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

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Generating political priority in order to tackle health disparities: a case study in the Dutch city of the Hague

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Abstract

Objectives: The problems associated with tackling health disparities are a major challenge for public health policymakers (1;2). Politicians should pay attention to this issue regarding the enactment of policies and the allocation of resources. Our objective for this prospective study was to study the factors that determined the success of a recent initiative to generate political priority for the problem of health disparities in the city of the Hague, the Netherlands.

Methods: Prospective design. The qualitative data collection included interviews, document analyses and observations.

Results: Crucial for the success of this initiative was the presence of powerful, inspired and credible actors. To achieve political priority for tackling health disparities, these actors effectively presented scientific evidence on the subject and framed the issue in the light of shared values, priorities, and policy principles. Finally, they were supported by the national context, including scientific research on health disparities.

Conclusions: The project in the Hague shows that political priority for tackling health disparities can be generated at a local level. Key factors for success included framing the issue in the light of shared values, and framing the problem and the solution in line with existing policy principles.
Introduction

The problems associated with tackling health disparities are a major challenge for public health policymakers (1;2). Health disparities are rooted in an unequal distribution of power, income, goods, education and housing and working conditions (3). Since the distribution of these social determinants is influenced by the allocation of public resources, policies for tackling health disparities depend on political action (4). Consequently, generating political priority for this issue is essential in order to adequately tackle the problem (3;5-7). In particular, the provision of investments in sustainable policies, actions and infrastructure (2) is urgently needed.

In general, generating political priority for policies to tackle disparities in health is difficult. Challenges include the fact that the causes of health disparities are complex and include health-related behaviour, working and living conditions, and accessibility of health care (8). In addition, policymakers were ready to point out that most of these determinants fall outside the influence of the health care sector – which implies that intersectoral collaboration with many partners would be required (9). Moreover, the impact that the actions of policymakers has on health may only be visible after many years (1;10). In some cases, for example, intersectoral action on physical environment and nutrition policies to tackle obesity among children in poor areas, the health benefits may only be visible after decades.

Given these complexities, how could political priority for policies to tackle disparities in health successfully be generated? In general, theories on agenda setting distinguish various types of factors: the way an issue is presented, opportune moments within political contexts and characteristics of the issue (11;12). Particular attention has been paid to the role of political and bureaucratic entrepreneurs. Empirical studies that look at the way in which these different types of factors contribute to the agenda setting for health disparities, including the role of the scientific community – are vital but remain scarce (13).

The aim of this paper is to explore the factors that determine the generation of political priority for tackling health disparities at a local level. Political priority is defined as the degree to which (1) political leaders actively pay attention to an issue, (2) the political systems lead to programs that address the problem, and (3) these programs are supported by financial, technical, and human resources (11).

In the city of the Hague, the Netherlands, health disparities have been prioritised for two council periods in a row. This city of about 475,000 residents is known as the most segregated city in the Netherlands (14). The average standardised household income varies from 70 percent of the Dutch mean in deprived areas to 220% in non-deprived areas. In general, 15 % of households in the Hague live at or below the legal minimum but in the city’s deprived neighbourhoods this percentage is as high as 43%. The neighbourhoods with a high deprivation score (as measured by income, unemployment, etc.) have a higher mortality rate (15). Cardiovascular disease, lung cancer, psychosocial problems and behavioural disorders are more common in these areas.

In 2002, health disparities were explicitly addressed by the Municipal Executive for the first time. This attention was prompted by data from the municipal health monitor that showed
socioeconomic differences in various health (related) outcomes between neighbourhoods. These differences were perceived as a part of, and reflection of, more generalised differences in health according to citizens’ individual socioeconomic position. In this paper, the term “disparities in health” refers to health differences between deprived and non-deprived neighbourhoods. More specifically, our prime concern was with the increased occurrence of health problems in disadvantaged neighbourhoods.

This issue then became part of the negotiations on a Policy Agreement to form a new Municipal Executive, resulting in a four-year action program (2002-2006) and based on a bottom-up, participatory approach. This program fell under the responsibility of the councillor for health affairs. During its implementation, the program changed from a public health sector initiative to an intersectoral program. From 2006 onwards, both the financial resources for the program and the number of policymakers and organizations involved increased (table 3.1).

Since 2002, we have followed the political developments taking place in the Hague. This prospective study, together with the successful outcome of the initiative, provides a unique opportunity to explore the factors which facilitated political priority for tackling health disparities. In this paper, we will systematically assess the role of the various factors involved. The following research questions were formulated:

a. Which actors played a vital role in generating political priority for tackling health disparities?
b. How did the actors frame the problem and possible solutions in order to gain political priority?
c. Which aspects of the context favoured the generation of political priority?

Methods

From 2003 to 2007, a prospective, single-case study was carried out using semi-structured face-to-face interviews, document reviews and observations.

The key participants were selected according to their role and position. We started with the policy community that had initiated the program. One senior staff member who acted as the leader of the program was interviewed 23 times. Starting with this person, we then followed a snowball method to identify the key actors. Besides the program leader, 13 persons were interviewed, with a total of 22 interviews conducted. They included councillors, managers and policymakers [appendix 3.1]. A councillor is a public administrator whose function at local level is comparable to that of state secretary (or minister) at national level.

For the interviews, we used open questions based on a list that included the following topics: individual engagement in the program, perceived added value of the program, key actors, key issues in agenda setting, and factors perceived to promote or to block agenda setting. By using this approach, we were able to assess relevant factors from the perspective of each individual interviewee. On average, these interviews lasted 1.5 hours, were audio-taped and transcribed verbatim.
In addition, all relevant documents produced in the years 2002 to 2007 were collected. The policy community provided us with formal and informal program documents, as well as the non-public minutes of meetings. Additional data was extracted from the political information system [Appendix 3.2]. Furthermore, we conducted a series of observations of 17 meetings of the programs municipal steering group. On various occasions, we also observed crucial political meetings such as those of the City Council.

The purpose of observing the 17 steering group meetings was to explore their strategies in mobilising political priority. Incidentally, we were also asked to participate as ‘experts’ in political meetings, such as that of a committee meeting of city council representatives concerned with health care. Our participation in those meetings consisted only of presenting our knowledge on health disparities in a PowerPoint presentation and subsequently answering questions on this issue.

Table 3.1: A summary of the Hague’s programme to tackle health disparities

<table>
<thead>
<tr>
<th>Political priority</th>
<th>2002</th>
<th>2007</th>
</tr>
</thead>
<tbody>
<tr>
<td>Draw attention to the issue – politicians</td>
<td>- Tackling health disparities is 1 of 61 priorities in Public Health Policy</td>
<td>Tackling health disparities is the main goal of Public Health Policy;</td>
</tr>
<tr>
<td>Enacting policies to address the issue</td>
<td>- A 4-year programme in 6 deprived neighbourhoods (150,000 inhabitants) based on a bottom-up, participatory approach and intersectoral policies</td>
<td>- Continuation of the programme; - Additional policy agreements on intersectoral programmes to tackle Health disparities on a city level, for instance: a) programme on health and environment (including city planning) b) programme on exercise and sport for youth c) programme on health insurance for inhabitants on social security d) health interventions as integrated part of work rehabilitation courses.</td>
</tr>
<tr>
<td>Provision of financial means, and human resources</td>
<td>- A budget of € 475,000 per year - Programme leader (0.6 fte) - Implementation coordinator at Municipal Health Centre (0.8 fte) - Contract with neighbourhood organization (€ 240,000) - Active involvement and support from the councillor for health</td>
<td>- A budget of € 915,000 per year for the neighbourhood programme - A budget of approximately € 500,000 per year for the intersectoral approach - Programme leader (0.4 fte) - Policy advisor at city level (1.0 fte) - Policy advisor ‘health broker’ at neighbourhood level (0.8 fte) - Implementation coordinator at Municipal Health Centre (1.0 fte) - Contract with neighbourhood organization (€ 540,000) - Active involvement of the councillor for health and support from the City Council</td>
</tr>
</tbody>
</table>
The interview data, documents and observational data were inductively analysed, following an open approach, using axial and selective coding techniques. We used the framework of Shiffman and Smith (11). Based on the analyses why some global initiatives receive priority from international and national leaders whereas others receive so little, Shiffman and Smith (11) proposed a framework of the main determinants, including; (1) the strength of the actors (2) the way in which the issue and possible solutions are framed (3) the political context (11;12). The first author (MS) coded the transcripts of the interviews and compared these with the documents and observations to verify, check and complement the analyses. Summaries and preliminary analyses of the materials were discussed with the interviewees to check for validity and completeness.

Results

Bearing the research questions in mind, we will describe the results according to three main sections; (1) the actors, (2) framing the issue of health disparities and the strategies needed to tackle them (3) contextual factors.

1. Actors

The two councillors involved in the program were crucial for generating political priority. Both were strongly committed to the policy aim of tackling health disparities. One of them even made health disparities a spearhead of his policy. For both councillors, this commitment was based upon their political ideology and vision on the government’s responsibilities:

‘See, my socio-democratic ideology also plays an important role here, I really want to speak up for residents who have not been so lucky. And those well-to-do can manage perfectly well on their own. [resp.no.1]’

‘I’m observing disparities in health and do feel responsible as local authority. We have to do something about it. [resp.no.2]’

One of the councillors (1) had credible records on local public health policy. She is known nationally for her neighbourhood orientation on tackling health disparities. This has increased her credibility:

‘Because I have achieved some sort of authority on the subject, I can say, ‘Yes ladies and gentlemen, I think we should move in that direction’ [resp. no.1]’

Both councillors represented the needs of residents from deprived neighbourhoods and frequently visited local initiatives. Councillor 2 actually lived in one of the deprived neighbourhoods, and used this information to introduce himself. He often used the argument ‘I hear what’s going on in my neighbourhood from people around me, usually on a street corner’. He further increased his credibility by taking a critical approach towards the policy progress and by involving academics in the political debate.
Across the municipality, a number of key individuals at policy level also stimulated the health disparities initiative, including the managing director of the municipal health service, policymakers and researchers. They were in frequent contact with each other on this issue and exchanged information regarding content. They thoroughly supported both the idea of tackling health disparities and the guiding principles of the program – especially the participatory approach and the emphasis on intersectoral action. In some cases, the stakeholders even showed a personal fondness for this approach:

_The fact that health disparities appeared in the health monitor, made me think ‘hey, that’s exciting, interesting to see if you can mobilise other sectors, outside your own domain of health care. ...When you speak about intersectoral action in this setting it primarily concerns the mobilisation of other sectors...those where you really have nothing to say – no voice in the matter. I’m really interested in that mechanism as such. [resp.no.4]_

2. The framing of the issue and strategies

In the initial stage of the process, political priority for this issue was not easily gained. Councillor 1 met strong resistance from her colleagues on the Board. Firstly, they raised doubts about the severity of health disparities in The Hague compared to the Netherlands as a whole. Secondly, they asked for evidence in order to be sure that health disparities were not a generic issue, but a structural problem in their city that required a determined and locally adopted approach. Thirdly, the moral way in which she spoke about disparities, using terms as ‘wrongful’ and ‘unfair’, resulted in a highly political, fundamental discussion around individuals’ own responsibility for their health. Opponents argued that health disparities were the logical consequence of differences among residents in seizing their opportunities in life, and should be considered the responsibility of each individual.

Three factors were crucial in overcoming the political resistance: 1. presenting the information, 2. linking up the issue with shared values and 3. linking up the proposed solutions with existing policies.

**Presenting the information**

Firstly, epidemiological data were presented in clear figures to demonstrate disparities in morbidity and mortality between high and low income neighbourhoods within the Hague. These figures were supported by national data. As well as a summary of the policy recommendations by a national committee on health disparities [1] these figures were included as a 6-page appendix in the white paper on public health policy 2003-2006. Excerpts were used to make the message accessible to politicians.

_Mrs X finds the observed health disparities shocking and thinks it is a good idea to initiate action plans for a number of neighbourhoods. [doc.no. L]_
Linking up the issue with shared values

Secondly, councillor 1 reframed the issue of health disparities. In order to gain the support of the Municipal Executive, after having observed the political resistance, she avoided using the word ‘unfair’. Instead she moved along with her opponents and started emphasising that residents themselves are primarily responsible for their health. According to councillor 1 and her policy makers, she subsequently convinced her opponents positively by pointing at the difficulties of individuals in disadvantaged circumstances regarding taking that responsibility. She argued that it is part of the government’s task to shape those circumstances in which persons are actually able to pick up the responsibility for their own lives. According to the councillor, disadvantaged circumstances are characterised by the environment in the deprived neighbourhoods. These include a shortage of sport and exercise facilities, an imminent shortage of general practitioners, and air pollution. All these issues had already received political priority among the members of the Municipal Executive.

The councillor also pointed out a link with the ideal of ‘participation in society’, as the central theme of the policy paper: ‘all of us together make the Hague’. She successfully argued that good health should be considered a prerequisite for residents in order to be able to participate fully in society.

Because tackling health disparities is in line with our municipal policy ‘all of us together make the Hague’ and full participation in society is the central theme. An important prerequisite to this is good health for all residents. [doc.no.H].

The councillor described her colleagues from the Municipal Executive as being approachable and open to discussion which was an advantage when she pleaded for the government to take more responsibility towards tackling health disparities.

‘It was a very intense political discussion…and I needed 3 rounds of meetings with the Municipal Executive to push the policy paper through...’ [resp. no. 1]

Linking up with existing policies

Just as the problem of health disparities was linked with issues already receiving attention from politicians, so the proposed strategies for tackling these health disparities were linked with policy principles that were widely supported. These principles included that of neighbourhood orientation as well as the intention to involve residents in the development and implementation of policy.

Neighbourhood orientation had been a central approach of the Municipal Executive and the City Council policies for years. This is partly due to the fact that the city of the Hague contains the most deprived as well as the richest neighbourhoods in the Netherlands. These differences between neighbourhoods require a targeted approach for each single area. In line with this, the councillors are each responsible for appointed neighbourhoods. Moreover, health care is partly organized along the lines of neighbourhoods, and supported by an organization for the promotion of health and welfare services that is financed by the municipality.
The involvement of residents in policy development was formulated as a core strategy of the program. This fitted in perfectly with the policy agreement, in which the involvement of residents in the design of local policy was proposed as a core value:

‘...then for this purpose it is necessary that each citizen, regardless of race, belief or background, is capable of and is required to think, talk about and decide in which direction the city is now and should move towards in the future...[doc.no.F]

However, the principle of involving residents had not been worked out in detail. The program has filled this gap by offering an implementation plan that allowed residents to be involved through neighbourhood health panels. This implementation plan was greatly valued by the Municipal Executive and management team and subsequently received a lot of attention. It was frequently mentioned as a good example of how the municipality of the Hague involves its residents.

3. National and scientific context

Between 2002 and 2006, during the execution of programs in the Hague, the national government of the Netherlands did not give political priority to the issue of health disparities [1]. However, before this period, health disparities had received increasing amounts of attention that was largely stimulated by two national research programs which were launched by the Minister of Public Health (1989-1993, and 1995-2000) (1). Consequently, the actors in the Hague were able to use the knowledge base that had been created by these research programs, for example, by bringing in academic experts and referring to the products of these programs.

A second relevant contextual factor was that an orientation on deprived neighbourhoods fits the political climate in the Netherlands of the early years of the twenty-first century. At

Table 3.2: Factors identified as key points for generating political priority

1. Actors
   - Inspired, credible and powerful councillors
   - Strategic and committed senior policy staff

2. Processes
   - Use of epidemiological data
   - Linking up with values that were shared among the coalition members, and with issues that already had political priority
   - Political intrinsic discussion
   - Linking up the policies to tackle health disparities with existing policy principles that already enjoyed broad support

3. Context
   - National research programmes
   - Popularity of neighbourhood approach (which is assumed an efficient means to target the most deprived individuals and to provide a context for involving local people in identifying local problems and delivering solutions (27).)

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that time, politicians were expected to bridge the gap between ‘politics’ and ‘residents’ by ‘going to the people’. Following national elections in 2006, for example, members of the new government visited deprived neighbourhoods over a period of 100 days in order to obtain input from residents and organizations for developing new policies.

The factors identified as key points for generating political priority for tackling health disparities in the Hague are summarised in table 3.2.

**Discussion**

On a national level, the issue of health disparities has been successfully raised on the political agendas in Britain (16) and Sweden (17). In the Netherlands, despite widespread attention to the issue, and a government statement on the importance of tackling health disparities, a consistent program for addressing health disparities at national level has not been put into practice (1). Nevertheless, the tackling of disparities in health was prioritised in a few municipalities. The aim of this paper was to describe, in a prospective design, the factors that determined the success of the priority setting process in one of these municipalities - the Hague. We conducted this study because understanding how political priority is generated is pertinent to addressing social determinants of health (18). The Hague’s initiative appeared to be successful, as the issue of health disparities did gain the attention of political leaders and was allocated financial and human resources. Crucial for the success was the presence of powerful, inspired and credible actors. To achieve political priority, these actors effectively presented scientific evidence. In addition, they framed the issue in the light of shared values and priorities, and linked the strategies for tackling this problem in terms of policy principles that were broadly supported. Finally, they were supported by the national context, including the scientific community and the popularity of the neighbourhood approach among politicians.

**Validity**

The findings of this case study were based on a thorough analysis of a broad range of documents, an extensive number of interviews conducted with a wide range of relevant participants, and the observation of a number of crucial meetings. This thorough approach allowed for interpretations which we could not have come up with if we had had a more superficial data collection. This applies in particular to the changes in the way that the issue of health disparities had been framed, and how this had contributed to the generation of political priority. Despite this approach, small pieces of information were not accessible for us as researchers. In particular, the initial negotiations between the Municipal Executive members (councillors and mayor) were not available. Consequently, with regard to this phase, we were limited to documents and the feedback of councillors. In addition, the interviews were unevenly distributed among the key persons. We nevertheless warranted the internal validity by triangulating sources (19). As the documents and interviews showed a consistent pattern, the lack of some information will not have biased our main conclusions.
A case study imposes limits on whether the results can be generalised. The case of the Hague does not offer a blueprint for political action that could be copied to local communities in other countries – not even elsewhere within the Netherlands. However, we identified some elements that may be critical to the success of similar future initiatives elsewhere. The relative weight of different elements may vary across countries. The Netherlands, for example, has a political climate which is strongly oriented towards a consensus model and ‘open’ debate, in which politicians profit from being ‘approachable’. Possibly this is more common in multi-party systems such as those found in other West-European countries.

The role of leading actors
The role of individuals has been recognized as a key to success where issue creation and agenda setting is concerned (12;20-22). The case study in this paper was no exception to this rule. The actions of the actors reflected the general principle of policymakers acting as entrepreneurs, seeking opportune moments to push forward their agendas (12). Various actors were considered credible communicators through their expertise, trustworthiness and goodwill (23).

Interestingly, the strength of the actors not only affected how the issue was prioritised, but also how the actors ‘used’ the issue of health disparities to strengthen their own position. For politicians, electoral benefit plays a role in their actions (12). Both councillors profiled themselves as ‘politicians for deprived neighbourhoods’. The health disparities program provided opportunities to consolidate this image. For instance, an Open Podium on Health was organized just before the local elections in 2006, where interventions and results of the program were presented by the councillor. This illustrates that, when framed in a way that fits the profile of the politician, politicians can also profit from the issue of health disparities in terms of political leadership.

Framing the issue in relation to common values
According to Stone, problem definition is a strategic activity in political processes (24). A policy message must be tailored to the interest of the parties involved by adapting to existing agendas and priorities (25). In order to build consensus among parties, it is critical to identify and reintroduce agreements on principles (26). The case study in this paper showed how a core feature of health disparities – namely the fact that it is subject to ideological debate – was successfully addressed. In fact, the councillor started the political debate with a conceptualisation of health disparities which is common in the scientific literature. In this literature, the issue is generally framed as the outcome of the influence of social determinants (income, educational level etc.) on health (3). The resulting disparities are generally considered to be unjust, in view of the fact that the underlying social determinants are beyond the control of the individual (3). When framing the issue like this, the councillor met with major resistance. This was because this conceptualisation conflicted with the ideology of some of the political actors, who argued that an individual should be held responsible for his/her own life. In
reaction to this, the councillor reframed the issue to avoid this ideological debate, by linking up the issue of health disparities with shared values. More specifically, tackling health disparities was made instrumental to realising the core theme of the coalition agreement, in terms of 'Participating in society'.

The experience of this case suggests that, at a local level, the argument of health disparities being unfair might not be sufficient to create political priority among a broad range of political streams. Other arguments need to be developed, such as equal opportunities for good health as a precondition for all residents to fully participate in society, or the necessity of creating conditions in which people can really be held responsible for their own life and health.

**Framing the strategies to tackle health disparities in terms of policies that enjoy broad support**

In the scientific debate on policies and interventions to tackle health disparities, *effectiveness* seems the dominant criterion for the appropriateness of these policies and interventions (1). The case of the Hague illustrates that developing strategies to tackle health disparities goes beyond employing the most effective interventions and policies. In fact, the findings suggest that if strategies are framed in such a way that they fit within strategies that already enjoy political support then this might increase the likelihood that strong actors will indeed succeed in generating various resources for these strategies. There is also another core feature of health disparities that is important – its multifaceted causes enable solutions to be presented in a way that is in line with existing policy.

Whether the resources that have been mobilised in the Hague have resulted in a program that has effectively reduced health disparities, goes beyond the scope of this paper. It is important to realise, however, that the way the central issue of health disparities obtained political priority, influenced the contents of the actual measures undertaken. More specifically, the neighbourhood orientation that promoted the prioritisation of the issue of health disparities led to the choice for a community-based approach. This might, however, not necessarily be the most effective strategy for reducing health disparities. Similarly, while a broad definition of the problem may facilitate support by a broad coalition – as illustrated e.g. by policy documents in the UK (27) – this might provide too little guidance for the implementation of specific measures.

The Hague exemplifies that political priority for tackling health disparities can be generated at a local level. This case-study indicates that framing the issue in the light of shared values, and framing the strategies to tackle this issue in line with existing policy principles might be a promising strategy to generate political priority. Our case study represents only a start in understanding this fascinating issue. We hope our results may inspire researchers to thoroughly evaluate similar initiatives in other states or cities. As political priority is imperative for policy strategies on social determinants of health, this type of knowledge is essential to improving population health and reducing health disparities.
Reference List


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(10) Exworthy M. Policy to tackle the social determinants of health: using conceptual models to understand the policy process. Health Policy Plan 2008; 23(5):318-327.


### Appendix 1: Interviewed respondents, their functions and involvement with the programme on Health Inequalities

<table>
<thead>
<tr>
<th>Function</th>
<th>Program involvement</th>
<th>Organisation</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Councillor of Public Health 2002-2006</td>
<td>Political responsible</td>
<td>Municipality of the Hague</td>
<td>1</td>
</tr>
<tr>
<td>2 Councillor of Public Health 2006-2010</td>
<td>Political responsible</td>
<td>Municipality of the Hague</td>
<td>1</td>
</tr>
<tr>
<td>3 Managing director</td>
<td>Chair of the Steering group</td>
<td>Municipality of the Hague</td>
<td>2</td>
</tr>
<tr>
<td>4 Manager</td>
<td>Member of the steering group</td>
<td>Municipality of the Hague</td>
<td>2</td>
</tr>
<tr>
<td>5 Manager</td>
<td>Member of the steering group</td>
<td>Municipality of the Hague</td>
<td>1</td>
</tr>
<tr>
<td>6 Manager</td>
<td>Member of the steering group</td>
<td>Municipality of the Hague</td>
<td>2</td>
</tr>
<tr>
<td>7 Senior policy staff</td>
<td>Member of the steering group until 2005</td>
<td>Municipality of the Hague</td>
<td>2</td>
</tr>
<tr>
<td>8 Senior policy staff</td>
<td>Member of the steering group</td>
<td>Municipality of the Hague</td>
<td>1</td>
</tr>
<tr>
<td>9 Senior policy staff</td>
<td>Program manager</td>
<td>Municipality of the Hague</td>
<td>23</td>
</tr>
<tr>
<td>10 Health promoter</td>
<td>Program executer</td>
<td>Municipality of the Hague</td>
<td>3</td>
</tr>
<tr>
<td>11 Health promoter</td>
<td>Programme executer</td>
<td>Municipality of the Hague</td>
<td>3</td>
</tr>
<tr>
<td>12 Senior policy staff</td>
<td>Collaborative partner</td>
<td>Municipality of the Hague</td>
<td>1</td>
</tr>
<tr>
<td>13 Director (until 2005)</td>
<td>Member of the steering group until 2005</td>
<td>STIOM</td>
<td>2</td>
</tr>
<tr>
<td>14 Director (from 2005)</td>
<td>Collaborative partner</td>
<td>STIOM</td>
<td>1</td>
</tr>
</tbody>
</table>
### Appendix 2: Selected documents

| H. Meantime report and corresponding letter to commission SHWI, 2 June 2003 | R. Minutes on special meeting ‘Health Inequalities’ of commission MO. 6 February 2007 |