Tackling health inequalities in The Hague: a process evaluation of a municipal programme to improve health in deprived neighbourhoods

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A neighbourhood-based approach for reducing health inequalities in The Hague: the conceptual framework

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Summary

Background: The neighbourhood-based approach is generally considered a promising strategy for tackling socio-economic inequalities in health. However, our knowledge about it effects is still limited. This is partly due to the fact that we know little about the intervention itself. The main aim of the evaluation of the programme for tackling health inequalities in The Hague, is to describe the process of the development of the programme. This should result in scientific statements on the value of the neighbourhood-based approach as a strategy for tackling inequalities in health.

Methods: Researchers, together with those who are responsible for the programme (policy-makers), have developed a conceptual framework.

Results: This framework indicates that the programme works along three lines: healthy lifestyle, healthy environment and improvement of primary health care. The following themes are being addressed: physical activity and healthy nutrition, pedagogical support, information on and access to health care and strengthening primary care. The interventions are based on three principles: intersectoral collaboration, professional integration and participation of the local residents. These principles, in their turn, are being embedded in a context that might promote these principles.

Conclusion: The framework shows that, in order to understand the programme in The Hague, a ‘simple’ effect evaluation, in terms of health or determinants of health, is not sufficient. Instead, the core principles also need to be described, as well as the way in which these principles will result in concrete activities and the context in which these principles are embedded. Following this framework, during the evaluation we will identify factors that account for the success or failure of the neighbourhood-based approach.
2.1 Introduction

In 1985, the WHO European region stipulated in its much talked about policy aims document Health for All, that “By the year 2000, the current health inequalities between countries and certain population groups will be reduced by 25%, by improving the health of disadvantaged groups. Today, however, we realise that the reality is different: health differences between socio-economic groups in the Netherlands do not seem to be reduced at all (1). Therefore, the need to reduce these health differences through interventions is equally important today as it was then.

One of the strategies used for reducing health differences is the so-called neighbourhood-based approach. One important guiding principle of this approach is that the population plays an important role both in defining health problems and in the development and implementation of interventions needed to reduce these problems. Moreover, it is important that the causes of bad health in a population such as, behaviour, environment, etc. are tackled on more than one front – which often requires a multisectoral policy to be taken (2).

This kind of neighbourhood-based approach is often singled out as promising. However, at present we do not know whether it can really contribute to reducing socio-economic health differences (3). This is partially due to the methodological complexity of evaluation studies surrounding such comprehensive programmes. For example, it has not been easy to evaluate neighbourhood-based programmes in a quasi-experimental setting – due to the fact that a good baseline assessment is tricky if the interventions have been developed together with input from people in the community (4). However, in spite of this, recent studies conducted in Eindhoven and Arnhem show that neighbourhood-based programmes can certainly be evaluated in a quasi-experimental design. Yet, solving the problems is not that easy. In both the above studies, which concurred with the results of studies from abroad, only a minimum effect on determinants of health were visible (5,6).

These negative results are not easy to interpret. They could point to the fact that it is not possible for a neighbourhood-based approach to have an effect “failure of intervention concept”, for example, because the participation of the local residents has led to non-effective interventions, but it is also possible that in these programmes the principles of a neighbourhood-based approach has not been sufficiently applied (failure of implementation) (7). Another possibility is that the approach does not work within the context of these specific programmes, for example, because the local residents concerned do not form a social unity.

In order to answer the questions that arise here, we need to look very closely at the neighbourhood-based approach and ask: through which mechanisms and under which conditions can a neighbourhood-based approach influence the health of the residents in the neighbourhoods? Because at present we only have limited insight into how this approach actually works, it has been decided to concentrate this evaluation study on the process of programme development. The guide to this evaluation is a conceptual framework that will be drawn up by both the researchers and policymakers prior to the start of the study. The framework will specify how neighbourhood-based working aims to achieve health gains. The
framework will build forth on more general models for the evaluation of health promotion interventions (8-10).

This conceptual framework will be further described in this paper. Firstly, the essential elements of the programme and are included in the evaluation will be described. These elements will then be integrated into one framework. The paper will end by reflecting on the value of evaluating a neighbourhood-based approach for tackling health inequalities.

2.2 The conceptual framework

For the purpose of evaluating the programme, the conceptual framework has been constructed according to the ‘theory of change’ approach. This approach requires that before a worthwhile evaluation of a changing process can be made, the assumptions that have driven the process are specified. This means that the people involved need to explicitly outline the theories, expectations and hypotheses regarding how the interventions will contribute to the final objective (11-12). This has taken place in The Hague in discussions between the policymakers and the researchers of the programme. The following four questions acted as the guiding principles for these discussions:

I) What is the final objective of the programme?
II) What are the interventions that need to be developed in order to achieve this final objective?
III) From which principles will these interventions be developed?
IV) What is the context within which the programme will be developed?

The outcomes of these discussions can be seen as the building blocks for the conceptual framework. Each of the above four principles will be discussed in the next section, first separately and subsequently integrated.

I. The final objective of the programme

The final objective of the programme is to improve the health of the residents of six neighbourhoods in the Hague. This will be done through interventions that focus on a number of health determinants that will be detailed later. The parameters for this general goal have first been set theoretically, consistent with the recommendations of the programme commission SEGV-II (3). The Commission has identified three groups of determinants by looking at how socio-economic status can have an effect on health: health-related behaviour, material living conditions and as well as psycho-social factors. The health of people in lower socio-economic positions can be improved by limiting their exposure to health damaging factors – for example, by reducing unhealthy behaviour and by increasing their exposure to factors that encourage health promotion – for example, by improving their living conditions. A second strategy that is being adhered to in the programme is that of offering extra or differentiated (curative) health care to people in deprived neighbourhoods. Both strategies have been combined in the programme into three lines of action, healthy lifestyle, healthy environment and improvement
of primary health care. The action line ‘healthy lifestyle’ is aimed at encouraging healthy behaviour at individual level. The action line ‘healthy environment’ is focused on improving the environment in which people live, for example, the spatial planning of a neighbourhood. The action line ‘improvement of primary health care’ aims at improving the coordination of primary care supply with the services that the residents in the neighbourhoods actually want.

After setting the theoretical parameters, the programme is substantiated by defining the aspects for which health gains will need to be made. This takes place in discussions, where the public are provided with the opportunity to comment, between policymakers from the local authority and professionals, and the residents from the target neighbourhoods. Based on the outcomes of the health monitor of the department of epidemiology within the sector Education, Culture and welfare (OCW) a top-5 list of the most important health problems in the Hague were being highlighted. This list of the top-5 – cardiovascular disease, lung cancer, accidents in and around the home, psychosocial problems and behavioural and developmental disorders in children – was presented to professionals in platforms for each neighbourhood. The professionals indicated that they recognised the health problems that had been identified and then translated the general problems into concrete problems that appeared in their neighbourhood. The residents of each neighbourhood were then consulted regarding their concrete health problems. The ensuing discussions were conducted in existing platforms as far as this was possible. The residents who took part in the discussions could identify themselves well with the themes that were put forward. Ultimately, these consultation rounds led to the definition of four action themes as follows, (1) physical activity and healthy nutrition, (2) pedagogical support, (3) information on and access to health care and (4) strengthening primary care.

II. Interventions
Each year the programme subsidised a number of interventions relating to the four themes. On this point, the policymakers have listened to comments from professionals about not developing new initiatives but to encourage the use of those already in place and to expand their scope. In 2004, a total of 14 large-scale interventions (including 7 pilot projects) have been subsidised; 7 of the 14 had already started before the programme was initiated. Text box 1 describes such an intervention. Since 2004 until 2006, a further 61 small-scale initiatives from

**Text box 2.1 Activity on Prescription (Bewegen Op Recept, BOR)**

This intervention aims to encourage physical activity of adult residents living in the target communities. This will be done both by individual and multidisciplinary approaches.

Those clients who, according to health professionals, will improve their health by doing more physical activity, will be given an official prescription for referral to a sport advisor and then an activity. The BOR can be used up to 20 times, after which, the client will be informed of the possibilities for continuing their physical activity.
the neighbourhoods have been subsidised (chapter 5). The small-scale projects are particularly aimed at addressing signals coming directly from the neighbourhood residents.

III. Development of interventions from three principles
The choice of a neighbourhood-based approach for tackling socio-economic health inequalities in The Hague is primarily based on the fact that residents with a lower health status can be found in certain neighbourhoods, we can refer to this as the neighbourhood being the detection area. At the same time, the neighbourhood can also be seen as a portal for concrete interventions (13). Within the framework of health promotion, this approach ascribes in general to two central principles: resident participation and intersectoral collaboration (2). In the context of the Hague, a third principle has been added, professional integration. What these principles mean exactly will be discussed in the next section.

Resident participation is considered one of the cornerstones of health promotion (10). While resident participation seems attractive intuitively, it is actually a complex phenomenon. In the literature, for example, there are many different views on the meaning of resident participation (14). One of the views is that participation itself should be seen as an aim because it improves health on its own (15). This view encompasses a link between the terms of resident participation and empowerment. The underlying thought is that people should be given more hold over their own lives so that they themselves opt for a healthier lifestyle or, where necessary seek effective help in the medical sector. In addition, resident participation can be construed as instrumental: by linking up with the social world, support in the target group can be achieved that will encourage the implementation of interventions (16).

In the action programme in The Hague, resident participation has been used up until now as a means of linking policies up with the concrete wishes of the neighbourhood residents (instrumental use). This linkage is not however, achieved by involving the residents in the choice for and the development of the interventions, but through the mediation of professionals in the neighbourhood, such as community workers, physiotherapists, dieticians etc. These professionals participate in the so-called neighbourhood health panels. In terms of empowerment, the formulation of the term resident participation plays a role where specific interventions are concerned, for example, through participation in specific interventions (such as Exercising on Prescription). These interventions aims to increase the amount of control that the individual has concerning his/her own health.

Intersectoral collaboration is the second guiding principle of the neighbourhood-based approach. Its necessity is prompted by the fact that many determinants of health and health inequalities are outside the influential constraint of health care. This implies that, in order to achieve a substantial reduction in socio-economic health inequalities, measures need to be taken in various policy areas (3). Intersectoral collaboration can be defined as ‘a recognised relationship between parts of various public sectors that is brought into effect in order to take action on certain issues for achieving better health outcomes in a more effective, more
efficient and more sustainable way than when the health care sector itself had worked on this issue’ (17). The relationships between the sectors can induce changes in two directions. Whilst on the one hand it can result in an improvement in the health determinants, such as a healthy layout of a neighbourhood, on the other hand, it can increase the awareness of other sectors concerning the health implications of their policies (17).

In this programme, the intersectoral collaboration is aimed in particular at the realisation of a healthy living environment. For this purpose, the programme has been included in the major cities policy for the period 2005-2009. In addition, it is expected that the concrete issues that come to the foreground from the neighbourhoods will stimulate the intersectoral activities at local authority level. One example of this is the signal given out by the residents on the lack of play facilities for children.

Professional integration is not often named as a specific central principle of neighbourhood-based work. However, in The Hague’s programme this has been done. The principle of professional integration is based on such concepts as transmural care and integrated care that became common practice in the 1990s in the Dutch health care sector (18). The concept is an answer to the widely borne idea that the care supply is too fragmented at present, meaning that it cannot sufficiently meet the care needs of the Dutch population. This is especially a problem because people have to increasingly cope with chronic, many different, complex, and multiple health problems – and in large cities these are often linked with social deprivation factors (19). In order to respond effectively, an integrated care supply is needed, in which care providers bundle their expertise and tasks together and harmonise them. This collaboration should be realised not only within curative care but is especially relevant for the welfare and preventive care sector (20).

In The Hague’s programme, collaboration between professionals such as general practitioners, health promotion and health education (GVO) graduates, district nurses, welfare workers etc. and organizations such as the Municipal Health Services (GGD) is seen as an important precondition for effective interventions. It is thought that this collaboration can be the foundation on which to base the health care initiatives in the neighbourhoods. The STIOM has played a role in this process since it was founded 10 years ago (21).

IV. Context

The description of the principles involved in this programme include a number of elements that are typical for the situation in The Hague. The STIOM is one example of this because it represents laying down a foundation for the further development of professional integration. These elements can influence the chance of the programme’s success. For this reason, they should be described in detail in the evaluation for the purpose of drawing final conclusions that could apply to other situations in future. In other words, the development and implementation of the action programme should be placed within a certain context during the process of evaluation. So how can this be conceptualised?
A choice has been made to present the context as a three-way interacting system. The first part of the system concerns the residents from the six target neighbourhoods. The second part of the system concerns the local authority where the managers and the officials draw up the local policy frameworks. The third part of the system consists of the professionals who are implementing the care on a daily basis, who work with each other and who ultimately are the people who have to develop and implement the interventions.

It is from this system perspective that during the evaluation, the principles of the programme will be studied regarding how they interact with each other and with the environment towards achieving the final objective of reducing health inequalities. Therefore, for the purpose of developing the principle of resident participation, it would appear to be important to look at the different kinds of properties that various neighbourhoods have. In this context, what are the existing social networks? What is the ethnic diversity in the neighbourhood? Do the residents mix just with people from their own neighbourhood or do their social contacts go beyond the neighbourhood where they live? These are examples of characteristics that can determine why resident participation is easier to set up in one neighbourhood than in another. In addition, intersectoral collaboration develops in interaction with the environment and depends on, for example, the attention that policy departments already pay to health care themes or the degree in which local authority uses instruments for monitoring and achieving the targets (22). Finally, the structure and organisation of care providers in the neighbourhoods has been undergoing many changes. Regarding the degree to which professional integration is realised, it can for example, make a difference whether or not there is already a professional collaborative initiative working in the neighbourhood on which the programme can be based.

The elements integrated in a conceptual framework

The four building blocks that have been described above – final objective, interventions, principles and system parts – have been integrated into one framework. Figure 2.1 shows the conceptual framework.

The framework shows that the programme works according to three action lines: healthy lifestyle, healthy environment and the improvement of primary health care services. This strategy will be applied to a number of health determinants (the central themes): physical activity and healthy nutrition, pedagogical support, information on and access to health care and strengthening primary care. The development of interventions for these determinants is based on three principles: the participation of residents, professional integration and intersectoral collaboration within the local authority. These principles in turn are imbedded in a context that contains both obstructive and stimulating factors. For this reason, the framework has been adjusted from back to front but can also be read from left to right so that it can be argued out in which way an intervention can contribute to the final objective of health promotion.
2.3 Discussion

How does the conceptual framework, as presented above, contribute to the evaluation of a neighbourhood-based approach for reducing health differences?

Firstly, the framework provides a perspective from which concrete interventions can be evaluated. The most accepted evaluation is that of the effects of the interventions on the determinants of health. In present programme, for example, the aspect of Exercise on Referral (text box 1) has been allocated for evaluation like this. However, the framework shows that it is equally important to evaluate the degree to which the interventions have been created through the principles of intersectoral collaboration, professional integration and resident participation. After all, these principles are ascribed a central role in the general notion of neighbourhood-based working and particularly in the programme in the Hague. By making the link between the interventions and the evaluation principles more explicit, the degree to which the programme has been true to the concept of neighbourhood-based working can be clarified. This will encourage conclusions to be drawn that can be generalised – that are based on the evaluation of this specific programme – concerning the benefits of neighbourhood-based working in general. One example of this concerns the evaluation of the neighbourhood health panels that have been previously mentioned. The functioning of these panels will be evaluated in a comparative case study for the degree in which they (each in their own neighbourhood) have succeeded in getting off the ground (chapter 5).

Secondly, the framework shows how the three central principles are not independent of each other but imbedded into the three-way system. In order to generate information than can be generalised concerning the way in which those principles can be specified and result in interventions, it is necessary to make the characteristics of the system in which the further
specification takes place more explicit (10). For the evaluation of The Hague’s programme, this
means that in the description of the development of intersectoral collaboration, professional
integration and resident participation, what also has to be analysed is, in which context the
interventions will take place. For example, in terms of existing collaborative ventures and socio-
demographic characteristics of the neighbourhoods.

Thirdly, the framework focusses attention on the importance of evaluating the development
of the central principles of the neighbourhood-based programme itself. After all, the principles
form the basis of the programme. A good formulation can ensure that, once the programme
is finished, the health promotion initiatives will be taken. In other words, with these three
principles, the aim will be to establish the programme in the three systems of residents,
professionals and local authority. For this purpose, the evaluation of the programme will also
look at how far this establishment has been successful, for example, by comparing the degree
of intersectoral collaboration before and after the programme.

In conclusion, the researchers and the programme developers (policymakers) of The
Hague’s programme for tackling health inequalities have together developed a framework
that explains more explicitly the logic behind the programme’s actions. This framework clarifies
that for a good understanding of how neighbourhood-based programmes work, more is
needed than just a measurement of the final effect of the intervention, in terms of health
gain or intermediary aims in terms of determinants of health. Moreover, the central principles
deserve detailed specifications as well as the way in which these principles result in concrete
activities and the context in which they can be further worked out. In this way, it should be
possible to identify both success and failure factors of neighbourhood-based working.

Whether or not this framework will ultimately help in getting to the bottom of the
neighbourhood-based approach, will largely depend on the results of the programme
evaluation. Nevertheless, we hope that the description of the framework will in itself contribute
to the development of research into the evaluation of a neighbourhood-based approach for
tackling health inequalities.
Reference List

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