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Do 'physicians in the lead' support a holistic healthcare delivery approach? A qualitative analysis of stakeholders' perspectives

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ABSTRACT

Objectives Value-based healthcare implies that healthcare issues are addressed most effectively with the 'physicians in the lead' (PIL) strategy. This study explores whether PIL also supports a holistic care approach that patients are increasingly demanding.

Design A qualitative research design was used.

Setting This study was conducted in a general hospital in the Netherlands with an integrated PIL strategy.

Participants Semistructured interviews were conducted with 14 hospital stakeholders: 13 stakeholders of an Obstetrics and Gynaecology department (the hospital's Patient Council (n=1), nurses (n=2), midwives (n=2), physicians (n=2), residents (n=2), the non-medical business managers of the Obstetrics and Gynaecology department (n=2) the Board of Directors (n=2)) and a member of the Dutch National Healthcare Institute's Innovative Healthcare Professions programme.

Results According to diverse stakeholders, PIL does not support a holistic healthcare delivery approach, primarily because of the strong biomedical focus of the physicians. Although physicians can be educated to place more emphasis on the holistic outcome, holistic care delivery requires greater integration and teamwork in the care chain. As different healthcare professions are complementary to each other, a new strategy of a 'team in the lead' was suggested to meet the holistic healthcare demands. Besides this new strategy, there is a need for an extramural care management coordination centre where patients are able to receive support in managing their own care. This centre should also facilitate services similar to the core function of a church or community centre. These services should help patients to deal with different holistic dimensions that are important for their well-being.

Conclusions The PIL strategy appears to be insufficient for holistic healthcare delivery. A 'team in the lead' approach should be considered to meet the holistic healthcare demands. Further research should focus on observing PIL in different cultures and exploring the effectiveness of the strategy 'team in the lead'.

Strengths and limitations of this study

- ► To our knowledge, this is the first study to explore the PIL strategy in the transition to holistic healthcare. This is a qualitative study offering insights into different stakeholders' perspectives. The perspectives from the study provide a broad understanding on how to enhance and provide holistic care in the context of physician leadership.
- ► The study is limited by the fact that it was conducted in one centre in one country. As the strategy of hospitals differ across settings and/or countries, the content may be less relevant to settings without a PIL strategy.
- ► All stakeholders were hospital-based and internally oriented, which may have influenced the way they described the organization of holistic care.
- ► Because our results are based on interviews with mainly hospital-based stakeholders, they are likely to present a limited picture of the effects of the PIL strategy on the transition to holistic healthcare.

INTRODUCTION

The healthcare system, which is traditionally organised around acute care delivery, seems to be inadequate for managing the changing healthcare demands of the increasing number of chronically ill and ageing patients.[1 2] To comply with these demands and manage the growing impact these demands have on healthcare budgets, a different approach to healthcare delivery is needed.[3–5] A relevant concept that is in line with changing patient demands is 'positive health' of Huber *et al*.[6] This holistic concept shifts the traditional and principally biomedical focused care towards a model with greater emphasis on five other dimensions of patients' lives, including psychological, social, and spiritual well-being (meaningfulness); their quality of life; and their daily functioning.[6]

In this time of change towards a holistic healthcare delivery approach, several transition models have been developed. One of these includes Porter's value-based healthcare delivery (VBHC).[7] VBHC uses a 'physicians in the lead' (PIL) strategy. This strategy engages physicians in organisational processes, making them responsible for the quality and

efficiency of their department's care delivery. This strategy arises from the belief that physicians have the power to lead the reform of healthcare and to provide care in an effective, efficient and cost-effective way.[8] Within VBHC, value is defined as the patient health outcomes per dollar spent,[7] and ideally, this high-value care delivery system would manage the healthcare needs of patients while keeping care expenditures in check.

VBHC comprises six interdependent components: (1) organising healthcare around patients' medical conditions (a full care cycle) rather than around physicians' medical specialties; (2) measuring costs and outcomes for each patient; (3) developing bundled prices for each care cycle; (4) integrating care across separate facilities; (5) expanding excellent healthcare delivery services across an area, state or country; and (6) building an enabling information technology platform to establish an efficient way of data reporting and information sharing between professionals as well as patients. VBHC provides many elements that could support a holistic care model, for example, an inter-professional team approach to rehabilitation as a way to improve patient outcomes.[7] VBHC prescribes integrated care that exceeds the traditional boundaries of care that is usually provided by a physician.

Although the transition to VBHC has already begun, as a PIL strategy to improve holistic care, VBHC has not been sufficiently covered in the literature. Porter does provide an approach to the full cycle of care and the link to health outcomes, yet implementation studies[9–11] do not address the holistic features of health proposed by Huber *et al*.[6] Moreover, Huber shows that there is a large discrepancy between the perspectives of patients and healthcare professionals concerning the relative importance of the various dimensions.[6] Whereas patients and nurses find all six dimensions almost equally important, physicians are of the view that dimensions other than bodily functions are less important.[6] As patients seem to have a broader view on their health than physicians do and since physicians may not sufficiently recognise the holistic needs of patients, the question arises whether a PIL model is capable of introducing and providing such holistic care.

The aim of this research was to elicit various stakeholders' perspectives on the PIL strategy during a transition to holistic healthcare and to understand the perceived advantages, barriers, opportunities for improvement and risks to PIL in this transition. The research questions were:

- What are the stakeholders' perspectives on the PIL strategy?
- What are the stakeholder's perspectives on holistic care?
- How do the stakeholders' perspectives on the PIL strategy relate to their perspectives on holistic healthcare delivery?

METHODS

Setting

This study was conducted at an Obstetrics and Gynaecology department in a general hospital in the Netherlands, which was halfway through the process of implementing VBHC and had integrated a PIL strategy. In this context, all physicians in a department share the responsibility regarding the quality and efficiency of healthcare delivery, with one PIL in each department. This PIL receives support from an operational manager and a business administration manager but remains ultimately accountable to the Board of Directors concerning the organisational processes, performance and quality of healthcare delivery of the department. The Board of Directors in turn support PIL by facilitating leadership and management courses and monitor patient care results as well as the alignment of departmental interests with hospital interests. Besides leadership and managerial tasks, the PIL is required to remain clinically active.

Study design

An interpretative and descriptive qualitative design was used.[12 13] Knowledge was gained from a deep understanding of the stakeholders' perspectives from their individual experiences. The use of open-ended questions during the interviews allowed the respondents to talk in-depth, choosing their own words. The format provided the interviewer an opportunity to probe for a deeper understanding, ask for clarification and allow the interviewee to steer the direction of the interview. In this way the interviewer could develop a real sense of the stakeholders' understanding of the situation, their experience and associated perspectives.

Participants and procedure

We used purposeful sampling to select the stakeholders.[12 13] Stakeholders were explicitly selected by a hospital administrator in hopes of generating appropriate and useful data. Two stakeholders of each relevant stakeholder group were selected to form a representative sample using the following criteria: active involvement in policy discussions and contributions to policymaking regarding the hospital's future healthcare delivery plans. Between April and June 2016, a physician (RM) conducted semi-structured one-on-one, in-depth interviews with members of all stakeholder groups of one obstetrics and gynaecology department: the hospital's Patient Council (n=1), nurses (n=2), midwives (n=2), physicians (n=2), residents (n=2), the non-medical business managers of the department (n=2) and the Board of Directors (n=2). In addition, a representative of the Dutch National Healthcare Institute's Innovative Healthcare Professions programme (from the advisory board for the Dutch Ministry of Health on innovations and improvements in healthcare professions and education) was interviewed (n=1). Of the 14 participants, 12 were women and two were men. One of the two men participants was a member of the Board of Directors and the other was one of the department's

non-medical business managers. The gender and ethnicity distribution were representative of each stakeholder group. All 14 stakeholders were approached for inclusion by email invitations, and all agreed to participate (the secretary of the hospital's Patient Council was approached to recruit two representatives; however, only one delegate was suggested). The number of participants was predetermined to obtain broad stakeholder perspective; data saturation was reached with the initial cohort. Saturation was evaluated by determining the amount of new data generated by each transcript. The Hospital Ethics Review Board waived the requirement for ethics approval. All participants provided written informed consent for audio-recording the interview and publishing of group data.

Patient and public involvement

Patient perspectives receive a growing attention in the healthcare delivery approach. Patients' preferences, priorities and experiences are important markers that help patients and physicians in the shared decision-making process. The client board of the hospital was identified to represent groups of patients. Patients were not involved in the conduct of the study.

Data collection

Keywords and phrases such as 'physicians in the lead', 'medical leadership', 'value□based healthcare', 'holistic care', 'healthcare transition' and 'healthcare delivery' were used in the PubMed, CINAHL, PsycINFO and Google Scholar search engines to find relevant literature in order to theoretically frame the transition to value-based and holistic healthcare delivery and PIL. A tailored topic list was drafted from theoretical concepts to structure the interviews and to organise the data collection (online supplementary appendix 1). In view of the exploratory goal of the study, questions were mainly open-ended. Each interview lasted 30–60 min with a median of 40 min.

Data analysis

The interviews were transcribed verbatim.[12 13] The transcripts were anonymised other than for the interviewer (RM) and were analysed by RM and another researcher using content analysis.[12 13] A qualitative data analysis software programme (MAX.QDA 2007) was used for coding the narratives. Data were categorised with open and axial coding. During the first step of open coding, sentences of the transcripts were coded with a label that summarised the meaning of that sentence; this resulted in a large number of labels. Subsequent axial coding reduced the number of labels by clustering the content of closely related labels into categories. Thirty-nine categories remained after axial coding.

This process was guided by the concept of Huber *et al*[6] and the research questions. In the final step of selective coding, connections were made between the categories identified in the axial coding process. This step was an iterative process, in which the research team repeatedly discussed until consensus was reached about the key themes.

RESULTS

Three key themes were derived from the analysis of the stakeholders' perspectives: PIL's role in the transition to holistic healthcare delivery, the requirements to achieve holistic care and a new strategy for hospitals to achieve holistic healthcare delivery. All data presented in the results are based on the stakeholders' perspectives, unless otherwise specified.

PIL in the transition to holistic healthcare delivery

All stakeholders mentioned that a transition to holistic healthcare delivery seems to be inevitable and a desired development. But the researchers wanted to understand if introducing 'PIL' is the same as introducing holistic care in the hospital.

Facilitators to holistic care through PIL

All stakeholders stated that the main advantages of PIL are related to the dimensions 'bodily functions' and 'daily functioning' of Huber *et al*.[6] The physician participants reported that they are able to see a patient holistically. The extent to which the physician has a holistic view, however, may depend on the physician's specialty. Besides specialty, the physician's experience can have a beneficial influence on the physician's capacity to provide holistic care.

> Geriatricians and oncologists will look not only at the bodily functions but will have a broader view of components that add value for patients. (Resident)

The physicians can lead the practice, as they have knowledge about the medical needs of patients, treatments available, resources needed for patient care, and developments in medical care. Physicians have a certain influence within a team, which can help in transferring a holistic view to the rest of the team.

> If physicians would have a holistic view it would be very favourable as they have a lot of influence on all levels of the organization to change things. If I want something from the Board of Directors, I have to pass several levels, and in the end, I will still not succeed to reach them. If a physician approaches the Board of Directors, they get through immediately. (Manager)

Barriers to holistic care through PIL

The first barrier to PIL providing holistic healthcare is time. The short time frame physicians have for each patient negatively impacts the ability to facilitate holistic care.

> A physician has ten minutes for each patient; they do not have time to check whether patients are healthy on all these dimensions. Moreover, I do not see any physician doing this. (Nurse)

Most stakeholders, except for the physicians themselves and the Board of Directors, felt that another barrier is that physicians have a narrow view due to their strong biomedical focus. This focus is often at the expense of other dimensions; for instance, this view rarely includes meaningfulness as part of the spiritual dimension. This narrowed view may result in an over-focus on diagnostics and interventions.

> Our profession is based on seeing clients from a healthy perspective. As soon as a gynaecologist is consulted for advice concerning a pregnant woman, you may assume that their care delivery approach is focused on disease. Then it is often just a matter of wait and see until they start their interventions, which are in my opinion not always necessary. (Midwife)

A third barrier concerns the physician's engagement in management and leadership tasks. Physician's priority is to be a clinician rather than a manager and leader. The management course that is provided in the hospital is considered insufficient, as managers usually study management for years. The time PIL get to run a department is also insufficient; managing a department is already a complex and full-time task on top on patient care priorities. Although many PIL manage to take care of their own department, they seem to lose sight of the bigger picture and do not act in collaboration with other departments and the hospital's interests.

> "Physicians in the lead manage to take care of their own department and their interests, but do not always manage to collaborate with other departments and act in the hospital's interests." (Board of Directors)

Opportunities for improvement

The main opportunity for improvement is educating physicians in the delivery of holistic healthcare and simultaneously in management and leadership. A second opportunity for improvement is enhanced collaboration with other professions such as nursing. Awareness about contributions of other professionals is important, as is awareness of the way in which different professions are complementary to each other.

> We work with nurses every day, but we do not know anything about the content of their education and what exactly they are competent and authorized for. (Resident)

For the current PIL, a broader view based on collaboration, interrelations between departments and alignment of departmental interests with hospital interests can be developed through educational programmes. Furthermore, not every physician is able to be a department leader or manager and perhaps some should focus mainly on patient care, while others should focus more on leadership and management tasks in addition to patient care.

Risks

Threats to the enhancement of holistic care are mostly related to either the consequences of the barriers or the failure to implement the opportunities for improvement. One of the risks is that holistic healthcare is not achieved because of physician's strong biomedical focus. Another risk is when self-interest of the department is prominent (rather than the inter-relations with other departments), leading to a potential consequence of the hospital not providing optimal care for patients. Furthermore, a hierarchic structure, where only the physician is in the lead, can result in insufficient representation of the perspectives of other professions. For other professions, it may be more difficult to realise changes.

> With this strategy there is one doctor at the top, if the doctor has a different view than the rest of the team, it is a burden for the team. (Midwife)

Requirements to achieve holistic care

From the stakeholders' perspectives, it became clear that the PIL strategy is insufficient to meet the holistic requirements proposed by Huber *et al*.[6] However, all participants confirmed that all six dimensions should be considered as important healthcare outcomes. As patients' health outcomes are not yet systematically measured, there is a lack of clarity about who should take the lead in detecting the needs of patients and arranging the processes needed to improve their health status. All stakeholder groups mentioned that the care is supposed to be value-based and holistic, but that this is often not yet the case in practice.

> The reality is always more persistent than the ideas that are being launched. Things always turn out differently than the perspectives that are outlined. As a patient, you are subject to this. (Patient Council)

The system still needs to re-organise and adapt to further meet the requirements for holistic care.

The care chain

In order to provide holistic care, it is essential that the healthcare providers have a shared vision. From the perspectives of several stakeholders, patients should be supported in a non-hospital setting to achieve holistic healthcare. A holistic approach should be the core of care delivery in every link of the care chain; therefore, hospital-based professionals should consider the six dimensions essential for patients to improve their health. Referrals and collaboration between a variety of complementary disciplines and professions in and outside the hospital is needed for holistic care delivery.

Roles in the organisation of holistic healthcare

From the stakeholders' perspectives, five important roles were defined besides PIL in organising holistic care; the role of patients, informal caregivers, nurses, general practitioners, and care coordination centres.

Patients

All stakeholders confirmed the need for empowering patients. The structure of 'patients in the lead' was mentioned several times. 'Patients in the lead' were thought to be able to take responsibility for their own health and to manage their care in a holistic way as much as possible. Illness and age were mentioned as possible reasons why patients may not be able to take responsibility for their own health.

> In current society, people were not raised with the mentality to take responsibility for their own health and manage their own care. It will take a generation to achieve this. (Doctor)

Support is thus needed to guide and help patients in coordinating and managing their own healthcare. Patients who are still not capable of managing their care, despite receiving support, are dependent on safety nets. At this point, the question emerged regarding who should help the patient by fulfilling a coordinating role if these limits are reached and who should take the lead in coordinating the healthcare of these patients.

Informal caregivers

A marked difference emerged in the perspectives of the various stakeholders on the role of informal caregivers. The representative of the Innovative Healthcare Professions programme and the representatives of the Board of Directors were confident that informal caregivers can provide a large part of the care that is needed. Several other stakeholders mentioned that society is increasingly individualistic, which makes informal care delivery not a very viable or desired option. They expressed their concern that a majority of patients might not even have an informal caregiver who could provide care that fits their health needs. Moreover, when care is provided by informal caregivers, the privacy of patients can be at stake.

> If my father poops in his pants, my mother cannot ask the neighbours to help him. What about his privacy? (Nurse)

Nurses

All stakeholders mentioned that nurses are an important link in the healthcare chain. They expressed the conviction that nurses are capable to function as case managers and to coordinate holistic care for patients in primary as well as secondary healthcare. This belief was attributed to the attention to holistic skills in the nurse training. Some remarked that it should be considered whether district nurses can get a good overview of a patient's health during their short visits and whether there might be time and resources to deploy them to take on a coordinating role in holistic care delivery.

General practitioner

The role of the general practitioner (GP) was also considered to be very important. The GP was seen as a generalist who has a holistic view of patients and would not unnecessarily refer patients to a specialist. Stakeholders agreed that follow-up can often be done by a GP, which has a proximity advantage for the patient and a cost advantage for the healthcare system. Overall, while the GP can be a good coordinator in a patient's healthcare, the limited amount of time for each patient and workload are obstacles to GPs fulfilling a leading or coordinating role.

The need for a new care management coordination centre

> If patients enter the hospital or a healthcare organization, they do not know where to go, there is so much bureaucracy that they first have to tell their story five times. (Midwife)

The majority of stakeholders mentioned that there is a lack of support for patients to manage their care. A suggested solution to this lack of support includes a new care management coordination centre, where patients can receive services that are similar to the core activities of a church, community centre and information desk. This coordination centre needs to function as an accessible place where people can easily gain information and support to manage their healthcare and function as 'patients in the lead'. Additionally, the need for such a centre is sometimes mentioned in conjunction with 'case managers'. Case managers are able to help people navigate their way. Huber *et al*'s dimension 'meaningfulness'[6] is assumed to be an objective that was traditionally paid attention to by the church or other religious organisations. This new centre could pay attention to the dimension 'meaningfulness' outside of the context of religion.

> Formerly, a lot of people went to the church, now this is much less the case. People are searching for alternatives for meaningfulness and mindfulness. (Physician)

A new strategy for hospitals to support holistic healthcare delivery

The main key to achieving a holistic approach to healthcare delivery seems to be the collaboration between all providers in the care chain. All healthcare providers within the hospital are complementary to each other, and physicians cannot be expected to consider and balance all the dimensions of holistic healthcare in silos. Continuing the PIL strategy alone may be at the expense of the holistic dimensions of Huber *et al*[6] and can be an obstacle in achieving holistic healthcare in VBHC. The majority of stakeholders mentioned that the department should be led by complementary stakeholders in addition to PIL to ensure holistic healthcare. A new strategy of 'team in the lead' was proposed by the researchers. Careful consideration should be given to the composition of the team; all professions should be adequately represented in the team.

> In my opinion, even the Patient Council may take part in this. (Midwife)

DISCUSSION

We performed a qualitative study and explored stakeholders' perspectives on the PIL strategy in the transition to holistic healthcare. We identified several bottlenecks, solutions and roles in organising this transition. Features of PIL in the transition were elucidated and did not seem to fully align with the aim of providing holistic healthcare. A new strategy of 'team in the lead' was proposed. Moreover, participants agreed that a new care management coordination centre is needed that may provide social and spiritual support as well as the information that patients need in order to manage their own care.

Comparison with the existing literature

The findings concerning the importance of integration of healthcare delivery are in line with the integrated practice units and system integration as described in VBHC.[11] Other concepts in the literature also support integrated care to improve healthcare delivery for patients.[14 15] Although PIL can contribute to controlling the increasing healthcare costs and improving organisational performance,[16–21] we noticed that PIL in our study do not seem to contribute sufficiently to the interrelations and integration needed between departments. Collaboration and integration within and between departments is necessary to provide holistic care. In addition, healthcare leaders are needed that go beyond integrated care and actively support people in all dimensions for optimised healing and managing their own health.[22] Based on our results, we postulate that holistic care may be achieved by establishing a 'team in the lead'. To create a patient-oriented team, it is needed to transform the relationships among individual providers.[23] The proposed 'team in the lead' in our research can be linked to models about 'shared leadership' in the literature.[24] Shared leadership is management or leadership at a team level, which empowers staff within the decision-making process.[24] Effective collaborative relationships and teamwork within shared leadership are thought to improve integration, care practices and patient outcomes.[24 25] Moreover, an effective and efficient 'team in the lead' requires collective competence. Lingard describes the necessity of team competence in medicine.[26] She mentions that individual competence alone, which is the focus in medicine, is insufficient for the quality of healthcare delivery and holds us back from meaningful change in how we educate for, and practice as, healthcare teams. Competent individuals can form incompetent teams. The competence of leadership is increasingly important in competency frameworks for healthcare professionals, but it is in complex relation to team collaboration.[26] Lingard claims that we risk perpetuating the myth that 'strong leadership' is the panacea for what ails teamwork but that what 'strong leadership' entails will vary according to clinical context; the nature of leadership in acute care delivery such as in surgical, resuscitation and trauma teams may be different from the leadership needed in teams that provide chronic and complex care.

Besides the concept of a 'team in the lead' to improve integration of care and realise a holistic healthcare delivery approach, the concept of a care management coordination centre seems to be required to support patients to be in the ultimate 'lead' of their health. This centre corresponds to features of integrated care centres described in the literature,[23] of which there are physician-led and non-physician (case managers, home care agencies or area agencies) led care centres. Such centres provide similar services to the ones we have described above, such as patient information and coordination of care. However, these integrated care centres that often serve medically and socially vulnerable patients with wide-ranging care needs, do not seem to offer services to meet the spiritual and social needs of patients. In reality, a care manager in such centres may still refer people who have such needs. Irrespective of the model used to integrate care, collaborative and interdependent formal and informal relationships between all the links in the care chain remain necessary for providing holistic care.[23]

Advantages and limitations

To our knowledge, this is the first study to explore the PIL strategy in the transition to holistic healthcare. Our findings are supported by comparable notions about organisational reforms in healthcare.[27] This study provides the advantages, barriers and opportunities for improvement and risks of the PIL strategy, thereby giving broader insights and exploration. To achieve reliability, we made use of transcribed recordings, instead of making use of handwritten notes.[12 13] Data were transcribed by the interviewer for accuracy and enhanced familiarity with the data. To ensure reliable data analysis, two researchers were involved in labelling the codes. The themes were discussed within the research team until consensus was reached. To ensure credibility, the respondents were chosen from individuals identified as representative of the group.[12 13] Moreover, quotes from the transcripts were tied to the text so the reader can see how the interpretation is based on the data. To ensure alignment between the shared information and the interpretation of the interviewer, the interviewer (RM) explored the hospital's strategy documents, in order to be aware of and understand the hospital's processes. In this way, the information shared could be better understood and interpreted. Questions were mainly open-ended to encourage information sharing. Answers were intermittently paraphrased and summarised to give the respondent the opportunity to add important perspectives, confirm the interpretations and to clarify misunderstandings of the interviewer. Information about anonymity was given prior to the interview. This was expected to encourage participants to speak freely.

The present study is limited by the fact that it was conducted in one country in one institution. As the organisation of the healthcare system and the strategy of hospitals differ across settings and/or countries, the content may be less relevant to other settings. In addition,

hospital stakeholders are internally oriented, which may have influenced the way they described the organisation of holistic care. Although these are aspects that limit the transferability of our findings, we think that the concepts used in this study are internationally recognised and the organisation of healthcare systems in different countries is similar enough to justify the assumption that our findings will have some relevance and potential transferability to other contexts and settings.

Suggestions for future research

Although we gained insights into PIL in the transition to holistic healthcare in the Netherlands, it would be interesting to explore the effect of introducing PIL in different cultures. Moreover, in order to improve the PIL strategy, observational studies may be useful to determine significant barriers of PIL in practice. Furthermore, research on the effectiveness of the proposed concept of a 'team in the lead' would be necessary to explore whether this model is effective and would lead to the desired holistic care in practice.

Implications

It is important for the PIL to be aware of the stakeholders' perspectives and of the holistic approach to healthcare delivery. Although physicians can be educated to focus more on the holistic outcome than on cure and treatment, a 'team in the lead' approach should be taken into consideration to achieve holistic healthcare. Organising holistic care requires more integration and teamwork across facilities in the care chain. Moreover, there is a demand for a care management coordination centre that coordinates care and supports patients on the different dimensions of holistic care. Better support on these dimensions may lead to healthier 'patients in the lead'.

CONCLUSION

The transition to a value-based and holistic approach in healthcare is desirable. Although VBHC is an important step in the right direction due to the integrative aspects it offers, the PIL strategy may be at the expense of the holistic aims in the healthcare delivery approach. To realise a holistic healthcare approach, a strategy of a 'team in the lead' should be considered, as different professional groups complement each other in the full care cycle.

Furthermore, the current organisation of holistic care lacks support for patients to manage their care. A care management coordination centre is required to support patients in realising the care that is needed to improve their health outcomes. A second important aspect in the organisation of holistic care is that every link in the care chain contributes to holistic care delivery. Therefore, collaboration and integration across the care chain is necessary.

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