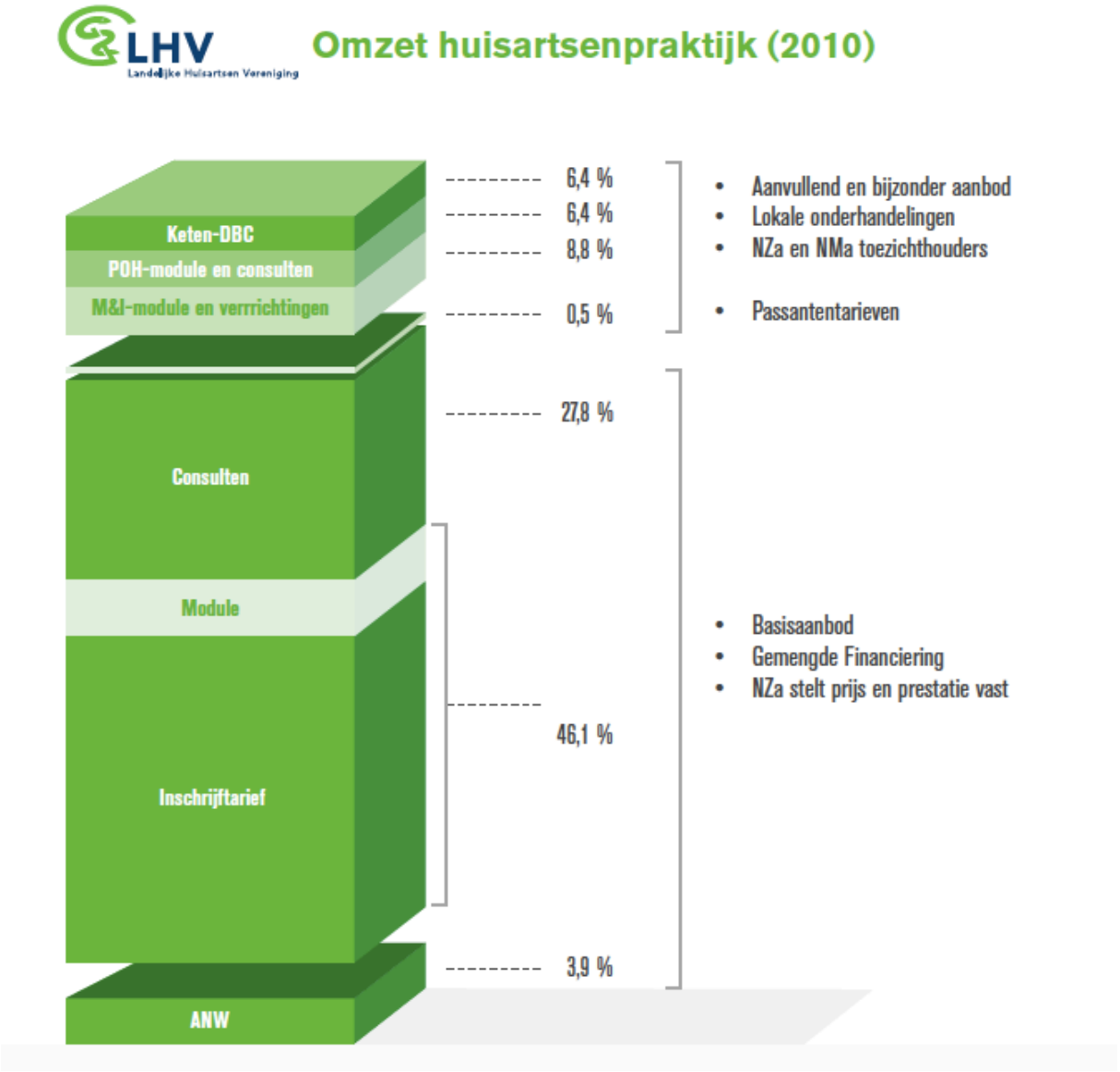


Figure A: Breakdown of a GP's practice sources of income.