Learning & Adapting and Service Delivery

INNOVATIONS FOR SUCCESSFUL SOCIETIES

A SOLID START FOR EVERY CHILD: THE NETHERLANDS INTEGRATES MEDICAL AND SOCIAL CARE, 2009–2022

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SYNOPSIS

Despite having a sophisticated health-care system and spending more on health care than do most countries in the world, by the early 2010s the Netherlands experienced some of the poorest perinatal-health outcomes in the European Union. Birth-related complications among women and infants were driven primarily by economic and social inequality. For example, women living in the country's low-income neighborhoods were up to four times more likely to die during childbirth than the Dutch average. In partnership with university researchers, the municipalities of Rotterdam, Groningen, and Tilburg began tackling the problem. After discovering that the growing disparities in perinatal health outcomes were driven in large part by social and economic challenges rather than by purely medical factors, the cities set out to build integrated, multisectoral teams—local coalitions—that brought together service providers working in both the health-care and social domains. To tailor care to an individual patient's own circumstances, the coalitions transcended the traditional boundaries that separated physicians, midwives, municipal officials, social workers, and other service providers. They worked to integrate their records and come to agreement on ways to monitor progress, and they designed referral systems and procedural road maps to deal with specific and individual client problems. In 2018, the national Ministry of Health, Welfare and Sport expanded the use of such local coalitions to reduce early-childhood health disparities in municipalities throughout the country. By early 2022, 275 of the Netherlands' 345 municipalities were participating in the program, dubbed Solid Start, and the new national government pledged to expand the program to every municipality in the country.

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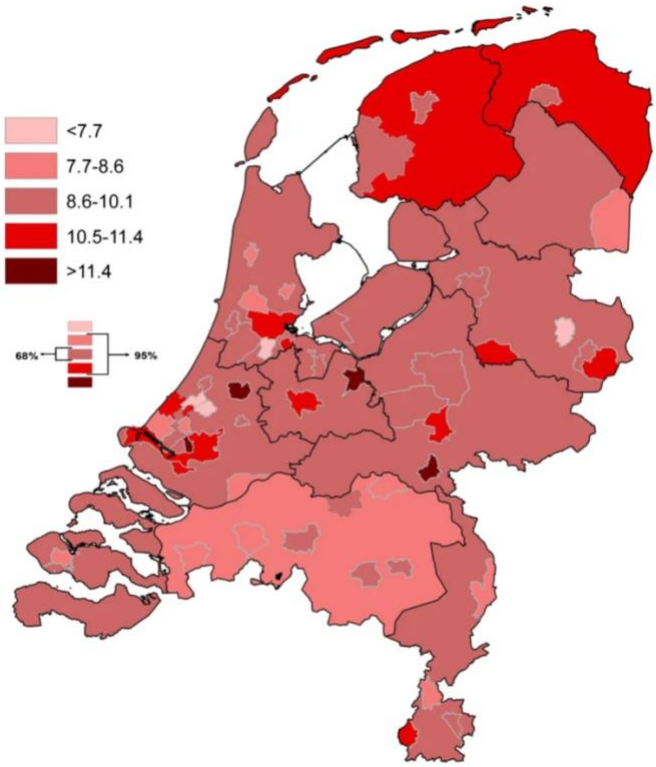
INTRODUCTION

In 2001, after he was appointed head of obstetrics at Erasmus University Medical Center in Rotterdam, Eric Steegers, a medical doctor, noticed many more cases of stillbirth, premature birth, fetal growth restriction, and other complications during the perinatal period than he had encountered while working in the smaller city of Nijmegen. Intrigued by this anecdotal evidence of important differences between the two cities, Steegers said he created a table of national perinatal health outcomes that revealed a higher incidence of birth-related problems per capita in big cities than in the rest of the country. (See figure 1)

Next, Steegers and his team plotted the same data on a map of neighborhoods in Rotterdam, where 45% of the approximately 4,000 babies born each year were born into poverty.[1] "We created a detailed heat map at the neighborhood level. Using different colors, we indicated the prevalence of complications of pregnancy. We noticed that the incidence was strikingly higher in deprived neighborhoods," Steegers said. "For example, in one of the deprived neighborhoods in Rotterdam, perinatal mortality was four times the Dutch average. That was unbelievable."

Initially, Steegers's team of researchers believed that poorer neighborhoods had higher case rates because they had significant numbers of migrant families that may have struggled to access health-care services. That theory proved to be wrong. "Further studies showed—and this was really striking for us—that the magnitude of problems was much higher for the native white women who lived in those neighborhoods than it was for migrant populations," Steegers said. The cause of these differences was unexplained, but Steegers suspected that social cohesion was stronger within

Figure 1: Absolute prevalence of perinatal mortality per 1,000 births in 2014



Source: https://bmcpregnancychildbirth.biomedcentral.com/articles/10.1186/1471-2393-14-253

migrant communities than among native-born white mothers-to-be, who were often alone and isolated, with related problems of poor nutrition and addiction. Furthermore, where unemployment and low income might have driven native-born, white women to reside in deprived neighborhoods, migrant families often located in these same areas simply because they could not find another place to live. An important implication was that lifelong access to high quality medical care did not offset the disadvantages of being poor.

"We understood that the problem was caused by poverty and deprivation," Steegers noted. "That was the first time, at least in my country, that we understood the impact of poverty and the social environment on outcomes of pregnancy."

In 2004 and 2010, the first and second versions of the European Perinatal Health Report, which measured and ranked perinatal health outcomes across the European Union (EU), found not only that the Netherlands had lost the top position it held in 1990 but also that it had become one of the worst performers in the EU.[2,3] Especially after the 2010 report confirmed that the situation had not improved, perinatal health became an important social and political issue in the country.

By the end of the decade, the problems that Steegers had discovered in the poorest neighborhoods of Rotterdam had become a matter of national concern. In response, Steegers proposed a new approach: the creation of local coalitions that would bring together family doctors, gynecologists, midwives, municipal officials, debt counselors, social workers, health insurance companies, and other service providers to offer tailored medical, social, and economic support to pregnant women and young children in deprived neighborhoods.

THE CHALLENGE

On average, someone born in the Netherlands in the mid-2000s could expect to live to the age of 79—almost a decade longer than the world average.[4] But life expectancy for an individual with lower socioeconomic status was 6.4 years shorter for women, and 7.3 years shorter for men.[5] Differences in healthy life expectancy were even greater, at 20.6 years for women and 19.2 years for men.[6] Health specialists knew that on average, immigrants with low levels of education died earlier, began suffering from medical problems at younger ages, and had higher risks of struggling with obesity and using harmful substances like tobacco. But it was becoming increasingly evident that those disparities affected people living in low-income neighborhoods whatever their backgrounds.

By the early 2010s, the European Perinatal Health Reports had placed the issue of health disparities firmly on the political agenda. But Steegers knew that persuading elected municipal leaders in Rotterdam and elsewhere to provide funding and resources in order to establish and maintain local coalitions between medical and social care providers would still be difficult. Once they understood the problem, "few politicians were against the idea in principle, but that's not the same as being willing to make it part of [their] policies," Steegers said.

Even with political support in place, getting buy-in from professionals in both the medical and social domains would present another hurdle. Municipalities had to know which people they wanted as part of the coalition and then persuade them to join it. Krista Okma from Pharos, a national nongovernmental organization (NGO) focused on reducing health inequality, pointed out that "sometimes officials in the medical and social domains have never even heard of one another before."

Coalition partners also had to confront significant differences in organizational cultures and work patterns in different fields. Doctors, midwives, social workers, youth care workers, debt counselors, municipal officials, and health insurance providers all had "cultures, ways of working and doing research that are hugely different," Steegers said.

Onno de Zwart, who worked for the city of Rotterdam for 25 years, including as director of welfare and youth care from 2012 to 2019, added that there were also cultural differences within the individual domains. For example, he said, "there's a kind of tension between gynecologists and midwives about who's in charge, and a tradition of midwifery's [concern about] 'the doctors taking over.'"

The medical and socioeconomic domains, too, had different ways of working with data. Steegers said primary care providers like midwives and postnatal-care providers were not accustomed to doing research, because their jobs were mostly hands-on and time-consuming. Partners who did conduct research differed from one another with respect to the metrics and data they employed to analyze problems. Debt counselors were not accustomed to working with medical data, for example, and gynecologists were unfamiliar with the psychometric indicators used by social workers.

In spite of all of those differences, coalition partners had to reach agreement on progress indicators and ways of monitoring the impact of their work. The monitoring system also had to take into account the fact that many of the benefits of early childhood investments took a long time to show up in the data as improved health-care outcomes. It was especially important to persuade policy makers to adopt time horizons longer than the four-year electoral cycles they traditionally focused on.

Most fundamentally for the work of the local coalitions, the partners had to link the different members of the network with one another. The purpose of the coalitions was to bridge the divides that traditionally separated the medical and social domains from one another so that clients could receive integrated support that was tailored to their unique circumstances and that addressed both medical and social problems. In practice, it meant that a doctor or midwife who suspected that a pregnant woman might be a victim of domestic abuse or might be homeless or might be facing financial difficulties had to be able to refer her to a social worker, a municipal housing official, or a debt counselor.

FRAMING A RESPONSE

In the years after his initial insights into the link between poverty and perinatal health, Steegers worked with the Rotterdam city council to establish one of the Netherlands' first projects focused on reducing the incidence of poor health outcomes in deprived neighborhoods in the port city of more than 600,000. That initial project, launched in 2009 and called Ready for a Baby (Klaar voor een Kind), introduced the idea of coordinating and integrating support services from the health and socioeconomic sectors to focus on the health of individual patients.

The primary aim of the local coalitions was not to create new health-care services or social services but to make existing services more accessible and more effective in supporting vulnerable residents. The Netherlands already had a sophisticated health-care system. In 2010, the country devoted over 10% of gross domestic product to spending on health care,[7] the sixth-highest rate in Europe.[8]

A hybrid private–public health insurance system made it mandatory for every resident to purchase basic insurance from private insurance companies.[9] The government regulated the services that had to be included in all basic insurance packages, which meant that insurers competed to attract customers and that hospitals and other health-care providers competed for contracts from insurance providers within a regulatory framework maintained by the state. The government subsidized insurance premiums for lower-income people, provided some flexibility so that users could lower their monthly premiums if they agreed to pay more out of pocket before the insurance kicked in, and allowed consumers to purchase top-up insurance for treatments like physiotherapy or advanced dental care—which 90% of people elected to do.[10] Top-up insurance provided additional coverage for specific purposes or when the purchaser's medical costs exceeded the coverage provided by regular health insurance.

Responsibility for providing health care was shared between the national government and municipalities. Each municipality had its own Municipal Health Service, and nearby municipalities collaborated at the regional level through 25 Gemeentelijke Gezondheidsdienst, or GGD (Municipal Health Services).

The country's existing health-care program also featured a well-developed and, in some respects, unique perinatal care system. The Netherlands had the highest rate of home births in Europe.[11] Although the rate of home births had declined during the previous decade, in 2010 nearly a quarter of all births in the country still occurred at home.[12] And although findings like those contained in the European Perinatal Health Report had triggered a debate on whether the high rate of home births contributed to the country's relatively poor performance on perinatal health indicators, many Dutch women regarded childbirth as a natural process rather than a condition that required medical care, which made the role of midwives particularly important.

Every pregnant woman was legally entitled to receive postnatal care by a trained maternity nurse for up to 10 days, although without top-up insurance,

women sometimes had to make an additional co-payment to use the service. During the first days after birth, the nurse visited the new mother in her home to check on the mother and her baby, to answer questions, to help with household chores, and sometimes to buy groceries. To obtain the service, a pregnant woman had to register prior to her 12th week of pregnancy.

Rotterdam's early efforts showed how coalitions could operate in practice. Informed by Steegers's work during the early 2000s, the city had implemented Ready for a Baby in cooperation with Erasmus University Medical Center in 2009. The coalition also included Rotterdam Midwifery Academy, local midwives, pediatricians, family physicians, maternity-care and pediatric clinics, and social service organizations.[13]

By 2011, the city had deemed the program a success that showcased best practice for bringing together policy makers, community organizations, and professionals working in the medical and social domains.[14] Subsequently, the Rotterdam city council, led by Hugo de Jonge, who was in charge of the health portfolio, decided to expand the program by adding services like counseling and life skills training and renamed it Solid Start. Rotterdam's experience had inspired other cities to follow suit, and beginning in 2011, Steegers turned his attention to helping expand the use of local coalitions to other municipalities.

The need for multidisciplinary cooperation to address the multifaceted problem of perinatal-health disparities was clear. The question was: Could it be scaled to other municipalities and, ultimately, nationwide?

GETTING DOWN TO WORK

The first step for any municipality in building a local coalition was to secure political support by raising awareness among elected leaders about perinatal-health problems and why multidisciplinary coalitions represented the best solution. Next, the partners had to select project managers to lead the work of the coalitions, establish ways of working, and find ways to bridge the divides between professionals not accustomed to working together. Each coalition found ways to integrate different data sets and agree on monitoring systems and progress indicators. Finally, and most important, each coalition designed so-called care pathways that empowered medical professionals to spot potential social problems and link their patients to the right service providers.

Securing political support

Steegers's experience in Rotterdam provided a template for securing political support from elected municipal leaders. Local neighborhood maps were the main tools he used for communicating the concentration of perinatal health problems in certain areas. After creating detailed maps of Rotterdam, "I went to the alderwoman responsible for health in Rotterdam, Jantine Kriens, and showed her the maps. Then she really understood it," Steegers recalled. "She said, 'Now it's not only your problem, but my problem as well.'" (An alderwoman is a member of the executive in a municipality and held accountable

by the councillors). As a result, in 2009, the municipality provided €2.5 million (US$2.8 million) to set up Rotterdam's local coalition under the Ready for a Baby program.

In 2010, de Jonge succeeded Kriens as alderman in charge of education, youth, and family in Rotterdam. He soon became the leading political champion for Rotterdam's citywide local coalition, and in 2016, he expanded the program's services and renamed it Solid Start.

Shortly after the Ready for a Baby program started its work, the national health minister at the time, Ab Klink, visited Rotterdam to see how the program was going. After his visit, "he said we have to do this in more municipalities," Steegers said. With support from the national health department, Steegers contacted other municipalities that had showed interest in setting up local coalitions. During visits to each municipality, Steegers again used maps of local neighborhoods to show how poorly some areas performed with regard to perinatal health. "What worked best in those municipalities was to create a sense of urgency by using those maps," he said. "Neighborhood maps showing those disparities are very, very instrumental." At one point, he said, "I was even asked to show those maps on the 8 p.m. news because the journalist said this is what people understand."

In 2011, 14 more municipalities, including Tilburg and Groningen, decided to establish multidisciplinary coalitions to address perinatal-health disparities. With funding support from the national health department, the 14 municipalities established their coalitions under a program called Healthy Pregnancy 4 All. (See Figure 2)

Figure 2: Participant municipalities in Healthy Pregnancy 4 All

Source: https://bmcpregnancychildbirth.biomedcentral.com/articles/10.1186/1471-2393-14-253

In parallel with Steegers's work and with vigorous debates within professional organizations about the need for

solutions, perinatal-health disparities attracted increasing political attention. Media coverage of the 2010 European Perinatal Health Report sometimes replaced the use of the term perinatal mortality with references to the country's high baby death rate.[15] Such plain language galvanized public pressure for improved outcomes and further incentivized elected leaders to tackle the problem. However, its use also created the mistaken perception that healthy babies were dying while the real concern was instead premature or intrauterine death.[16]

The Dutch Parliament also played an important role in generating political support. Following the 2010 European Perinatal Health Report, members asked so many questions and triggered so many parliamentary debates about perinatal mortality that the health ministry designated the issue a key priority.[17] The pressure even forced the ministry to establish an internal working group, nicknamed the Baby Club, to discuss solutions and come up with answers to the flood of parliamentary questions and the intense public scrutiny.[18]

Working together

Once a local council decided to establish a coalition, the next challenges were to identify and bring together medical and socioeconomic care providers, appoint a project manager, and define the processes and mechanics of how the coalition would go about its work. This was easier said than done, however. De Zwart said people were "used to working in silos, doing the best they could, working according to their own professional standards, taking in new knowledge, and thinking, 'That's what I'm paid to do.'" The challenge was to "broaden their perspective so that they understood that these other aspects also influence the outcome of the health and development of children, which is just as important as the care you provide."

Karin Smeets, a strategic adviser to the alderman responsible for the coalition in Tilburg, added that demonstrating the benefits of multidisciplinary cooperation was essential to securing widespread buy-in for any coalition. Medical professionals—whether general practitioners, specialists, or midwives—all "love their patients," Smeets said. "If a patient has a medical issue caused by social factors and doctors see how someone from welfare helps that patient, they see that they get something back for their investment [in the coalition]. You have to persuade them that it's a win-win."

Vivian Jacobs, a member of the Groningen local coalition and a board member of the Sterk Huis organization for youth and adult care, stressed that participation in local coalitions was strictly voluntary. "The ambition is to work with people who want to be there," she said. "Sometimes we miss an organization because they are not inspired yet. But we are not going to push."

In Groningen, over time, the coalition members grew to include the municipality, the GGD, general practitioners, maternity care providers, the regional health insurance company, gynecologists, obstetricians, and midwives from University Medical Center Groningen, social workers, and a primary care

support organization. The coalitions in Rotterdam and Tilburg comprised many of the same partners, with Tilburg's coalition also including the local police and housing corporation. All three municipalities further decentralized the coalition by setting up subteams focused on neighborhoods most in need of support.

Aside from having to buy into the concept of multidisciplinary cooperation and coordination, prospective partners also faced practical problems. "People were afraid about whether they could integrate the concepts of the coalition into their work and whether it would add to their workload," de Zwart said. One such practical problem was that municipal officials usually held meetings during the workday prior to 5 p.m., but health-care workers became available usually only after that time. "It's a simple example, but the local municipality had to adapt to hold meetings after 5 p.m.," he added.

More significantly, because multidisciplinary meetings were not recognized as part of the regular work of doctors or midwives, health insurers did not pay for the time doctors or midwives spent consulting with coalition partners. It thus fell to local governments to compensate coalition partners for their time, but the amounts were normally small and mostly "symbolic," said Christa Hoeksema, an official in Groningen's local coalition.

Getting health insurers on board could also be challenging—especially for smaller municipalities. Insurance companies were organized at the regional level, with six big companies covering most of the country. "Because of the different scales, it's not possible for them to work with all of the smaller municipalities," de Zwart said. "They were happy to work with Rotterdam because it's a big city." In the case of smaller municipalities, "the GGD could play a role though, because it is also organized at the regional level," he added.

Selecting the right project manager was important. Over time, the coalitions learned that it could be better to appoint a professional project manager even if the person did not come from the medical or social domains. Isabelle Diks, deputy mayor of Groningen and head of the city's health portfolio, said, "It's a key element that we have a dedicated person working on this coalition, keeping it together, and broadening it." But smaller municipalities faced a specific challenge in that regard. Although bureaucracies in cities like Rotterdam were so big that one or more officials could be assigned specifically to support the coalition, in smaller municipalities the lack of capacity meant officials could work with the coalition only on a part-time basis because they had so many other tasks to attend to.

Local coalitions adopted structured ways of working. In Rotterdam, Steegers and de Jonge hosted an annual high-level meeting. A steering committee that included de Zwart and Steegers also met two or three times a year and reported annually to the city council; professionals met in different working groups more regularly.

In Tilburg, Jacobs described the coalition as a "swarm," in which "sometimes the government flies ahead, other times the hospital or youth care flies ahead." Tilburg's coalition board met quarterly, and other members met

two or three times a week. "We also hold big meetings twice a year where we focus on lessons learned," Jacobs added.

In Groningen, Hoeksema said the board met once a month, and the broader coalition met every two months, with two big annual meetings that included the local alderman. In addition, the Groningen coalition was divided into four working groups dedicated to periods before pregnancy, during pregnancy, and after pregnancy; and a fourth group focused on public communication.

Municipalities tried their best to make it attractive for as many partners as possible to join, but it was challenging to "work with some parties—especially because we were not funding them and didn't actually have a formal relationship with them. This meant we had to find new ways to do that," de Zwart said. "Ultimately, it was a program mostly for professionals who were motivated to do this."

It was a "coalition of the willing," Smeets agreed.

Integrating data and monitoring progress

With partners and structures in place, the coalitions next had to agree on which interventions and which neighborhoods to prioritize and how to monitor progress. But it soon proved impossible for individual municipalities to fully integrate the vast data sets used by the municipality as well as partners from the medical and social domains. "Our dream was to combine the data from all partner organizations, but we quickly realized that that would take 10 years," Jacobs said.

Instead of tasking the coalition partners with the integration of different data to guide decision making, the coalitions outsourced that work. Rotterdam relied on Steegers's maps as well as medical and socioeconomic data from Erasmus University Medical Center, de Zwart said. "This provided the baseline we could all agree upon."

The Tilburg coalition also turned to its own local university. Researchers from the Tilburg University data science department had access to data held by Statistics Netherlands, the country's national statistics agency. Together, the coalition and university researchers drew up a project plan that the university submitted to Statistics Netherlands. "We had to motivate for every piece of data we wanted, and they would give it to the university only after checking that it was fully anonymized," Jacobs said. The university researchers then analyzed the data at the household level and furnished the analysis to the coalition.

The Tilburg coalition also worked with the university's ethical studies department to develop a checklist that would guard against any violations. "For us it's important to think about why we want to know something," Jacobs said. For example, "a few years ago, it was standard to use data on ethnic background in our analysis. But now we constantly have to discuss whether we really need it, because we do not want to profile anyone." At the same time, "children who start school not speaking Dutch have lower chances of timely development. And

because Statistics Netherlands does not keep information on language, we are forced to use ethnic background to identify families that need language support," she explained.

To monitor progress, the coalitions in different cities initially wanted to use the same indicators that guided decisions about priorities. But health outcomes data like perinatal deaths, low birth weight, and social outcomes data like rates of alcohol abuse, indebtedness, and homelessness were "long-term effects," Steegers pointed out. In Rotterdam, "that was a discussion with [de Jonge] because he initially wanted to see results in two or four years. That was not possible, so we also had to look at process indicators." Examples of such process indicators included the number of people who had access to preconception care, how often the coalition met, and how often risk assessment was conducted to identify families that needed social support.

Creating care pathways

Equipped with a set of key priorities, local coalitions turned their attention to establishing work protocols and cooperation between different parts of the medical and social domains. The process started with the empowerment of medical professionals to detect and report potential social risks such as alcohol abuse, domestic abuse, or homelessness. In Rotterdam, the coalition designed a standardized Rotterdam Reproductive Risk Reduction (R4U) scorecard for use by medical professionals during a pregnant woman's first prenatal visit—normally before the 12th week of pregnancy. After going through various iterations, the final version of the scorecard contained a set of questions whose answers were either yes or no, with each question weighted according to its correlation with poor health outcomes.

On the medical side, the scorecard covered standard areas like whether the pregnant woman was older than 40 or younger than 18, had a history of miscarriages, or had previously had a caesarean section, as well as length of time between the current and any previous pregnancy.[19] On the social side of the equation, the R4U scorecard assessed whether the woman lived in a deprived neighborhood, suffered domestic violence, had irredeemable debts, faced housing problems, worked while standing up, used alcohol while pregnant, or had any history of mental illness.[20]

In Groningen, the coalition designed a similar questionnaire that pointed coalition members to the correct care pathways. "The care pathways are intended as tools for health-care providers to be able to map the psychosocial situation of prospective parents and potential risks," the coalition's plan stated. "Using these care pathways, they can quickly find the required support as well as contact information for relevant care providers."[21]

As with the R4U tool, the first step was to help health-care providers identify the correct route to take. For example, if the pregnant woman was a refugee, there was a specific care pathway called pregnancy care for asylum seekers. The coalition similarly designed dedicated pathways for tackling such

issues as housing problems, poor literacy, teenage pregnancy, domestic violence, and drug use.[22] The document was updated annually to ensure all of the contact details were current.

Next, the coalition mapped every step of the route for each care pathway. For instance, if the pregnant woman's doctor or midwife identified signs of domestic abuse, the first step was to discuss the issue with the woman. If the woman confirmed that she or her family suffered violent domestic abuse, the doctor or midwife referred her to Safe Home (Veilig Thuis), a program to help victims of domestic abuse. If the woman was experiencing sexual abuse, the health-care provider could refer her directly to the Center for Sexual Violence. And if she experienced relationship problems that were not yet violent, the pathway referred her to social services.[23]

The care pathway also offered suggestions for handling situations in which a woman was afraid to admit she suffered domestic violence despite clear evidence. The first step was for the doctor or midwife to consult the municipality's social services provider, which would send a social worker to speak with the woman. If the social worker confirmed that the woman was likely trapped in an unsafe situation, the worker alerted Safe Home, which followed clear protocols for intervening in cases of domestic violence. Groningen's care pathways plan also adhered to the stipulation embodied in the idea behind the local coalition that rather than being mere observers, medical practitioners "have an active role to play in signaling the presence of domestic violence and initiating help."[24] The city's 24-hour telephone advisory service had the care pathways document on hand to point doctors and/or midwives in the right direction.

The creation of care pathways was a standard step, but some municipalities also launched additional projects designed to meet local needs. One example came from Tilburg, which in 2014 pioneered Not Pregnant Now (Nu Niet Zwanger). Aimed at addressing the fact that one in five pregnancies in the Netherlands was unplanned, the project trained medical professionals to provide counseling for vulnerable women who visited their practice in order to avoid unwanted pregnancies.[25] "Pregnancy is often not a conscious choice but something that happens to a person," the program plan stated. "That's why it's important for professionals to speak with their clients about their desire for children, sexuality, and contraceptives."[26]

OVERCOMING OBSTACLES

Even as the coalitions worked to implement appropriate care pathways, a 2011 political decision loomed in the background. After a protracted public debate about which level of government was best able to provide social support services, the national government, the provinces, and the municipalities signed an agreement to decentralize social service provision to the municipal level.[27]

Following a transition period for implementation of required legal changes, procedures, and funding arrangements, the planned decentralization would take effect in 2015. Under the new arrangement, municipalities would assume

responsibility for a wide range of social services, including youth care.[28] As a result, early adopters of the local-coalition approach to reducing perinatal-health disparities had to design their coalitions without knowing exactly how the decentralization would play out.

On January 1, 2015, the Netherlands decentralized social services—including youth care services—to the municipal level. The funding for social services came in the form of unconditional block grants from the national government to municipalities, and the national sphere was empowered to regulate and monitor quality of service.[29]

Decentralization was motivated by the idea that municipalities were familiar with the specific characteristics of their communities and would therefore be better equipped to deliver youth care services tailored to local conditions. The shift was also intended to overcome fractured service delivery by assigning responsibility for youth care to a single entity: the municipality.

But there were downsides to decentralization too. The use of an unconditional grant meant that municipalities could reallocate funding away from programs that had previously been funded and managed by the national government.[30] There was also a risk was that without direction from the national government, the use of local coalitions would not scale up across the country fast enough to respond to perinatal-health problems. Moreover, evolving youth care to the lowest level of government made it more difficult to capitalize on economies of scale—especially in smaller municipalities.[31] Lastly, local health services as well as insurance companies were organized on regional rather than municipal levels, making it difficult for them to participate in dozens of different coalitions in smaller municipalities.

Leon Noorlander, deputy director of Pharos, the national NGO focused on reducing health disparities, said, "The local communities really had to learn how to work with all these responsibilities. After two or three years, we saw it wasn't working as we had hoped. [Municipalities] were doing what was legally required, but they were not learning and innovating."

In response, national and local government leaders "sat together to create a safe environment in which to innovate," Noorlander said. The discussions between national and local governments led to the 2017 creation of the Social Domain Program (Programma Sociaal Domein, or PSD). The PSD called itself a "learning program" that sought to identify what was needed at the local level in order to tackle disparities in health outcomes.[32]

But before the PSD could be implemented, it was partly overtaken by events. De Jonge, the former alderman for health in Rotterdam who oversaw the creation of the Solid Start program there before becoming national health minister in October 2017, wanted to introduce the program nationally—and to do it quickly.

Ciska Scheidel, who originally worked with de Jonge in Rotterdam and later became director of public health in the national health department, said that shortly after de Jonge became minister, "we discussed what kind of programs he wanted. Nationally, there was no program similar to Solid Start as it existed in

Rotterdam, and he wanted to do something like that on the national level because he thought that it was also necessary to give more attention to the first 1,000 days of children's lives in the rest of The Netherlands." The need for a national program was clear given that most of the existing coalitions had faced similar challenges such as bringing the different role players together around the same table, integrating data, agreeing on priorities, and monitoring progress.

Scheidel added that "within a few minutes, we decided to also introduce Solid Start on the national level. Because the results in Rotterdam were that good, we wanted to do it in the whole Netherlands as well." She added, "We also knew that all of the local governments had to be involved. It was not that the national level would do the whole program on its own. We would do it together." The national government had to provide instruments and guidelines, finances, and had to finance scientific research and would stimulate local governments to organize local coalitions. The national government had to support local governments - not take over their job.

In early 2018, a trip to Harvard University provided an opportunity for the national government to discuss the proposal with municipal leaders. "The training [at Harvard] was organized by the Bernard van Leer Foundation [a Dutch foundation] and focused on leadership for scaling up early childhood development," Scheidel said. "We went there with a couple of municipalities and organizations. We learned from the experiences of other countries, but it also enabled the national government to talk to other organizations, so that we could think in the same way and create a backbone of organizations that can work together."

In February 2018, de Jonge announced the creation of a national Solid Start program. (De Jonge made the announcement in Tilburg because of its status as a "leader in the provision of care to vulnerable parents and children."[33])

The national government realized it would have to incentivize or subsidize municipal participation if it wanted to sustain Solid Start. From 2018 to 2021, the national government allocated €41 million (US$45 million) to the program.[34] The additional funding would be used for subsidizing the work of local coalitions in every municipality that signed up for it. De Jonge's department also contracted Pharos to support participating municipalities in establishing local coalitions.

Under Solid Start, municipalities applied to the national health department to join the program and qualify for their share of the subsidy. According to Okma, the amount allocated to an individual municipality was based on a calculation of the number of vulnerable residents. "When the program was first announced, people were excited to get money for prevention, which is always a challenge. But then they saw the amounts, and there was some disappointment" because the money was less than expected, she said. "But the [financial subsidy provided by] Solid Start is enough to create a focus on prevention in the first 1,000 days, stimulate collaboration between the social and medical domains, and make better use of what is already there."

The national health department regarded the funding as an initial subsidy to stimulate the creation of Solid Start coalitions, with the money often used to

cover the costs of coalition meetings and to pay project managers' salaries. Smeets, from the Tilburg municipality, pointed out that midsize cities received about €80,000 (US$88,000) annually from the program. "We are quite free to allocate it as we see fit to support the coalition," she added.

The national health department also introduced a support process to help municipalities set up new coalitions. The first step was to apply to the department, and then Okma's team from Pharos would contact the municipality to discuss the program, explain its aims, and outline the different roles involved in making a coalition work.

Next, "we go over the numbers," Okma said. "We look at the vulnerabilities in that particular municipality, looking at things like perinatal mortality, low birth weight, alcohol use during pregnancy, smoking, literacy levels, and numbers of people reached for pregnancy guidance before the 20th week. We use those numbers to draw a picture of the municipality."

Based on the specific challenges of each municipality, "we then discuss who needs to be at the table initially," Okma said. The list usually included a project manager, local general practitioners, midwives and maternity care nurses from the medical domain, and youth care workers and social workers from the social domain. "We then help [the municipality] find those people and get in touch with them. That's the first moment when the different domains meet each other," she added.

Because earlier coalitions had sometimes become bogged down by disagreements over how to share and how to integrate different data sets, the Pharos team now helped municipalities work through the data together. "We take the numbers [initially discussed with municipal officials] to the people at the table to see whether something is missing," Okma explained. Partners then had an opportunity to identify priorities based on the data. When disagreements arose, "we try to [resolve disputes] based on democratic decision making."

In what was generally the final step of Pharos's support of municipalities in setting up Solid Start coalitions, the organization combined the analysis and identified priorities to create an action plan. "Sometimes we also help them create small work groups focused on different areas, and we make sure to divide responsibility so that different people are all contributing to the program," Okma said.

The national Solid Start program further helped coalitions with planning by dividing their work into three distinct phases: before pregnancy, during pregnancy, and after pregnancy. In the first phase, the goal was to empower families to make informed decisions about when to have children. Each coalition thus implemented Not Pregnant Now and provided women from vulnerable backgrounds with access to preconception care. Once a woman was pregnant, the coalitions used risk assessment tools like R4U and their local care pathways to identify and support vulnerable women through social interventions like finding housing, debt counseling, and help with domestic or substance abuse. Finally, after the birth, the coalitions ensured that families had access to

services like parenting training, maternity care nurses, counseling, and youth care services.[35]

In addition to helping municipalities establish their coalitions and putting together action plans, the national Solid Start program addressed the problems coalitions had previously faced when it came to monitoring progress. Rather than leave it to hundreds of different municipalities to figure out ways to monitor the program, the national health department contracted the National Institute for Public Health and the Environment (Rijksinstituut voor Volksgezondheid en Milieu, or RIVM) to facilitate monitoring for all coalitions. Jeroen Struijs, who headed monitoring work for the RIVM, explained that the program had two sets of indicators: one for the national level and one for local monitoring.

To track the national picture, the RIVM team assembled a panel of 30 experts who defined 15 core indicators to measure whether the Netherlands made progress on reducing perinatal-health disparities. The indicators included descriptive process indicators as well as some outcome indicators, such as percentage of municipalities that had local coalitions, whether Not Pregnant Now was being implemented, percentage of pregnant women from vulnerable situations who received counseling from their 10th week of pregnancy, percentage of pregnant women with problematically high levels of debt, and percentage of children born into vulnerable families.

"The first thing municipalities told us was that this national indicator set is very good, but it's not useful for us," Struijs said. In response, the RIVM brought together representatives from 11 local coalitions—including from Rotterdam, Groningen, and Tilburg—that had done their own monitoring in the past. Using the indicators initially identified by the 11 coalitions, Struijs's team put together another panel—of 40 experts—which eventually narrowed the local monitoring tool down to 19 core indicators.[36] (Leontien Peeters from the Bernard van Leer Foundation however added that it was more challenging to identify indicators for the period after birth, as the data was not always readily available or uniform across municipalities.) (See figure 3)

Individual coalitions could now use the RIVM monitoring tool to track progress within their municipalities. The 19 indicators included percentage of local families with access to a preconception consultant, percentage of men and women of reproductive age who had significant debts, percentage of pregnant women with physical or psychological problems, percentage of children born prematurely or with low birth weight, and percentage of families that made use of maternity care services.[37]

In addition, the RIVM drew on Statistics Netherlands' extensive data to create its own unique data analysis tool called Data Infrastructure for Parents and Children (DAIPER). To protect the privacy of families and comply with the

Figure 3: Municipalities that participated in designing RIVM's monitoring indicator

Source: https://www.rivm.nl/sites/default/files/2021-11/Factsheet%20Indicatorenset%20voor%20Lokale%20Monitor%20%20Kansrijke%20Start_def.pdf

European Union's General Data Protection Regulation, Statistics Netherlands anonymized all data by using random identification numbers. This meant that "even though we knew a lot about these people" and "we could link the outcomes of pregnancy and follow those persons over time, we do not know who they are," Struijs said. In addition to anonymizing the data, Statistics Netherlands ran checks on all figures or tables requested by the RIVM, so as to ensure that the information could not be used to determine someone's identity. "If it was possible to identify someone, they do not allow us to access that data," Struijs said.

ASSESSING RESULTS

From less than two dozen municipalities using local coalitions to tackle perinatal-health disparities prior to 2018, by early 2022, 275 of the country's 345 municipalities had set up local coalitions under the national health department's Solid Start program. "During the past couple of years, you saw the coalitions popping up all over the map," Struijs said. "If it was a weather map, we could say it is raining local coalitions everywhere in the Netherlands."

As Solid Start scaled up throughout the country, Okma noticed that the coalitions usually varied between different municipalities. "They don't take one specific shape, and big cities look very different from tiny municipalities. Amsterdam, for example, has a coalition with lots of working groups that operate at different levels with different organizations and that tailor their plans to specific neighborhoods. In small municipalities, there's just one coalition, and you're just happy that a few enthusiastic people are at the table," she said.

Angela Uijtdewilligen of the national health department concurred and emphasized that "there are big differences between the coalitions. Some have been going for a long time, but others have just started. Our impression is that coalitions are happy to be brought together to talk to one another and work together in better ways than they used to."

Based on feedback from focus groups of municipal officials run by the RIVM, Struijs noted that local coalition participants "really say it's more structured than before; they really start to know each other; and it is all more intensive than it was before." He added: "They really are noticing that those coalitions are stimulating collaboration between the social domain and the medical domain." This was important because the improved collaboration fostered by the coalitions held the key to improving health outcomes.

However, Struijs cautioned that although descriptive statistics and process indicators all showed that the coalitions were active, it was too soon to confirm a causal link between the coalitions' work and improved perinatal-health outcomes. "If we look at DAIPER [the data system], we can see that the big two indicators—premature births and low birth weight—are going in the right direction," Struijs said. "But a lot of things are happening in the Netherlands regarding maternity care," and it was not yet clear which interventions had the greatest impact. He added that the RIVM was busy with research to investigate the causal link. "We know when the local coalition started [in every municipality], so we are now looking at whether improvements on the big two [indicators] happened after that or whether they predated the coalition."

Steegers referred back to his experience in Rotterdam, where, in the early 2000s, some neighborhoods experienced perinatal mortality rates of up to four times higher than the national average. "We succeeded in lowering the perinatal mortality rate in Rotterdam to the national average. So, although you have to be modest about the possible effects of other influences, the point is that it succeeded."

The outbreak of the COVID-19 pandemic in early 2020 complicated matters. One of the most important indicators the RIVM used for monitoring progress involved the number of women in vulnerable situations who were visited by a maternity care nurse after giving birth. "But during COVID, especially in the beginning, nobody wanted to have a maternity care assistant in their homes. You can see it in the data. That one is going in the wrong direction," Struijs said.

Even though more work was needed to parse the exact impact of the coalitions and even though it would take a few years for the work of the coalitions to filter through into improved perinatal-health outcomes, it became clear in 2022 that the concept of using local coalitions to integrate the medical and social domains with a view to reducing health disparities had taken off in the Netherlands.

Nothing demonstrated the momentum behind local coalitions better than the fact that the new national coalition government that came into office on

January 10 prominently committed itself to expanding Solid Start. (Hugo de Jonge, whose political leadership had been vital to expanding the use of local coalitions to hundreds of municipalities, stayed on in the new coalition government but moved to the portfolio for housing and spatial planning.)

In the coalition agreement that formed the basis for the government's work up to 2025, the political parties represented in the Cabinet undertook to "implement the Solid Start program in every municipality, thus supporting mothers and newborns in the first 1,000 days, which are crucial for health, wellbeing and a child's later development."[38] Peeters of the Bernard van Leer Foundation said that "a structural budget of €23 million [US$24.3 million] per year will also be made available, starting in 2023."

REFLECTIONS

The Netherlands' national Solid Start program supported municipalities in their efforts to learn from early adapters like Rotterdam, Tilburg, and Groningen in meeting the challenges of perinatal health-care. It did so by bringing disparate service providers to the same table in local coalitions, by integrating data, by helping to set priorities, and by monitoring results and progress. At the same time, it was entirely up to individual coalitions to determine the content of their work and to map the most-appropriate care pathways given their local context.

In effect, Solid Start struck a balance between the advantages of decentralized care by empowering local governments to respond and continually adapt to the changing local context while simultaneously responding to some of the drawbacks of decentralization by supporting municipalities with funding, coordination, and monitoring.

In each of the municipalities that first set up coalitions, as well as at the national level, political will was decisive. Onno de Zwart, Rotterdam's director of welfare and youth care from 2012 to 2019, said local coalitions "wouldn't have happened were it not for Eric Steegers. He is a pioneer in his field, and he was really single-mindedly working on it." The relationship that Steegers formed with Hugo de Jonge, former alderman for health in Rotterdam and, later, health minister, also proved decisive. "That political leadership was key. De Jonge consistently pushed Solid Start from every podium," said Jeroen Struijs, head of monitoring at Solid Start.

Steegers and de Jonge successfully promoted the battle against early-childhood health disparities—which often had their roots in other perinatal-health problems—as "something all politicians could relate to. It was not partisan. Everybody wanted to give children a good start in life," de Zwart added.

Ciska Scheidel, director of public health in the national health department, added that political will was also a key factor that distinguished strong coalitions from weaker ones. "If the local alderman is not really involved, the coalition is not really working well. It's really important that the alderman and the director of the department be really involved."

Sheidel also highlighted the important role played by Pharos, the national non-governmental organization that sought to reduce health disparities. "Pharos could really look inside the coalition and see the exact needs. Every coalition is unique, and Pharos can see up close what kind of support is needed."

Some elements of the programs put in place proved controversial, though sensitivities sometimes stemmed from misunderstandings. For example, there were instances when the Not Pregnant Now component became politically controversial. Isabelle Diks, vice mayor of Groningen, recounted an example wherein she was "attacked on Twitter" for promoting Not Pregnant Now. "People said I wanted to prevent poor people from having children, which is of course not true." Although she added that many people also came out in defense of Not Pregnant Now and that Groningen "wholeheartedly supports it" because it "empowers vulnerable women in making their own decisions concerning their bodies," the incident showed that the topic was highly sensitive politically.

A paper published by Steegers and his colleagues at Erasmus University Medical Center in 2016 similarly noted that "although the media attention [focused on perinatal-health disparities] appeared to be a useful tool in the beginning, it was felt that the attention became incontrollable and the nuances in the perinatal mortality debate were lost."[39] Nonetheless, Steegers said that "creating a sense of urgency is by far the most important thing. You do that by explaining that the first 1,000 days of life—including the months before birth—are really of the utmost importance."

Looking to the future, de Zwart said the question of funding had to be addressed to make the coalitions sustainable. "This shouldn't be only a program for professionals who are motivated to do it; it has to become part of the regular work," he said. In addition to funding from national and local governments, it was also important to speak with health insurers about "creating a new tariff for [time that medical professionals spent] on consultation and coordination, so that tasks like these could be covered by the regular health-funding system," he said. Although it might prove difficult to make the use of local coalitions a national statutory requirement given the extent of devolution in the Netherlands, de Zwart recommended that preventive care, including through improved early childhood development, "should be addressed and better organized" in law.

For Steegers, the doctor who paved the way for medical professionals to transcend their traditional boundaries by collaborating with local governments and non-profit service providers, the next challenge was to get traffic flowing in both directions on the care pathways he helped design. "There's been a lot of focus on getting the medical domain to link patients with the social domain, but it's still a mission of mine to make it run vice versa as well," he said. He hoped to empower young people to speak up for their own needs and aspirations. "When a young couple visits a social worker regarding housing, I think they should also talk about a possible pregnancy wish so that the social worker can refer them to a general practitioner, midwife, or gynecologist for a preconception consultation."

Steegers also said the collaboration between the medical and social domains had not yet reached its full potential. Pregnancy presented an opportunity to connect. For both mother and child, "pregnancy can be the starting point for all kinds of preventive measures" that could improve life prospects and reduce risk, Steegers said.

Crucially, the Netherlands' experience in building local coalitions also had broader relevance. The use of multidisciplinary teams to implement a systemic response to perinatal-health disparities offered a potential model for tackling other multidimensional problems. Like persistent health problems, most socioeconomic challenges had more than one cause and transcended policy boundaries. Their solution, like the Netherlands' local coalitions to reduce perinatal health disparities, required new forms of collaboration, new types of data-sharing, and a new ethos of cross-sectoral collaboration.

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