Intersectional collaboration and the development of prevention infrastructures: a qualitative study

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Abstract

Purpose – Investing in prevention could be of great benefit to public health. Especially for people with health risks, such as overweight, depressive symptoms, low social-economic status or people who experience loneliness or a sedentary lifestyle. In the Netherlands, different parties are responsible for financing and organising selective and indicated preventive interventions: the government, municipalities and health insurance companies. The aim of this study was two-fold: First, to describe the transition towards a sustainable prevention infrastructure. And second, to gain insight into barriers and facilitators associated with intersectoral collaboration regarding organising prevention for high-risk groups.

Design/methodology/approach – A longitudinal qualitative study was conducted among collaborative networks working together to build a prevention infrastructure. During a five-year study period, 86 semi-structured interviews were held. The COM-B model was used for data analysis.

Findings – Barriers to intersectoral collaboration are: unknown (cost-)effectiveness, limited incentives to invest in collaboration, lack of clarity about responsibilities, differences in priorities and organisational culture between municipalities and health insurers. Facilitators are commitment, trust, sharing knowledge between parties, meeting regularly within the network and acknowledgement of mutual responsibilities. Also, national policy interventions targeted at the development of regional prevention infrastructures facilitated collaboration.

Originality/value – This study shows that collaboration regarding prevention is becoming increasingly common. It can be concluded that the transition towards a sustainable prevention infrastructure has started. The relationship between key stakeholders, like municipalities and health insurers, is generally stronger than it was five years ago. They have a better understanding of each other's interests and expectations.

Keywords Primary care, Health policy, Governance structures, Qualitative research, Prevention, Intersectoral collaboration, Public health

Paper type Research paper

Introduction

There is increasing attention to (disease) prevention within healthcare. Many countries have presented their national prevention programme in the last few years (Rijksoverheid, 2018; Bensberg *et al.*, 2021; United Kingdom Government, 2021; Matheson *et al.*, 2020, Naqvi, 2023).

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Prevention is defined as measures taken by or applied to persons who are not currently affected by a disease, intended to decrease the risk that disease will afflict them in the future. Prevention is traditionally classified into three levels: primary, secondary and tertiary (Gordon, 1983). Investing in prevention could be of great benefit to public health for several reasons. At first, people who are in good health are better able to lead fulfilling and productive lives and contribute to society (Bodenheimer and Sinsky, 2014). Secondly, implementing preventive programmes would increase the average quality of life (QoL) of the people participating. In turn, an improved QoL leads to a lower demand for care and thus lower pressure on our healthcare systems and healthcare providers' workloads (Fitzpatrick, 2019). Thirdly, preventive interventions for high-risk groups can reduce the use of expensive medication or treatments and could therefore lead to economic benefits (Boom, 2009; Van Gils *et al.*, 2020). These factors correspond to the goals of the quadruple aim of increasing population health, improving patient and provider experiences and lowering cost growth (Bodenheimer and Sinsky, 2014).

Despite potential benefits and the general consensus that policy strategies should focus more on prevention, there is a gap between policy and desired outcomes (Cairney and St Denny, 2020). One of the intended outcomes is the implementation of a complete range of preventive interventions for high-risk groups, because this is currently not conclusive. High-risk groups are people who are not sick yet but are at risk of getting sick because of their biological characteristics, lifestyle or life events (Gordon, 1983). For example, people with overweight, depressive symptoms, low social-economic status or people who experience loneliness or a sedentary lifestyle. Developing and implementing preventive programmes for high-risk groups is often complicated due to a lack of clarity about financing, few financial incentives, the different responsibilities of the stakeholders involved and different organisational cultures (Heijink and Struijs, 2016; Bekker and Wagemakers, 2021; Alders and Schut, 2019). For high-risk groups, selective and indicated prevention are important. Selective preventive interventions target high-risk populations and aim to prevent individuals from actually getting sick (Greenberg and Abenavoli, 2016). While indicated preventive interventions target individual people with early symptoms and aim to prevent complaints from worsening into a disorder (Gordon, 1983; Arango *et al.*, 2018). Selective and indicated prevention partly correspond with primary and secondary prevention but divide prevention based on target group instead of disease phase (Edelman and Kudzma, 2022; Hawkins *et al.*, 2015).

In the Netherlands, the government, municipalities, professional organisations and health insurance companies are collectively responsible for organising preventive interventions (Jeurissen and Maarse, 2021). Parties operate in a decentralized healthcare system of regulated competition (Kroneman *et al.*, 2016). Financing collective (selective) prevention legally belongs to public responsibility (government and municipalities) and financing individual (indicated) prevention belongs to health insurance companies (Jeurissen and Maarse, 2021). However, the dividing line between selective and indicated prevention is less clear, causing ambiguity in governance regarding responsibilities and financing (Kroneman *et al.*, 2016). Similar problems can be seen in other countries with comparable healthcare systems (Heijink and Struijs, 2016).

In order to overcome the pitfalls of organising prevention for high-risk groups, involved stakeholders need to work together in a structured, sustainable way. In recent years, several policy interventions have been introduced in the Netherlands to stimulate intersectoral collaboration and the transition from occasional to structural collaboration in the healthcare system (Boer, 2021; Ministry of Health, Welfare and Sport, 2016). This intersectoral collaboration forms the basis for the intended prevention infrastructure. According to the WHO, intersectoral collaboration for health entails cooperation between several sectors, for example, in developing and implementing public policies intended to

improve health, equity and well-being. Intersectoral collaboration makes it possible to take action that is more effective or efficient than taking action by one of the sectors alone (WHO, 2023). From an international perspective, there is growing interest in the use of intersectoral collaboration (e.g. alliances, coalitions, partnerships and joined-up governments) as a shared health governance structure to address complex, health-related issues in local communities (Hearld *et al.*, 2019; Perri 6, 2004). Collaboration across organisations, disciplines and sectors is considered a necessary element of dealing with today's healthcare system challenges and is increasingly addressed in healthcare policy (Dahlgreen, 1995; Bteich *et al.*, 2017). However, collaborating is complex and requires behavioural changes, as parties have to look beyond their own sectoral borders (Karam *et al.*, 2018; Alderwick *et al.*, 2021; Van der Vliet *et al.*, 2022). Having a supportive architecture (or structure) is found to be important in creating integration and collaboration (Carey and Crammond, 2015). Despite the growing attention for intersectoral collaboration in recent literature (Mondal *et al.*, 2021), the everyday practices of intersectoral collaboration for public health policy remain largely unexamined (Chircop *et al.*, 2015). Few longitudinal studies have been conducted to understand how strategies, attitudes and perceptions about collaborating in a network change over time (Bryson *et al.*, 2015; Hearld *et al.*, 2019). This results in a lack of understanding of the long-term effects of policy interventions in public health (Van Vooren *et al.*, 2023).

The lack of a complete range of preventive interventions for high-risk groups has several causes, as explained above. Part of the solution may lie in collaboration between different responsible parties. Policy has attempted to stimulate this in recent years. The aim of this study was two-fold: First, to describe the transition towards a sustainable prevention infrastructure. And second, to gain insight into barriers and facilitators associated with intersectoral collaboration regarding organising prevention for high-risk groups.

Research methodology

Setting

This study was conducted in the Netherlands. Since 2016, regional collaborative networks have been encouraged and facilitated by the national government through a "Prevention Coalition grant" (Preventie Coalitie subsidie) for setting up a collaborative structure. National policy aimed to encourage intersectoral collaboration targeted at prevention for high-risk groups (Boer, 2021; Ministry of Health, Welfare and Sport, 2016). In total, the Dutch Ministry of Health, Welfare and Sports approved 20 prevention coalitions over the programme's duration (2016–2022) (Kemper *et al.*, 2022). Involvement of financing parties (municipality and health insurer) was a requirement for receiving the grant.

Design and procedure

This longitudinal qualitative study was conducted over a period of five years (2016–2021), following 11 collaborative networks that focused on organising prevention for high-risk groups and received the prevention coalition grant. In this study, a longitudinal qualitative research (LQR) design is applied because this method allows following change over time. LQR can be used for follow-up studies and evaluation studies (Holland, 2007; Calman *et al.*, 2013). In order to learn more about the complicated transition towards a sustainable prevention infrastructure and intersectoral collaboration, changes over time need to be taken into account, which is why LQR is appropriate. Reviewing the interview data and modifying

interview guides between data collection points are characteristics of LQR. The research team designed the interviews to build on rather than duplicate the previously collected interview data (Tuthill *et al.*, 2020). Interview topics concerned: network characteristics, designing collaboration, experiences with collaboration, developments in their regional prevention infrastructure and preventive interventions.

Theoretical framework

Several theoretical frameworks have been developed and used to gain a better understanding of the processes (behaviours) that play a role in collaboration between multiple sectors, such as the Framework for Collaborative Action (Fawcett *et al.*, 2010), the CAHN framework (Steenkamer, 2020), the Bergen model (Corbin and Mittelmark, 2008) and the HALL framework (Koelen *et al.*, 2012). One framework used previously developed behaviour models and simplified them into one coherent model, the COM-B model. The COM-B model proposes three factors that influence and interact with behaviour: capability (C), opportunity (O), motivation (M) and behaviour (B). Capability refers to an individual's psychological and physical ability to participate in an activity. Opportunity refers to external factors that make a behaviour possible. Lastly, motivation refers to the conscious and unconscious cognitive processes that direct and inspire behaviour (Michie *et al.*, 2011). Compared to other theoretical frameworks, the COM-B focuses on understanding the people involved in collaboration rather than focusing only on the system in which they operate, making it a suitable model to study intersectoral collaboration (Michie *et al.*, 2011). The COM-B model recognizes that behavioural change does not occur in a vacuum, yet factors interact and mutually affect each other. The components of COM-B can be construed at any level (e.g. individual and group) (Hendriks *et al.*, 2015). It provides a clear structure and simple classification for reflecting on barriers and facilitators. Furthermore, it was successfully applied in similar studies about intersectoral collaboration (Hendriks *et al.*, 2015; Van der Vliet *et al.*, 2022; Wakida *et al.*, 2018; Gomez-Rossi *et al.*, 2022).

Data collection

Since 2016, each year, the number of regional collaborative networks with a "Prevention Coalition grant" has increased. Using purposive sampling, new coalitions were approached annually to participate in an interview. Based on distribution across the country, size of the region and variation in involved health insurers. Over the years, data saturation was reached with the following 11 networks in total: Interviews were held with representatives of municipalities, health insurers, municipality health services and programme managers involved with the network. Networks were followed over time and therefore, approached annually for an interview (re-interviews). Two to six interviews per network were conducted during a five-year study period. In addition to the networks distributed over the years, seven people involved with providing(?) a specific preventive interventions, four national stakeholders (e.g. the umbrella organisations of health insurers and municipalities), six healthcare insurers and 13 municipalities were interviewed about their experiences with intersectoral collaboration in general. Interviews were repeated every year around September–December (Figure 1). In total, 86 semi-structured interviews were held online by telephone or face-to-face. Interviews were audio recorded, and the length of the interviews varied between 30 and 90 min.

Analysis

Interviews were transcribed verbatim. Except for the first two data collections in 2017 and 2018, summaries were used for those interviews. During the study, in total, nine researchers

were responsible for conducting and analysing the interviews. The analysis consisted of two steps. Transcripts from every interview were coded by two researchers using MAXQDA (versions 18, 20 and 22). Any disagreements between the two researchers were discussed to ensure consensus.

Step one included thematically analysing the data after each year of data collection (cross-sectional). A code tree was drawn up based on the interview guide. Deriving from what the researchers found in the transcripts, the code tree was supplemented with new codes. Thematic analysis enabled us to find themes and patterns within and across the data set of interviews per year and was mainly inductive. Step two included a longitudinal analysis, which focused on differences and similarities between the yearly evaluations. Data from all the consecutive years were included and analysed together through a deductive approach (Figure 1). The COM-B model was used in this step to identify and categorize facilitators and barriers associated with intersectoral collaboration. Longitudinal results were produced using an iterative process to summarize, analyse and consolidate themes. The transition towards a sustainable prevention infrastructure was analysed by listing objective events and pulling them apart from the experiences.

Ethical approval

This study was approved by the Ethics Review Board (ERB) of Tilburg University according to the Medical Research Act (reference number EC-2017.97). The interview respondents were informed of the study's purpose, mode of participation and confidentiality. Respondents gave written or oral informed consent prior to the interview.

Findings

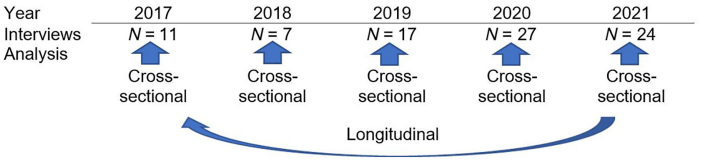
The first part of the results section describes the transition towards a sustainable prevention infrastructure in the collaborative networks and the changes over time based on the yearly interviews. The second part describes barriers and facilitators based on stakeholders' experiences in setting up and maintaining intersectoral collaboration.

Transition towards a sustainable prevention infrastructure

At the start of the study, few collaborative networks in the field of prevention for high-risk groups existed. The interviewees recognized its importance, but real collaboration was still in its infancy.

> We [health insurer] are in the "care" sector, and "welfare" is for the municipality. And if you ask me, I would like to keep that separate. (Interviewee health insurer, 2020)

Networks started with identifying local health issues and choosing themes and target groups accordingly. Networks also inventoried existing interventions in the region and worked towards a plan of action or cooperation agenda. In the regions where a Prevention Coalition network emerged, the municipality and health insurer often already had a good collaborative



Source(s): Authors' work

Figure 1.
Data collection and analysis schematically illustrated

relationship, according to the interviewees, which often prompted them to apply for the grant and further develop their plans. In the initial phase of these new networks, the intensity of collaboration between municipalities and health insurers varied greatly.

On a national level, according to interviewees, collaboration was further stimulated by implementing preventive interventions, a regional working structure, national conventions and an ambassador. In 2019, the implementation of four different preventive/lifestyle interventions was stimulated by the national government, namely: combined lifestyle intervention (CLI), social prescribing (SP), falls prevention and diabetes prevention. Municipalities and health insurers were obligated to cooperate regarding the implementation. Many collaborative networks indicated that they embraced these interventions. The CLI was the only one included in the Health Insurance Act.

> We really saw that [for the municipality] as an opportunity to make the GLI work, [. . .] because it is also a really great opportunity for the health insurer to contribute to this intervention. So we sat down with the GP cooperative, partners from the university, the hospital, the municipality and sports club, etc. (interviewee municipality, 2020)

Exchanging knowledge about successful interventions, experiences and best practices took place through national conventions. In addition, a national ambassador was appointed in 2019 by the Ministry in order to advice potential regional collaborative networks based on experiences in other networks. A regional working structure of health insurers and municipalities was formulated by its umbrella organisations in early 2020. In this structure, regions consisting of multiple municipalities were designated to cooperate with a particular health insurer, primarily the largest health insurer in the region. If the working structure matched the existing way of working, it was found to be a stimulus. If the structure did not fit well with the health insurer's self-established structure, it was perceived as counterproductive, according to the interviewees. The obligatory regional working structure stimulated cooperation because municipalities and health insurers were, for the first time, jointly responsible for making agreements about prevention for individuals at risk.

> On the other hand, it sometimes helps to wave with the document [about the regional working structure], because it says very explicitly: you will discuss with each other at a regional level. And, and I sometimes need that, to wave along because municipalities really feel the need to talk to the health insurer at a local level. And that, that's just not possible. (Interviewee health insurer, 2021)

A rising trend can be seen over the years in which municipalities and health insurers were increasingly able to find each other, according to the interviewees. They made agreements on organising prevention for high-risk groups through regional cooperation agendas and arrangements regarding preventive/lifestyle interventions, such as CLI and SP. The number of prevention coalition networks has increased considerably over the last five years as well as their list of cooperation partners. Respondents mentioned that more parties joined the network, also outside the healthcare sector (such as housing associations, (special) education and employers). When the grant period reached its end, the prevention coalition networks tried to sustain what they had achieved.

Barriers and facilitators for intersectoral collaboration regarding prevention infrastructure

This section elaborates on promoting and impeding factors divided into the three COM-B themes: capability, opportunity and motivation. In Table 1, an overview of the facilitators and barriers is presented.

Capability. Several factors influenced one's capability to collaborate around prevention for high-risk groups. The sheer basis of working together is getting to know and, more importantly, understand each other's language. This basis is of great importance as a starting point in formulating a shared vision or ambition. In 2016, parties experienced major

	Capability (e.g. knowledge and cognitive abilities)	Opportunity (e.g. access and cultural norms)	Motivation (e.g. beliefs and values)
Facilitators	- creating a shared vision/ambition - sharing knowledge and experiences between organisations - appointing regional coordinators and getting to know each other - learning each other's language	- using the prevention coalition grant/financing for setting up collaborative network - meeting regularly between collaboration partners - regional working structure - enough time, right people and commitment - low-threshold contact and short lines of communication	- shared sense of urgency - mutual trust - enthusiasm of parties and individuals involved - focus on prevention by national parties - realizing the importance of collaborating
Barriers	- unfamiliar with each other - major differences in culture and language between organisations - high staff/personnel turnover within organisations - political changes (key players) on all levels (local, regional and national)	- limited possibilities within laws and regulations - lack of structural financing for collaborating - limited incentives to invest in collaboration - lack of time to collaborate and build relationships - lack of integrated subsidies - municipal cutbacks - lack of real life meetings and trainings due to the COVID-19 pandemic	- differences in priorities and interests between organisations - lack of clarity about municipalities' and health insurers' responsibilities - unknown (long term) financial implications of investing in prevention - uncertainty about impact on health outcomes

Source(s): Authors' adaptation of the COM-B (Michie *et al.*, 2011)

Table 1. Overview of facilitators and barriers for intersectoral collaboration in prevention, categorised according to COM-B

differences in culture and language between different types of organisations on a local level. This made working together complex. It was found conducive when, within networks, knowledge about successful interventions, experiences and best practices was exchanged. A major threat to the continuity of the collaboration was a change in the people involved, for instance, the change of councillors after municipal elections. Multi-year agreements exceeding political terms were found to be a strategic solution to this threat.

> We are 99% sure that the current councillor will not stay [after the elections]. And she is very passionate about prevention. So now we are checking whether we can already emphasize the importance of prevention in municipal documents. (Interviewee prevention coalition, 2021)

Another solution was appointing regional coordinators within municipalities and health insurance companies (part 1) who ensured that, despite personnel changes, parties continued to work together and learned to know each other. On this basis, mutual understanding about responsibilities and interests grew and tasks were better allocated. As a result, parties became increasingly familiar with each other and the relationship became stronger.

Opportunity. Intersectoral collaboration became increasingly common over time; a number of factors related to "opportunity" are highlighted below. The Prevention Coalition grant facilitated the establishment of a collaborative network in which parties from the medical and social sectors met regularly and could make agreements about collaboration and organising prevention for individuals at risk. However, getting and keeping all parties involved in the network was found to be labour-intensive, especially as the network grew over time.

> I notice that these appointments are simply difficult to plan with four external parties in [city name], we are faced with [the hospital, the municipal health service and the municipality], with so many different agendas that an appointment is scheduled for months later, and I notice that the energy is really gone a bit. (Interviewee municipality, 2020)

General practitioners were recognised as important collaboration partners in those networks because they could refer people to preventive interventions. However, in practice, they were not always well engaged. Building, maintaining, expanding and sustaining collaboration requires time to invest in these relationships. Interviewees indicated that structural financing was needed to enable collaboration across sectors and make long-term commitments. After all, grants were only temporary and often fragmented per high-risk group. According to the interviewees, health insurers and municipalities had limited financial possibilities or incentives to invest in collaboration with regard to prevention, and municipal cutbacks put the budget for prevention even more at risk. Lack of manpower and an insufficient budget at municipalities to organise cooperation were major barriers. Most interviewees were, over the years, increasingly convinced that legal adjustments were necessary to compel and enable involved parties to implement preventive interventions.

Motivation. There were several factors that influenced the motivation to set up an infrastructure around prevention for high-risk groups. Firstly, there had to be a shared sense of urgency. Over the years, interviewees increasingly indicated that prevention was essential in order to keep healthcare sustainable and affordable. The parties realized that they needed each other and should make agreements about prevention in order to collectively achieve goals and keep healthcare accessible.

> And this is, yes, a wicked problem that we cannot solve alone. So, we need the insurer for this, we need municipalities for this, we need the institutions for this, we need the social sector for this, to organise care and support differently. (Interviewee prevention coalition, 2021)

With regard to making agreements, it was found helpful if trust between parties had grown. On an organisational level, the sense of urgency was affected by the priorities of network parties, defined by their tasks and obligations. Secondly, motivation was negatively affected by the long-term effects of prevention on health and healthcare costs and the uncertainty of whether these effects would actually be realized. Network parties wanted and needed more insight into health outcomes to stay motivated and be able to make informed decisions. However, overall, motivation to collaborate grew among the various parties.

> And also mutual trust [between the municipality and the health insurer]. [. . .] And well, you have to build that up. That bond of trust and also showing that you also pay attention to the issues facing the municipalities and vice versa. (Interviewee health insurer, 2020)

Discussion

This study followed collaborative networks over time to gain insight into experiences (perceived barriers and facilitators) with intersectoral collaboration regarding organising prevention for high-risk groups. Furthermore, it aimed to describe the transition towards a sustainable prevention infrastructure in the local healthcare system. The results suggest that the transition towards a sustainable prevention infrastructure has started. Policy has stimulated intersectoral collaboration in the last few years. Organisations from the health and social sectors were found to be genuinely motivated and willing to work together as a result of a shared sense of urgency. Collective coordination of preventive interventions is becoming increasingly common. However, many barriers are still present and ask for new policy interventions on responsibilities and financing. For a complete overview of the facilitators

and barriers, we refer to Table 1. In the following sections, findings will be discussed and compared to earlier research.

Transition towards a sustainable prevention infrastructure

The creation of regional prevention coalitions has been encouraged by the Dutch government in the past few years. Over time, networks grew, collaborated more, and implemented intersectoral interventions that best suited their region and residents. The obligatory regional working structure stimulated cooperation because municipalities and health insurers were, for the first time, jointly responsible for making agreements about prevention for individuals at risk. Previous research also shows that assigning increasing stakeholder responsibilities is essential for a sustainable prevention system. For example, in Denmark, municipalities are responsible for ensuring that local communities provide healthy environments and activities and promote well-being and prevent disease (Schmidt *et al.*, 2019). Likewise, in Germany, health insurers are explicitly given the (financial) responsibility to invest in prevention in settings such as neighbourhoods and schools (Hildebrandt *et al.*, 2012). Future research should further examine in what way collaboration is likely to succeed in a prevention infrastructure. However, finding ways for organisations that are organised differently to work together is eternal and universal, according to Perri 6. Differences between and within countries are not random or necessarily based on culture, but rather on fundamental organisational limitations and on conflicts and competitions with each other (Perri 6, 2004).

When it comes to organising and financing prevention, primacy lies with politics. The extent and manner in which attention is paid to prevention, especially for high-risk groups, is strongly related to the prevailing political view of citizens' own responsibility (RVS, 2023). In recent years, the challenges regarding prevention have been considered increasingly urgent in the Netherlands. There seems to be a small political shift towards more "social" policies; is the need for prevention finally being recognised? However, despite increased focus on prevention and numerous prevention policies, spending is not yet increasing (Van Gils *et al.*, 2020).

Barriers and facilitators for (intersectoral) collaboration regarding prevention infrastructure

Capability. Previous research on intersectoral collaboration found similar barriers and facilitators related to capability, as shown in the present study. Having a shared vision of the problem to be addressed was also an important success factor in health promotion activities, according to Van Dale *et al.*, (2020). Others found that a new (long-term) vision helped collaborative partnerships (Steenkamer *et al.*, 2020; Van der Vliet *et al.*, 2022; Buist *et al.*, 2019). According to Alderwick *et al.*, differences in decision-making processes were an important barrier concerning capability. In the present study, this barrier is comparable to differences in organisational culture. Furthermore, a lack of accountability between organisations was found to hinder collaboration (Alderwick *et al.*, 2021). In the present study, this was described as a lack of clarity about responsibilities.

Opportunity. According to the interviewees, an important facilitator related to opportunity was "receiving finance for setting up a collaborative structure". Arranging additional funding for collaboration is often recognised as beneficial in the literature (Steenkamer *et al.*, 2020; Van der Vliet *et al.*, 2022). Others argue that partnerships would be too busy collecting, distributing and accounting for those funds or grants (Eisenstein and Chang, 2017). Furthermore, according to Siegel *et al.*, the overwhelming reliance on short-term partnership financing is not aligned with the task of long-term, multisector integration and therefore, sustainable change in the healthcare system (Siegel *et al.*, 2018). This raises the question of whether networks survive after the end of the grant period.

Another important factor concerns building relationships and being committed, especially if parties do not have a history of collaborating (Steenkamer *et al.*, 2020). Cooperating partners from different sectors each come from a unique culture of thinking and communication, and they may fail to find common goals and benefits or lack of commitment (WHO, 2018; Storm *et al.*, 2016).

Motivation. On the motivation part, we found that enthusiasm from parties involved, as expected, contributed to collaboration. Having common goals, creating a win-win situation for the partners in the collaboration and recognising shared problems lead to higher motivation. High motivation is also an important theme in other studies (Van der Vliet *et al.*, 2022; Mondal *et al.*, 2021; Corbin *et al.*, 2018). Mutual trust is the foundation for collaboration and can grow over time. The importance of communication, trust and good relationships between collaborating parties is frequently cited in the literature (Mondal *et al.*, 2021; Corbin *et al.*, 2018). Provisionally granting trust and respect for first steps generates momentum to develop more trust and respect ahead (Kerrissey and Singer, 2023). Another factor that influenced organisations' motivation to join the network was a growing societal movement about a broad view of health (De Bekker *et al.*, 2023). This movement increased parties' willingness to engage in broader partnerships and jointly focus more on prevention. This led to more parties participating outside the healthcare sector (such as housing associations, (special) education and employers).

Overall, in this study, many facilitating factors for intersectoral collaboration within prevention were found, especially in the capability and motivation component of the COM-B model. Stakeholders are genuinely motivated and willing to work together and have the necessary knowledge. However, all three COM-B themes are required in order to change behaviour and establish the actual execution of that desired behaviour. Barriers concerning financing (opportunity) are currently holding back intersectoral collaboration and should be recognized as a conditional factor. To bridge this gap, policymakers need to adopt new financing methods that create an enabling environment for multisector partnerships (Siegel *et al.*, 2018). Recent developments in Dutch prevention policy concern a specific payment for prevention, which is part of the national Healthy and Active Living Agreement (Gezond en Actief Leven Akkoord) (GALA, 2023). The first insight about this regulation is that it meets the need for clarity about responsibilities and the need for allocated resources. Although a certain tension between the two financing parties (municipalities and health insurers) will probably remain due to their legal responsibilities (Van Duijn *et al.*, 2022). Future research has to show whether it has an effect on the offer, availability and usage of preventive interventions. Based on this study, it is considered necessary to make the recommendations below.

Recommendations for a sustainable prevention infrastructure:

(1) Establish responsibilities around prevention for high-risk groups, for instance, through legislation;

(2) Create structural financing to support and sustain intersectoral networks and

(3) Create economic incentives for financing bodies to implement effective disease prevention and health promotion programmes.

Limitations

Through LQR, many different networks and stakeholders were interviewed over the course of five years. Because of the design of the study, the reliability of the results is high. The shift to a sustainable prevention infrastructure is a long-term transition; a longitudinal design fits the bill. LQR may contribute to increased awareness among researchers about the importance of time (Carter, 2006; Calman *et al.*, 2013). In this study, it was observed that the Prevention Coalition grant provided an initial push to work together. Next, the networks ran into all sorts

of obstacles when working together. Those obstacles emerged over time, becoming more and more specific. This allowed the researchers to make more targeted recommendations for policy (Kemper *et al.*, 2022). A disadvantage of a long follow-up time is the high probability of staff changes. Networks in this study had to deal with frequent changes of contact persons, which caused knowledge to be lost as well as the cooperation relationship that had been built up. Usually, an LQR benefits from the development of a history between the researchers and the participants (Carter, 2006); this was only the case to a limited extent in this study.

Conclusion

The transition to a sustainable prevention infrastructure has been set in motion. The longitudinal nature of this study allowed us to look at changes over time. Because of the element "time", trust grows, parties get to know each other better and the challenges regarding prevention are considered more urgent. This study shows that collaboration regarding prevention is becoming increasingly common. The relationship between key stakeholders, like municipalities and health insurers, is generally stronger than five years ago. The working structure ensured more regional and local agreements. Knowing the factors that facilitate or hinder intersectoral collaboration can help stakeholders improve or develop their collaboration infrastructure. Many facilitators were found, but eventually, a prevention infrastructure will not be sustainable if structural financing and clarity about (legal) responsibilities are not arranged.

References

Alders, P. and Schut, F.T. (2019), "The 2015 long-term care reform in The Netherlands: getting the financial incentives right?", *Health Policy*, Vol. 123 No. 3, pp. 312-316, ISSN 0168-8510, doi: 10.1016/j.healthpol.2018.10.010p.

Alderwick, H., Hutchings, A., Briggs, A. and Mays, N. (2021), "The impacts of collaboration between local health care and non-health care organizations and factors shaping how they work: a systematic review of reviews", *BMC Public Health*, Vol. 21 No. 1, p. 753, doi: 10.1186/s12889-021-10630-1.

Arango, C., Díaz-Caneja, C.M., McGorry, P.D., Rapoport, J., Sommer, I.E., Vorstman, J.A., McDaid, D., Marín, O., Serrano-Drozdowskyj, E., Freedman, R. and Carpenter, W. (2018), "Preventive strategies for mental health", *The Lancet Psychiatry*, Vol. 5 No. 7, pp. 591-604, ISSN 2215-0366, doi: 10.1016/S2215-0366(18)30057-9.

Bekker, M. and Wagemakers, A. (2021), "Cross-domain collaboration: the Dutch combined lifestyle intervention", *European Journal of Public Health*, Vol. 31 No. 3, doi: 10.1093/eurpub/ckab165.020.

Bensberg, M., Joyce, A. and Wilson, E. (2021), "Building a prevention system: infrastructure to strengthen health promotion outcomes", *International Journal of Environmental Research and Public Health*, Vol. 18 No. 4, p. 1618, PMID: 33567719; PMCID: PMC7914461, doi: 10.3390/ijerph18041618.

Bodenheimer, T. and Sinsky, C. (2014), "From triple to quadruple aim: care of the patient requires care of the provider", *Annals of Family Medicine*, Vol. 12 No. 6, pp. 573-576, doi: 10.1370/afm.1713.

Boer, J. (2021), "Preventief gezondheidsbeleid 2006-2018. Wat zijn de effecten en lessen? [Preventive health policy 2006-2018. What are the effects and lessons?]", [In Dutch], doi: 10.21945/RIVM-2021-0088

Boom, J.H.C. (2009), "Uitgavenmanagement in de zorg. Het effect van disease management en preventie op de zorguitgaven. [Healthcare expenditure management. The effect of disease management and prevention on healthcare spending]", [In Dutch], available at: https://www.rivm.nl/publicaties/uitgavenmanagement-in-zorg-effect-van-disease-management-en-preventie-op-zorguitgaven

Bryson, J.M., Crosby, B.C. and Middleton Stone, M. (2015), "Designing and implementing cross-sector collaborations: needed and challenging", *Public Administration Review*, Vol. 75 No. 5, pp. 647-663, doi: 10.1111/puar.12432.

Bteich, M., Da Silva Miranda, E., El Khoury, C., Gautier, L., Lacouture, A. and Yankoty, L.I. (2017), "A proposed core model of the new public health for a healthier collectivity: how to sustain transdisciplinary and intersectoral partnerships", *Critical Public Health*, Vol. 29 No. 2, pp. 241-256, doi: 10.1080/09581596.2017.1419167.

Buist, Y., Rijken, M., Lemmens, L., Baan, C. and De Bruin, S. (2019), "Collaborating on early detection of frailty; a multifaceted challenge", *International Journal of Integrated Care*, Vol. 19 No. 2, p. 6, doi: 10.5334/ijic.4176.

Cairney, P. and St Denny, E. (2020), *Why Isn't Government Policy More Preventive?*, (Oxford, 2020 edn, Oxford Academic, 20 Feb. 2020), available at: https://doi.org/10.1093/oso/9780198793298.001.0001 (accessed 22 December 2023).

Calman, L., Brunton, L. and Molassiotis, A. (2013), "Developing longitudinal qualitative designs: lessons learned and recommendations for health services research", *BMC Medical Research Methodology*, Vol. 6 No. 1, pp. 13-14, PMID: 23388075; PMCID: PMC3598728, doi: 10.1186/1471-2288-13-14.

Carey, G. and Crammond, B. (2015), "What works in joined-up government? An evidence synthesis", *International Journal of Public Administration*, Vol. 38 Nos 13-14, pp. 1020-1029, doi: 10.1080/01900692.2014.982292.

Carter, S.M. (2006), "Longitudinal qualitative research design: experience over time", *ACSPRI Social Science Methodology Conference*, pp. 1-11.

Chircop, A., Bassett, R. and Taylor, E. (2015), "Evidence on how to practice intersectoral collaboration for health equity: a scoping review", *Critical Public Health*, Vol. 25 No. 2, pp. 178-191.

Corbin, J.H., Jones, J. and Barry, M.M. (2018), "What makes intersectoral partnerships for health promotion work? A review of the international literature", *Health Promotion International*, Vol. 33 No. 1, pp. 4-26, doi: 10.1093/heapro/daw061.

Corbin, J.H. and Mittelmark, M.B. (2008), "Partnership lessons from the global programme for health promotion effectiveness: a case study", *Health Promotion International*, Vol. 23 No. 4, pp. 365-371, doi: 10.1093/heapro/dan029.

Dahlgreen, G. (1995), "'The Need for Intersectoral action for health: European healthy policy conference: opportunities for the future'. Volume II", in Harrington, P. and Ritsatakis, A. (Eds), *The Policy Framework to Meet Challenges: Intersectoral Action for Health*, World Health Organization Regional Office for Europe, Copenhagen.

De Bekker, A., Beijer, M., Lemmens, L. (2023), "Towards an integrative approach of healthcare. Implementing Positive Health in three cases in The Netherlands", *(preprint)*.

Edelman, C. and Kudzma, E.C. (2022), *Health Promotion throughout the Lifespan*, Elsevier, St. Louis, p. 14.

Eisenstein, J. and Chang, D.I. (2017), "Case study: improving population and individual health through health system transformation in Washington state", NAM Perspectives, Discussion Paper, National Academy of Medicine, Washington, DC, doi: 10.31478/201704e

Fawcett, S., Schultz, J., Watson-Thompson, J., Fox, M. and Bremby, R. (2010), "Building multisectoral partnerships for population health and health equity", *Preventing Chronic Disease*, Vol. 7 No. 6, Supp. A118, PMID: 20950525.

Fitzpatrick, B., Bloore, K. and Blake, N. (2019), "Creating a healthy workplace. Joy in work and reducing nurse burnout: from triple aim to quadruple aim", *AACN Advanced Critical Care*, Vol. 30 No. 2, pp. 185-188, doi: 10.4037/aacnacc2019833.

Gezond en Actief Leven Akkoord (GALA) [Healthy and Active Life Convenant] (2023), Dutch. Den Haag: Ministerie van Volksgezondheid, Welzijn en Sport, available at: https://www.rijksoverheid.nl/documenten/rapporten/2023/01/31/gala-gezond-en-actief-leven-akkoord

Gomez-Rossi, J., Schwartzkopff, J., Müller, A., Hertrampf, K., Abraham, J., Gassmann, G., Schlattmann, P., Göstemeyer, G. and Schwendicke, F. (2022), "Health policy analysis on barriers and facilitators for better oral health in German care homes: a qualitative study", *BMJ Open*, Vol. 12 No. 3, e049306, doi: 10.1136/bmjopen-2021-049306.

Gordon, R.S. (1983), "An operational classification of disease prevention", *Public Health Reports*, Vol. 98 No. 2, pp. 107-109.

Greenberg, M.T. and Abenavoli, R. (2016), "Universal interventions: fully exploring their impacts and potential to produce population-level impacts", *Journal of Research on Educational Effectiveness*, Vol. 10 No. 1, pp. 40-67, doi: 10.1080/19345747.2016.1246632.

Hawkins, J.D., Jenson, J.M., Catalano, R., Fraser, M.W., Botvin, G.J., Shapiro, V., Brown, C.H., Beardslee, W., Brent, D., Leslie, L.K., Rotheram-Borus, M.J., Shea, P., Shih, A., Anthony, E., Haggerty, K.P., Bender, K., Gorman-Smith, D., Casey, E., and Stone, S. (2015), "Unleasing the power of prevention, American academy of social work and social welfare", Working Paper No. 10.

Hearld, L.R., Alexander, J.A., Wolf, J.L. and Shi, Y. (2019), "The perceived importance of intersectoral collaboration by health care alliances", *Journal of Community Psychology*, Vol. 47 No. 4, pp. 856-868, doi: 10.1002/jcop.22158.

Heijink, R. and Struijs, J. (2016), "Organisatie en financiering van preventie in het zorgstelsel: wat kunnen we leren van het buitenland?", *Tijdschr Gezondheidswet*, Vol. 94 No. 4, pp. 131-135, doi: 10.1007/s12508-016-0052-z.

Hendriks, A., Jansen, M.W.J., Gubbels, J.S., De Vries, N.K., Molleman, G. and Kremers, S.P.J. (2015), "Local government officials' views on intersectoral collaboration within their organization – a qualitative exploration", *Health Policy and Technology*, Vol. 4 No. 1, pp. 47-57, doi: 10.1016/j.hlpt.2014.10.013.

Hildebrandt, H., Schulte, T. and Stunder, B. (2012), "Triple Aim in Kinzigtal, Germany: improving population health, integrating health care and reducing costs of care – lessons for the UK?", *Journal of Integrated Care*, Vol. 20 No. 4, pp. 205-222, doi: 10.1108/14769011211255249.

Holland, J. (2007), "Qualitative Longitudinal Research: exploring ways of researching lives through time", Real Life Methods Node of the ESRC National Centre for Research Methods Workshop held at London South Bank University 2007, available at: http://www.reallifemethods.ac.uk/training/workshops/qual-long/documents/ql-workshop-holland.pdf.

Jeurissen, P. and Maarse, H. (2021), "The market reform in Dutch health care: results, lessons and prospects [Internet]", Copenhagen (Denmark): European Observatory on Health Systems and Policies; 2021. (Observatory Studies Series, No. 55.), available at: https://www.ncbi.nlm.nih.gov/books/NBK577820/.

Karam, M., Brault, I., Van Durme, T. and Macq, J. (2018), "Comparing interprofessional and interorganizational collaboration in healthcare: a systematic review of the qualitative research", *International Journal of Nursing Studies*, Vol. 79, pp. 70-83, doi: 10.1016/j.ijnurstu.2017.11.002.

Kemper, P.F., Lemmens, L.C. and De Bekker, A. (2022), "Eindevaluatie preventie in het zorgstelsel", Ontwikkelingen en ervaringen 2016-2022. [In Dutch], available at: https://www.rivm.nl/documenten/eindevaluatie-preventie-in-zorgstelsel-ontwikkelingen-en-ervaringen-2016-2022

Kerrissey, M.J. and Singer, S.J. (2023), "Factors affecting collaboration between clinical and community service organizations", *Health Care Management Review*, Vol. 48 No. 2, pp. 130-139, doi: 10.1097/HMR.0000000000000359.

Koelen, M.A., Vaandrager, L. and Wagemakers, A. (2012), "The healthy alliances (HALL) framework: prerequisites for success", *Family Practice*, Vol. 29 No. 1, pp. i132-i138, doi: 10.1093/fampra/cmr088.

Kroneman, M., Boerma, W., van den Berg, M. Groenewegen, P., De Jong, J. and Van Ginneken, E. (2016), "World health organization. Regional office for Europe, European observatory on health systems and policies. The Netherlands: health system review", *Health Systems in Transition*, Vol. 18 No. 2, pp. 1-239, available at: https://apps.who.int/iris/handle/10665/330244

Matheson, A., Walton, M., Gray, R., Wehipeihana, N. and Wistow, J. (2020), "Strengthening prevention in communities through systems change: lessons from the evaluation of Healthy Families NZ", *Health Promotion International*, Vol. 35 No. 5, pp. 947-957, doi: 10.1093/heapro/daz092.

Michie, S., Van Stralen, M.M. and West, R. (2011), "The behaviour change wheel: a new method for characterising and designing behaviour change interventions", *Implementation Science*, Vol. 6 No. 1, p. 42, doi: 10.1186/1748-5908-6-42.

Ministry of Health, Welfare and Sport (2016), Letter to the parliament. Prevention in the healthcare system, [In Dutch: Ministerie van Volksgezondheid, Welzijn en Sport. Kamerbrief. Preventie in het zorgstelsel: van goede bedoelingen naar het in de praktijk ontwikkelen van resultaten.] Den Haag: Tweede Kamer 2015-2016, 32793 letter number: 213.

Mondal, S., Van Belle, S. and Maioni, A. (2021), "Learning from intersectoral action beyond health: a meta-narrative review", *Health Policy Plan*, Vol. 36 No. 4, pp. 552-571, doi: 10.1093/heapol/czaa163.

Naqvi, H.A. (2023), "Expectations of the ontario healthcare system following the implementation of ontario health teams", *Journal of Health Management*, Vol. 25 No. 2, pp. 135-143, doi: 10.1177/09720634221128099.

Perri 6 (2004), "Joined-up government in the western world in comparative perspective: a preliminary literature review and exploration", *Journal of Public Administration Research and Theory*, Vol. 14 No. 1, pp. 103-138, J-PART, doi: 10.1093/jopart/muh006.

Raad voor Volksgezondheid en Samenleving (2023), "Met de stroom mee", (in Dutch) [Council for Public Health and Society. Go with the flow], available at: https://www.raadrvs.nl/documenten/publicaties/2023/06/20/met-de-stroom-mee

Rijksoverheid (2018), "Nationaal preventie akkoord", (In Dutch) [Central government. National Prevention Agreement], available at: https://www.rijksoverheid.nl/documenten/convenanten/2018/11/23/nationaal-preventieakkoord

Schmidt, M., Schmidt, S.A.J., Adelborg, K., Sundbøll, J., Laugesen, K., Ehrenstein, V. and Sørensen, H.T. (2019), "The Danish health care system and epidemiological research: from health care contacts to database records", *Clinical Epidemiology*, Vol. 11, pp. 563-591, doi: 10.2147/CLEP.S179083.

Siegel, B., Erikson, J., Milstein, B. and Pritchard, K.E. (2018), "Multisector partnerships need further development to fulfill aspirations for transforming regional health and well-being", *Health Affairs*, Vol. 37, p. 1, doi: 10.1377/hlthaff.2017.1118.

Steenkamer, B.M., Drewes, H.W., Putters, K., Van Oers, H. and Baan, C. (2020), "Reorganizing and integrating public health, health care, social care and wider public services: a theory-based framework for collaborative adaptive health networks to achieve the triple aim", *Journal of Health Services Research and Policy*, Vol. 25 No. 3, pp. 187-201, doi: 10.1177/1355819620907359.

Storm, I., den Hertog, F., Van Oers, H. and Schuit, A.J. (2016), "How to improve collaboration between the public health sector and other policy sectors to reduce health inequalities?", *A Study in Sixteen Municipalities in the Netherlands*, Vol. 15 No. 1, p. 97, doi: 10.1186/s12939-016-0384-y.

Tuthill, E.L., Maltby, A.E., DiClemente, K. and Pellowski, J.A. (2020), "Longitudinal qualitative methods in health behavior and nursing research: assumptions, design, analysis and lessons learned", *International Journal of Qualitative Methods*, Vol. 19, p. 160940692096579, doi: 10.1177/1609406920965799.

United Kingdom Government (2021), "Department of Health and Social Care. Policy paper. Transforming the public health system: reforming the public health system for the challenges of our times", available at: https://www.gov.uk/government/publications/transforming-the-public-health-system/transforming-the-public-health-system-reforming-the-public-health-system-for-the-challenges-of-our-times

Van Dale, D., Lemmens, L.C., Hendriksen, M., Savolainen, N., Nagy, P., Marosi, E., Eigenmann, M., Stegemann and Rogers, H.L. (2020), "Recommendations for effective intersectoral collaboration in health promotion interventions: results from joint action CHRODIS-PLUS work package 5

activities", *International Journal of Environmental Research and Public Health*, Vol. 17 No. 18, p. 6474, doi: 10.3390/ijerph17186474.

Van der Vliet, N., den Broeder, L., Romeo-Velilla, M., Staatsen, B., Kruize, H., Friedrich, B. and Schuit, A.J. (2022), "Facilitators and barriers of intersectoral co-operation to promote healthier and more environmentally friendly behaviour: a qualitative evaluation through focus groups for the INHERIT project", *BMC Public Health*, Vol. 22 No. 1, p. 617, doi: 10.1186/s12889-022-12974-8.

Van Duijn, S., Bannink, D. and Ybema, S. (2022), "Working toward network governance: local actors' strategies for navigating tensions in localized health care governance", *Administration and Society*, Vol. 54 No. 4, pp. 660-689, doi: 10.1177/00953997211033818.

Van Gils, P.F., Suijkerbuijk, A.W.M., Polder, J.J., De Wit, G.A. and Koopmanschap, M. (2020), "Nederlandse preventie-uitgaven onder de loep", *TSG: Tijdschrift Voor Gezondheidswetenschappen*, Vol. 98 No. 2, pp. 92-96, doi: 10.1007/s12508-020-00258-8.

Van Vooren, N.J.E., Janssen, L.M.S., Drewes, H.W., Baan, C.A. and Bongers, I.M.B. (2023), "How to collaborate for health throughout the project timeline - a longitudinal study reflecting on implemented strategies in three projects for a healthy living environment", *BMC Public Health*, Vol. 23 No. 1, p. 67, doi: 10.1186/s12889-022-14898-9.

Wakida, E.K., Obua, C., Rukundo, G.Z., Maling, S., Talib, Z.M. and Okello, E.S. (2018), "Barriers and facilitators to the integration of mental health services into primary healthcare: a qualitative study among Ugandan primary care providers using the COM-B framework", *BMC Health Services Research*, Vol. 18 No. 1, p. 890, doi: 10.1186/s12913-018-3684-7.

WHO (2018), "Multisectoral and intersectoral action for improved health and well-being for all: mapping of the WHO European Region. Governance for a sustainable future: improving health and well-being for all", Copenhagen, Denmark. WHO/EURO:2018-2667-42423-58849.

WHO (2023), *Working Together for Equity and Healthier Populations: Sustainable Multisectoral Collaboration Based on Health in All Policies Approaches*, ISBN: 978-92-4-006753-0.

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