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

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From political rhetoric’s towards professional action: a case study on implementing a local program on tackling health inequalities in the city of The Hague

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Summary

Background: It is broadly acknowledged that implementing policies tackling health inequalities asks for mobilizing health systems at the local level. The problem of health inequalities is diverse, persistent, complex and multidimensional that no one person, organization or sector can achieve health inequality reduction on their own (7-9). Moreover, the local level is considered a good entry point for both matching health interventions to the health needs and for involving the targeted population in their own health (10). In this study we explore how the local authority of the city of The Hague aimed to implement its programme on tackling health inequalities by mobilizing the local health system.

Methods: We employed a case study drawing on qualitative semi-structured interviews and document review. 22 key players were purposefully sampled for their position, organisation and their role in the implementation process. Data were inductively analysed against a theoretical framework dividing policy implementation into three phases: formulating policy objectives, translating policy objectives into interventions, and executing health interventions. More open techniques were used to explore how the mobilizing of the local health system worked out in each phase.

Results: In reframing the policy objectives, the political and bureaucratic rationale of the local authority put in more weight in the decision making than epidemiological data or the view of consulted professionals working in the local health system. The translation of the policy objectives into health interventions was rather pragmatic and only loosely based on health needs and/or evidence. The projects that were granted from the programme not necessarily reflected the initial stated policy objectives. The execution of health interventions was primarily done by the local authority at arm’s length through two intermediary organizations (STIOM and GGD) with limited delegation of responsibilities and resources to the local health system.

Conclusion: The local authority played a dominant role in implementing the programme on tackling health inequalities in The Hague. Despite attempts to initiate and accommodate bottom-up initiatives, the municipal administrative plan and control cycle was the major rationale for the implementation strategy. Given the resulting limited mobilization of the local health system, alternative strategies need to be explored, including strategies with more emphasis on decentralization of control and strengthening of bottom-up responsiveness.
4.1 Introduction

A growing number of countries are moving from acknowledging the existence of health inequalities towards developing policies to reduce them (1,2). Many of these policies tend to focus on setting explicit targets in areas such as life expectancy, cancer mortality, and smoking prevalence, and then to commit relevant stakeholders to meet these targets. This is illustrated by the Health Action zones in the UK (3,4). Public health research evaluating these policies is primarily focused on the development of the policies and the measurement of their effect in achieving targeted reductions in health inequalities.

Notwithstanding the relevance and importance of advancing this body of research, attention should also be drawn towards policy implementation. This is as critical as policy formulation for having any prospect of reducing health inequalities across populations (5). Implementation is then defined as the pursuing of the right course of action to achieve the goals of health inequality reduction articulated in authorized policy statements. The few studies reported on this topic show that implementation often fails obscuring the attainment of desired outcomes (6).

It is broadly acknowledged that implementing policies tackling health inequalities asks for mobilizing health systems at the local level. The problem of health inequalities is diverse, persistent, complex and multidimensional that no one person, organization or sector can achieve health inequality reduction on their own (7-9). Moreover, the local level is considered a good entry point for both matching health interventions to the health needs and for involving the targeted population in their own health (10). Hence, mobilizing local health systems, i.e., the processes and procedures used by local government for activating and bringing together of professionals, institutions and resources at the local level to improve the health of the population it serves, is essential to devise policies on tackling health inequalities and to foster their implementation. Although mobilizing local health systems has become increasingly topical for conceiving and implementing public health policies, little is known how this works and could be purposefully managed. There is a need to identify processes and dilemmas that influence the interaction of local governments with local health systems.

The situation in the city of The Hague, The Netherlands, is interesting in this regard. We explored how the local authority implemented its programme on tackling health inequalities by mobilizing the local health system in three stages: the formulation of policy objectives, the translation of these objectives into concrete health interventions and the execution of these interventions. This is articulated in the following research question: How did the local authority of The Hague mobilize the local health system to implement its programme on tackling health inequalities?

The context of The Hague is interesting in this regard. The mortality in deprived areas is 11% higher than elsewhere in the city, and residents in these areas live on average 12 years shorter in good health (11). The differences in health expectancies at that time were amongst the highest reported in The Netherlands. Foremost, the local authority had to mobilize a local health system consisting of a broad array of public and private providers.
Since the Dutch health system is regulated and financed through a mixture of private and public insurance schemes, and municipal budgets, implementation cannot be enforced top down, but has to be pursued through engagement and negotiation. At the local level, a broad array of public health, primary care, and social care services are delivered by providers such as general practitioners, midwives, pharmacists, dentists, physiotherapists, home care nurses, health promotion specialists, youth care physicians, public health officers, and social carers. Implementing tasks were primarily executed by two programme coordinators, controlled by one programme leader, and supervised by a steering committee consisting of municipal administrators who formally decided on subsidizing activities. For the programme in the time period of 2002-2006, there was a budget of 1.9 million euro’s made available.

4.2 Methods

A single case study was carried out in the period 2002-2006 using face-to-face semi-structured interviews and document review.

Sampling & recruitment

Semi-structured interviews
Participants were purposefully sampled for their position, organisation and role in the implementation process. Key municipal administrators including the project leader, programme coordinators, aldermen, and several members of the steering committee were asked to participate in the study. Key representatives of the local health system were conveniently selected by asking the programme leader and coordinators for their main contacts. Potential participants included directors, project leaders, health promotion specialists, and general practitioners, who were approached by phone and/or email. All agreed to participate or appointed a colleague if they were unable to participate themselves. Informed consent was not requested as it was not eligible under Dutch law. Appendix 4.1 shows the sample of 22 participants.

Document review
Documents were continuously collected during the study period. Participants drew our attention and/or provided us hard copies of documents. Furthermore, documents were found via the Internet and downloaded from websites of relevant stakeholders (e.g., www.denhaag.nl, www.welzogezond.nl, www.lijn1haaglanden.nl, www.stiom.nl). Selected documents included a broad array of public information, official policy reports, fact sheets, working documents, research and discussion papers, minutes of meetings, slides of presentations given during conferences, and professional literature. TP and MS selected the documents when they considered it (or parts of it) relevant with regard to the research question (see appendix 4.2).
Procedure
Two researchers (TP and MS) interviewed the participants face-to-face in a convenient environment of their choice, most often their working office. Five interviews were conducted by two researchers and the rest by one. Interviews gave the participants the opportunity to give an account of their experiences and share what was important to them concerning the implementation of the programme on tackling health inequalities. A topic list was developed on the basis of the research question and used to guide the interviews. It contained rather open questions thus leaving room to encourage participants to expand and clarify their answers. The interviews took approximately one hour each, were recorded, and later transcribed verbatim. Researcher’s observation and reaction notes were recorded after each interview. Additionally, the document review was used to verify personal accounts and statements.

Data analyses
We inductively analyzed the interview data and documents against a simple theoretical framework to describe the mobilizing process in three stages of policy implementation (see figure 4.1). As defined earlier, policy implementation is the pursuing of the right course of action to achieve the goals of health inequality reduction articulated in authorized policy statements. It essentially means formulating policy objectives, translating these stated policy objectives into concrete health interventions and investments, and then managing (or governing) their execution. Within each stage, we analyzed how the local authority mobilized the local health system, i.e., activating and bringing together of relevant professionals and institutions, and what rationales and interests were leading in this process clarifying the ultimate outcome. The analyses were performed by TP. MS read all transcripts, discussed and confirmed the findings in co-operation with TP. For additional validation, the findings were presented to the research team, and other colleagues working at the department of social medicine.

Figure 4.1: Analytical framework

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4.3 Findings

**Formulating policy objectives**
The primary objective of the programme as stated in the political assignment was improving the health of residents living in deprived neighbourhoods of The Hague (b). This objective was reframed into more practical terms for developing the programme, whereby three rationales were critical.

First, epidemiologists of the municipal health service extracted from several municipal monitors such as the health monitor and the youth monitor, the five most prevalent health problems in the city. Notwithstanding slight differences amongst neighbourhoods, the top five included heart disease (related with diabetes type 2), lung cancer, accidents at home, psychosocial problems, and behavioural and developmental problems amongst children (b).

Second, at the start of the programme in 2002 professionals such as physiotherapists, midwives, general practitioners, community workers, health promotion specialists, social workers, and mental healthcare workers were consulted, and put forward four themes: information on healthcare and access to care, healthy diet and physical exercise, pedagogical support, and strengthening primary care (b). As such, the professional focus was more on preconditions supporting the functioning of the local healthcare system rather than addressing the top five health problems per se.

Third, municipal administrators basically took over the four themes of the professionals, but considerably specified them by adding criteria for guiding the decision making process on what health interventions to be supported and implemented (see table 4.1). Conceptually, a link was made with so called “action lines” (criterion 2), derived from the recommendations of the Dutch national committee on tackling health inequalities (12). The other criteria were more administrative and procedural in nature, but also confined the practical focus of the programme.

<table>
<thead>
<tr>
<th>Criterion</th>
<th>Description</th>
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<tbody>
<tr>
<td>a.</td>
<td>The intervention focuses on one of the themes reflecting the needs of residents and healthcare professionals;</td>
</tr>
<tr>
<td>b.</td>
<td>The intervention is worked out alongside healthy lifestyle, healthy environment and quality improvement of care and is therefore called ’innovative’;</td>
</tr>
<tr>
<td>c.</td>
<td>Assumably, the intervention positively contributes to health inequality reduction;</td>
</tr>
<tr>
<td>d.</td>
<td>The intervention provides opportunities for intersectoral policy across healthcare, welfare and other policy areas;</td>
</tr>
<tr>
<td>e.</td>
<td>The intervention increases the self-support of residents;</td>
</tr>
<tr>
<td>f.</td>
<td>The intervention has an acceptable price, volume and quality ratio;</td>
</tr>
<tr>
<td>g.</td>
<td>The results of the interventions can be measured in terms of process and/or outcome indicators;</td>
</tr>
<tr>
<td>h.</td>
<td>The intervention has a good prospect of structural implementation on the long run;</td>
</tr>
<tr>
<td>i.</td>
<td>The intervention can be executed in one or more neighbourhoods;</td>
</tr>
<tr>
<td>j.</td>
<td>The intervention has an added value to the existing supply of health, care and welfare services in the neighbourhoods.</td>
</tr>
</tbody>
</table>

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When reflecting on the reframing, various municipal administrators notified that epidemiological realities played a minor role. They clarified this by the innovative nature of the programme as articulated in the desire to mobilize the local health system. The four professional themes were quite easily adapted without much debate. This lack of debate was attributed to unease amongst municipal administrators to keep the mobilization process going and purposefully use it for reframing the programme objectives.

“I thought it was interesting that in the beginning there was a top five of health problems based upon epidemiological data. Diseases like heart problems, smoking etc. These were the biggest problems in the neighbourhoods. But during the interactions with the professionals and residents, there were other themes highlighted. So, what are you going to do as a local authority? You want to mobilize the local health system, and therefore the themes are important. However, the epidemiological data suggest other themes.” (Participant 6)

Moreover, this was also attributed to the functioning of the steering committee. Most members of the steering committee said they missed conceptual debate on reframing the programme objectives. Discussions within the committee predominately concerned the shaping of bureaucratic procedures and processes, i.e., how to adequately running the programme in accordance with bureaucratic and administrative rules. Further specifying the four themes as put forward by the professionals was insufficiently done to obtain clear and concrete objectives. This was also attributed to the membership of the steering committee where key figures from the local health system were not represented.

“In my view, the steering committee is not functioning as it ought to be. The committee is busy with internal administrative procedures.” (Participant 14)

“There is a lack of dialogue within the steering committee on the content. The programme leader is searching this dialogue, but outside the steering committee.” (Participant 12)

Last, participants notified that the reframing did not result in explicit targets or outcomes set in terms of health inequalities reduction. Most municipal administrators were reluctant in doing this, as they considered it impossible to achieve measurable reductions within the 2002-2006 timeframe.

“If we succeed in keeping this theme on the policy agenda and invest at least five more years in tackling health inequalities. At that time we can set targets in terms of percentages reductions in health. I do not see that happen within those five years.” (Participant 12)

“At the outset, [we knew] that this problem cannot be tackled within the four year period of the Alderman for health. It just takes more time. (...) In my view, this is a structural problem that needs structural attention.” (Participant 7)
As a result, the municipal rationale was leading in specifying the four themes put forward by the professionals. The reframed programme objectives were more on the process (e.g., creating support for the programme amongst healthcare professionals, and designing appropriate subsidy procedures) than on the content (i.e., what health targets should be explicitly set in terms of health inequality reduction and how will they be accomplished).

**Translating policy objectives into interventions**

In theory, the set of criteria shown in table 4.1 should guide the translating of objectives into health interventions. In practice, the criteria were loosely applied. This is reflected in the projects that were funded (see table 4.2a + 4.2b). The link between the criteria and funded projects is equivocal, which was also notified by the participants. Their main criticism was the inability to check whether the granted interventions most effectively contribute to tackle health inequalities.

“The question is whether health inequalities are reduced with the interventions currently supported by the programme. I believe that there is no straightforward justification for the decision making process underlying the granting of projects.” (Participant 11)

“There are overviews of granted projects, which give me concrete insight in the interventions employed. However, I am more interested in assessing whether these interventions are needed. Are these the interventions related to our objectives which we want to meet? (Participant 6)

<table>
<thead>
<tr>
<th>Project</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community-based information &amp; advise</td>
<td>Opening easy accessible information points in the neighbourhoods to inform residents/patients on community activities.</td>
</tr>
<tr>
<td>Youth care in the neighbourhood</td>
<td>Two youth care professionals, based at a GP practice, provide youth care to ethnic youth and their families in collaboration with GP’s, and ethnic community organisations.</td>
</tr>
<tr>
<td>At the frontiers</td>
<td>Suicide prevention amongst youth with an ethnic background by strengthening their identity in relation to Dutch society</td>
</tr>
<tr>
<td>Triage in general practice</td>
<td>To reduce the inappropriate use of general practitioners by substituting the selection of urgent patients to practice assistants.</td>
</tr>
<tr>
<td>Web based Care portal</td>
<td>Making information on the local health system available on the website of the local authority of The Hague.</td>
</tr>
<tr>
<td>Booklet healthcare in The Hague</td>
<td>To reprint a booklet with information on healthcare supply in The Hague in seven foreign languages.</td>
</tr>
<tr>
<td>Dutch classes for ethnic minority peer group educators</td>
<td>Improving the mastery of Dutch language by ethnic minority peer group educators in two series of 8 classes.</td>
</tr>
<tr>
<td>Healthy ageing</td>
<td>Providing an educational course to elderly with an ethnic background on self management, prevalent elderly health problems, and healthy ageing.</td>
</tr>
<tr>
<td>‘Gaming rules’ project</td>
<td>Changing the development of children with a high risk on behavioural problems by offering an integrated mix of interventions.</td>
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</tbody>
</table>
When reflecting on granted projects, participants said that at least three rationales, other than the ‘managing by objectives’ rationale, underpinned the translation process. First, municipal administrators, supported by local professionals, decided to fund already existing interventions in order to keep them upright and/or to give them more time to get structurally embedded in the local health system.

“*I said that the budget was insufficient and asked whether the local authority had ideas for funding. [...] Then, they came up with funding from the programme on tackling health inequalities. The funding was not that much. Besides, I support the objective of reducing health inequalities. Thus, it fits in with my project.*” (Participant 22)

Second, subsidized projects should lead towards quick and visible wins. This was considered important for maintaining political and community support. Arguably, this is one of the reasons subsidizing the broadcasting of local television programmes. Apart from promoting health, both television programmes highlighted granted health interventions, and thus seemed to serve electoral purposes as well.

“The desire of the alderman for health is especially many visible activities.” (Participant 12)

Third, municipal administrators said the programme budget had to be quickly spent preventing budget cuts the next year. The bureaucratic logic of municipal procedures is that saved money will not automatically add up to the budget for the next year. This clarifies the differences in granted pillar projects and the short-term projects in 2003 (see table 2a + 2b).

<table>
<thead>
<tr>
<th>Provider(s)</th>
<th>Target population</th>
<th>Programme funding in 2003</th>
</tr>
</thead>
<tbody>
<tr>
<td>STIOM</td>
<td>Adults with healthcare demands</td>
<td>€ 5,000,-</td>
</tr>
<tr>
<td>STIOM</td>
<td>Youth from ethnic minority background with psychosocial problems</td>
<td>€ 10,000,-</td>
</tr>
<tr>
<td>Bureau Public health</td>
<td>Youth from ethnic minority background with psychosocial problems</td>
<td>€ 26,600,-</td>
</tr>
<tr>
<td>Bureau Public health</td>
<td>General practitioners &amp; adults with healthcare demand</td>
<td>€ 20,000,-</td>
</tr>
<tr>
<td>Local authority</td>
<td>All residents &amp; professionals in The Hague</td>
<td>€ 10,000,-</td>
</tr>
<tr>
<td>Municipal health service (GGD)</td>
<td>Migrants, expats &amp; foreign delegates</td>
<td>€ 11,662,-</td>
</tr>
<tr>
<td>Municipal health service (GGD)</td>
<td>Ethnic minority peer group educators</td>
<td>€ 6,970,-</td>
</tr>
<tr>
<td>Municipal health service (GGD)</td>
<td>Elderly ethnic minority groups</td>
<td>€ 3,980,-</td>
</tr>
<tr>
<td>Municipal health service &amp; Youth care (GGD)</td>
<td>Children with a high risk on behaviour problems &amp; their parents</td>
<td>€ 21,000,-</td>
</tr>
</tbody>
</table>
Consequently, the projects that were granted not necessarily reflected the primary policy objective of tackling health inequalities. The translating process seemed to be rather pragmatic (i.e., granting interventions that pop up in the local health system) only loosely dealing with health needs based and/or evidence (i.e., granting those interventions that address the most pressing health problems as articulated in the policy objectives, and are effective as shown by research).

**Executing health interventions**

To execute health interventions, the local authority mobilized the local health system, in particular the municipal health service (GGD)\(^1\) and the Foundation to support healthcare and social care in The Hague (STIOM\(^2\)). Both organisations provided infrastructures for mobilizing the local health system. So, it was very likely and pragmatic to contact both organisations. Some municipal administrators pinpointed the availability of STIOM being one of the enabling factors of implementing the programme.

“I was really on my own and puzzled by the question how to build the programme. So, you start orienting and calling organizations in the local health system. The organizations that deserved most to receive a phone call were the municipal health service, STIOM and later on foundation BOOG\(^3\). (Participant 1)

<table>
<thead>
<tr>
<th>“Pillar” project</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Micro grant scheme</td>
<td>To fund small scale initiatives of residents and community workers in order to stimulate innovation and community health action.</td>
</tr>
<tr>
<td>Exercise referral scheme</td>
<td>Patients are referred to a 20-week exercise programme by a general practitioner (GP) or other health professional.</td>
</tr>
<tr>
<td>Healthcare consultants for ethnic minority groups</td>
<td>Consultants provide advice and information on health and healthy living to patients with an ethnic minority background during individual consults or when consulting a healthcare professional.</td>
</tr>
<tr>
<td>HOPLA</td>
<td>A campaign stimulating healthy diet and physical exercise to stabilise the prevalence of overweight amongst children in the age of 0 to 6.</td>
</tr>
<tr>
<td>Children’s symphony</td>
<td>Providing 11 classes to educate parents in stimulating their children in their health, language and physical development.</td>
</tr>
<tr>
<td>Educational Television</td>
<td>Two television series on healthy diet and physical exercise broadcasted on local television.</td>
</tr>
<tr>
<td>The ‘home doctor’</td>
<td>Informing the public on little health problems to stimulate their self-support.</td>
</tr>
</tbody>
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1 The municipal health service is officially integrated within the local authority department of Education, Culture and Welfare and delivers public health services (i.e., health promotion, infectious disease control, and epidemiology) in the city.
2 STIOM is a project and developmental organization founded in 1994 with the objective to support primary care in The Hague by community-based working, health networking as well as starting innovative projects (www.stiom.nl). STIOM runs platform meetings on a monthly basis attended by local healthcare professionals working in the deprived neighbourhoods (e).
3 Foundation Boog is an organisation providing social care in The Hague with specialized expertise in community building (f).
Nonetheless, several participants also criticised the close collaboration with the municipal health service (GGD) and STIOM. Both organisations gradually functioned as intermediary organisations towards other care providers in the local health system putting the local authority at arm’s length of the execution of the programme. Both organisations could thus influence the implementation process whilst also safeguarding their own interests. This is illustrated by the fact that both organizations executed most of the granted projects, and thus consumed most of the programme budget (see table 4a + 4b).

Using the infrastructure of STIOM meant that networks did not have to be constructed anew for the programme, but it also restricted the scope of the programme to the existing network. Care providers not attending platform meetings were not actively mobilized. This problem surfaced, when STIOM encountered serious financial problems. According to the new director, STIOM had lost sight of its core business, i.e., signalling health-related issues in the neighbourhoods and then to communicate these to the local authority or healthcare insurers. Instead, STIOM developed projects top down without prior support of the local healthcare professionals. In the long run, STIOM lost their support, did insufficiently succeed in acquiring new funding for projects and ran out of finance.

“What I concluded was that STIOM got funding for developing projects. But STIOM was never explicitly asked by local providers to do that. (…) So, providers [in the local health system] perceived STIOM as being arrogant trying to dictate what they should do. So, providers not automatically implemented the projects developed by STIOM.” (Participant 15)

The close relationship of STIOM with the local authority even strengthened this negative perception. Local healthcare providers, especially primary care providers such as general practitioners, saw STIOM as a policy instrument of the local authority. They perceived that the
local authority was implicitly imposing their health policies via STIOM, and thus withdraw their support for STIOM.

“Care providers like or dislike STIOM. Aversion is nurtured by the impression that there seems to be a strong imperative of the local authority behind STIOM. (...) An ideological drive on how the local health system in deprived neighbourhoods should look like. This will not work. (Participant 20)

Even so, the local authority itself was critical about the functioning of STIOM, which was illustrated by setting up the micro grant financial scheme in the targeted neighbourhoods. For this scheme, the local authority set up its own infrastructure alongside the one of STIOM to activate and bring together local healthcare professionals and community workers for initiating small scale initiatives (13). Municipal administrators questioned whether STIOM had the expertise and capacity to mobilize the local health system. This criticism was also raised against the role of the municipal health service.

“It cannot be that one small institute like STIOM is running the programme for the whole city with just a few people.” (Participant 3)

This was one major reason for the local authority to mobilize and invest in the relation with another organization, i.e., foundation Boog, a provider of social services with expertise in community building (f). So, the local authority mobilized two intermediary organizations rather than the whole local health system. This restricted the scope of the programme and kept the local authority on arms length of the care professionals working in the neighbourhoods.

4.4 Discussion

The case study in The Hague reveals that the local authority intended to implement the programme on tackling health inequalities by mobilizing the local health system, through two intermediate organizations (STIOM, GGD). The local health system was partially activated and brought together in the three phases of the implementation process. However, the rationale of local policy making, a mixture of political and bureaucratic notions, seemed to override other rationales in factual decision making.

This finding fits in with the few research studies showing that implementing policies tackling health inequalities is often obscured (5,6) It is also in line with the debate on evidence based policy making criticising governments for the way they are designing and implementing policies on tackling health inequalities making meaningful evaluation impossible, and thus undermining the building of a proper evidence base . As stated in a UK paper: Governments would rush in with insufficient thought, do not collect adequate data at the outset, do not formulate clear objectives, make numerous changes to the policies and its objectives and do not maintain the policy long enough to know whether it has worked (4).

Despite that our case study partially feeds this criticism, we believe that a more nuanced interpretation of the findings is justified. Like various policy researchers notify, health policy
making is not a linear and rational process moving from formulation towards implementation, but rather an incremental, disjointed and messy one (14,15). Policies are developed within a pre-existing context with multiple stakeholders having multiple, often diverging, interests that effectively limits opportunities. Furthermore, execution of municipal programmes has to abide to the rules of the municipal plan and control cycle which is not designed to be flexible and facilitative towards ad hoc responsive reactions, but is based on well planned and transparent use of public resources. As such, ambiguity is an inherent aspect to policy making which should be taken as the starting point for researchers rather than the endpoint for criticising policy makers. In this perspective, health targets setting alone will not suffice to achieve measurable reductions in health inequalities. To become a meaningful steering mechanism for local heath policies tackling health inequalities, health targets must be consciously embedded in the planning and control cycles of local authorities. This does not only mean securing that targets make sense for the policy context within which they are employed, that they are closely monitored, and that the results are consciously communicated with the public (3). It is merely a matter of focussing on those other rationales that seem to override the rationale of ‘managing by objectives’ (i.e., health targets setting) and especially learning how to purposefully align them with each other.

Our findings suggest that this purposeful alignment asks for considerable investments in the administrative capacity made available by local authorities. In this regard, it is important to notify that municipal administrators in The Hague succeeded in continuing the programme for the period 2007-2011 (16). Moreover, the new alderman for health has invested in implementing the programme by increasing the capacity of its administrative workforce as well as strengthening the infrastructure for mobilizing the local health system by letting STIOM merge with a local development organisation for primary care called Line One which is considered by the professionals more as “their own” support organization rather than a municipal agency. This organisational structure underlines the relevance of developing effective strategies to mobilize the local health system. Local authorities especially need (scientific) support in developing strategies with more emphasis on decentralising control and strengthening bottom up responsiveness to successfully implement effective policies reducing inequalities in health. This seems even more important when local health systems lack an existing infrastructure for actively involving and bringing together of local healthcare professionals.

In future it might also be advisable to make sure that interests are well balanced in the steering group that monitors the development and execution of a programme like the one in The Hague: getting embedded in the logic of municipal administrators and the municipal plan and control cycles seems one of the limiting factors of executing a programme on tackling health inequalities.
4.5 Conclusion

Political systems and professional systems may have common value systems and a common goal of reducing health inequalities. However, decision making procedures, organisational structure and cultures differ. Interacting may help to address this, but working at arm’s length via intermediary organizations does not necessarily provide the panacea for success. Implementing a programme via a local authority is not the execution of a plan in a hierarchical organization. It has more the character of a continuous negotiation process. As such, strategies that allow local authorities to delegate actual control in terms of responsibilities and accountability of use of resources to parties in the local health system need to be experimented with.
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