Health Policy 119 (2015) 1–8

Contents lists available at ScienceDirect

Health Policy

journal homepage: www.elsevier.com/locate/healthpol

Working towards integrated community care for older people: Empowering organisational features from a professional perspective

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ARTICLE INFO

Article history:
Received 14 August 2013
Received in revised form
26 September 2014
Accepted 29 September 2014

Keywords:
Integrated care
Older people
Long-term community care
Multidisciplinary teams
Multidisciplinary cooperation
Organisational reform
Organisational empowerment

ABSTRACT

Although multi-disciplinary cooperation between professionals is a prerequisite to provide integrated care in the community, this seems hard to realise in practice. Yet, little is known about the experiences of professionals who implement it nor about the organisational features professionals identify as empowering during this cooperation process. Therefore, a case study of a multi-disciplinary geriatric team was performed. The data-collection included observations of meetings, in-depth interviews and focus groups with professionals ($N = 12$). Data were analysed inductively and related to the three organisational levels within the model of organisational empowerment of Peterson and Zimmerman. Signs of empowering organisational features on the intraorganisational level were mutual trust and clear working routines. On the interorganisational level important features included improved linkages between participating organisations and increased insight into each other's tasks. Tensions occurred relating to the inter- and the extraorganisational level. Professionals felt that the commitment of the management of involved organisations should be improved just as the capacity of the team to influence (local) policy. It is recommended that policymakers should not determine the nature of professional cooperation in advance, but to leave that to the local context as well as to the judgement of involved professionals.

1. Introduction

The last decades, there has been a growing attention to improve and reform care for older people with integrated care and empowerment as key concepts.

Diverse stakeholders emphasise the importance of a strong and integrated primary care as older people living at home often face complex, multi-facetted problems that cannot be resolved by one professional alone [1–6]. Furthermore, the integration of care is regarded as an important means to support vulnerable people in their own empowerment process [7–9].

In order to stimulate approaches for integrated community care, a variety of organisational structures are set up in different western countries [10] in which professionals cooperate in networks of interdisciplinary care services

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http://dx.doi.org/10.1016/j.healthpol.2014.09.016
0168-8510/

[11–14]. Integration of care is thereby often suggested as a panacea for various problems, for example to avoid the decline of older people's social capabilities, to increase their level of social inclusion, to avoid fragmented, inadequate and more expensive medical care [3,15–17], and to provide tailored care [5,18].

Despite the (political) attention on cooperation in community care, there are signs that integrated care is hard to realise in practice. Moreover, research shows that the rise of integrated care teams did not necessarily result in a greater proportion of older people remaining living at home [19]. Barriers mentioned in the literature include cultural cleavages between professionals [12,20], interface problems between professionals and organisations [21], organisational and procedural rules and regulations prevailing in the sector [12,22], the supply-driven design of the system, the complexity of the system, financial and legislative problems [21], limited outside expertise and management capacity [23] and power relationships between newly integrated services and professionals [20].

According to Lipsky [24] the discrepancy between policy measures as formulated by policymakers and the implementation of these measures in actual practice can be explained by the existence of professionals having frequent contact with citizens (street level bureaucrats). He argues that policy implementation is influenced in a large amount by those who implement it. To measure the effectiveness of policy measures like the realisation of integrated care, Lipsky therefore emphasises the importance of monitoring at the implementation of policy into practice. However, few empirical studies have been published on how professionals experience the provision of integrated care in the community and the organisational features they identify as empowering during this cooperation process.

This study aims to fill this gap. A theoretical model developed by Peterson and Zimmerman referred to as the "Nomological network of Organisational Empowerment" [9] is used to deepen our understanding of these experiences.

2. Empowering organisational features while working towards integrated care

Parallel to the emphasis on integrated care, empowerment is increasingly recognised by policymakers as a vision guiding the reforms in the health and social care [25–29].

An important objective of empowerment is to strengthen both individuals and organisations and to improve their ability to act. As empowerment is considered multilevel in nature it is important to not only study it on the individual level, but also to take the organisational level into account [9,30,31]. The attention to this level will help organisations to "develop both the climate and structures for generating reflective practitioners" [32: p. 50]. Organisations can provide opportunities to their employees for learning new skills, building a sense of control and improving community life, among other things [31]. Paying attention the organisational level furthermore implies increased focus on systemic issues and system thinking rather than short-term solutions [32].

Box 1: Health and social care in the Netherlands: contextual background

In the Netherlands the health care system can be divided into primary care, secondary care and long-term or tertiary care with a strong position of primary care [4,16]. The field of primary care includes self-care, informal care and community care and support and involve practitioners like general practitioners, physiologists, pharmacists, social workers and home care nurses [16]. Characteristics of Dutch primary care are among others geographical accessibility and care coordination by a general practitioner who serves as a gatekeeper for the whole health care sector [35]. In 2006 a major health reform and new policy initiatives have been taken place. Starting point of this transformation is the participation and social inclusion of citizens in society. The transformation consisted among others of a new division of the responsibility for the care. It concerned a switch of responsibilities from the national government to local municipalities, insurers, providers and patients. Furthermore, managed competition for providers and insurers became a major driver in the Dutch health care system [16].

Peterson and Zimmerman [9] show that the success of organisations at achieving their goals and missions is a complex interplay between organisational features, empowerment at the level of individual participants and the characteristics of the community. In their "nomological network of organisational empowerment" they distinguish three levels that may be critical for the performance of an organisation: the intra-, inter- and extraorganisational level.

The theoretical insights of their model can help us to enhance our understanding of empowering organisational features while working towards integrated community care for older people.

3. Method

3.1. Design

Our study was part of a naturalistic inquiry [33]. This type of research "takes place in real world settings without attempting to manipulate the phenomenon of interest" [34: p. 39]. We performed a case study in which we studied a group of professionals in the form of a multidisciplinary community based geriatric team ("the team") in the Netherlands for 1.5 years.

In Box 1 the contextual background is provided about the health care situation in the Netherlands.

We observed the team members during their team meetings and interviewed them in their own agencies. We then used the data we obtained from the observations and the in-depth interviews as input for two focus groups. This refers to our cyclical way of working.

Two main reasons to select this case were: (1) the team departed from the same theoretical vision (empowerment) as this study and (2) the team is regarded as an "innovative practice" with a high "learning potential" [36]. As the team has been functioning for more than 12 years they have