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

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General Discussion
This thesis concerns the process evaluation of the programme for tackling health inequalities in the city of the Hague. In 2002 this theme gained political support and was allocated 1.9 million euros by the governing coalition. Subsequently, a programme aimed at improving the health of residents in the six most deprived neighbourhoods of the Hague, was initiated. Many of the programme activities are still ongoing. The present report concerns the evaluation of the first episode of this policy (2002-2006).

The goal of this thesis was to explore the mechanisms through which the programme aimed at influencing population health. To serve this goal, the research described in this thesis aimed at gaining insight into the developmental process of the programme and in particular the activities that were identified in the three social systems in which the programme operated; (1) the local authority at the city level and (2) the local health system and (3) the local residents on the neighbourhood level. Furthermore, we added a chapter about the evaluation design in which we closely collaborated with policymakers from the sector MVZ of the municipality of the Hague.

The following research questions have been formulated:
1. What was the shared conceptualisation of the programme and its goals by the researchers and policymakers?
2. How did the programme mobilise political priority within the local authority?
3. How did the programme mobilise the local health system;
   A. In general during implementation of the programme?
   B. With a specific activity called ‘the micro grant financing scheme’?
4. How did the programme mobilise the residents through an exercise referral scheme?
5. How did the researchers unite the two diverging goals of the research (assisting the programme while producing scientific knowledge)

In this chapter, the main findings of the study as well as some methodological considerations will be discussed. We conclude this chapter with implications for public health policy and collaborative research with regard to health inequalities.

8.1 Main findings

What was the shared conceptualisation of the programme and its goals by the researchers and policymakers?

To guide the collaboration of researchers and policymakers, we co-constructed a conceptual framework in order to obtain a shared conceptualisation (see figure 8.1). In this framework, the strategies and ideas of the policymakers were complemented by researchers with theoretical concepts from the literature. The right part of the framework specifies that the programme worked along three lines in order to improve health: healthy lifestyle, healthy environment and improvement of primary health care. The following determinants of health were being
addressed: physical activity and healthy nutrition, pedagogical support, information on and access to health care and strengthening primary care. The left half of the framework shows that the interventions are based on three principles: intersectoral collaboration, professional integration and participation of the residents. These principles in their turn, are linked to three separate social systems: the local authority, the local health system and the local residents.

Our framework clarified that to gain in-depth understanding of such a health promotion programme we need to do more than just measuring effects in terms of (determinants) of health. Also, the main principles should be made more explicit – just as the mechanisms through which they result in concrete interventions and under what conditions. As such, this framework guided the research topics that were addressed in the later chapters of this thesis.

**How did the programme mobilise political priority within the local authority?**

In chapter 3 we described our explorative study of key factors for generating political priority for tackling health inequalities. Two generic processes were identified as key factors. In the first process, the presence of strong actors who were able to overcome resistance by strategically framing the issue of health disparities. Specifically, initial resistance when health disparities were framed as ‘unfair’, gave way to support when the issue was reframed as a prerequisite to realising the core theme of the coalition agreement ‘Participating in society’. In the second process, the proposed strategies for tackling health disparities were strategically connected to policy principles that enjoyed broad political support, for example, the concept of community participation. Finally, we identified contextual elements that supported the actions of the actors and the processes they initiated, such as the involvement of scientists in the political debate. The results imply that such a complex issue as health disparities can be catapulted onto the political agenda by framing the issue strategically and embedding the strategies.
in existing policy principles. In order to do so, the presence of a strong policy community of competent policymakers and aldermen and a favourable context seems vital.

**How did the program mobilise the local health system?**

The role of the local health system in the programme on tackling health inequalities has been specified in two chapters (4 and 5). In chapter 4, we explored how the local authority of the city of The Hague in general aimed to implement its programme on tackling health inequalities by mobilizing the local health system. Our results indicate that the local health system was activated and brought together by the local authority in the three phases of the implementation process (1) formulating the policy objectives, (2) the translation of these objectives into health interventions and (3) executing the interventions. We have found that in framing 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. The results imply that 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.

In chapter 5 we continued the discussion on mobilising the local health system by exploring a specific activity taken up by the programme. To involve the professionals in the programme more thoroughly, a micro grant financing scheme was employed. The scheme was twofold, consisting of (1) micro grants of 500 to 3500 Euros which were easy obtainable by local health and community workers and (2) neighbourhood health panels of health and community workers, functioning as distributing mechanism. This study demonstrated that first of all, the community workers developed skills and experience through increased networking and information sharing. These are considered crucial steps in the process of activating communities (1). Secondly, the panels fuelled a process in which health inequalities entered the agenda of a variety of organisations from multiple sectors. This is important, since improving community health goes beyond the capability and resources of any single sector. Thirdly, a large amount of health-promoting initiatives were set up. However, although these initiatives were attended by many residents, the actual public participation was limited. According to the workers, the attendance of residents in the initiatives was a first step towards actual participation for
their target group. Attendance by the residents in deprived neighbourhoods was seen as a preparation phase in which participant capabilities were developed. Participation is known to have certain predisposing factors, such as sufficient awareness, and knowledge and skills (2). Nevertheless, it appeared to be a challenge for the workers to turn this attendance into actual resident participation. Although resident participation was an important principle, the lack thereof might also be partially explained by the applied governance approach of the local authority. Residents were not directly participating in the policymaking but were assumed to be represented via professionals. They were not able to apply for grants on their own behalf; and there was no specific approach developed on how to involve them in the application and development of the initiatives.

How did the programme mobilise the residents through an exercise referral scheme?

The role of the residents in the programme on tackling health inequalities has been shortly discussed in the chapter about the micro grants. The participation of residents in the programme was for the greater part limited to attendance to specifically organised activities. The exercise referral scheme described in chapter 6 is an example of an intervention in which residents participated.

Because new and effective interventions often reach the more advantaged and this programme was targeting the most deprived individuals, we explored the socio-demographic (and psychosocial characteristics) of the participants. The aim was to explore the factors that promote participation in the population of the deprived neighbourhoods. Exercise referral schemes (ERS) have become a popular way of promoting physical activity (3-7). The aim of these schemes is to encourage high risk patients to exercise. This study supported the idea that ERS interventions appeal to people from lower socio-economic groups, including ethnic minorities. The majority of participants had a migrant background, a low level of education, no paid job and a high body mass index. The ERS as implemented in The Hague seems to meet the contextual, economic and cultural needs of the lower socio-economic groups and ethnic minority groups. The ERS appealed to them because of its specific elements: the compulsory character of the referral, supportive environment, financial incentive, supervision and neighbourhood setting.

How did the researchers unite the two diverging goals of the research: assisting the programme while producing scientific knowledge?

In chapter 7 we described and reflected upon our experiences collaborating with policymakers in a local programme on tackling health inequalities. In collaborating with policymakers, the challenge for scientists is to gain a greater understanding of policy-making and programme implementation without losing sight of the scientific rigour of their research. During our research we encountered challenges in meeting the scientific standards and employed several strategies in order to cope with them. The most important were obtaining measurable results, evoking reactivity while trying to control for it, warranting independency and competing goals of reporting interim findings in short reports versus writing in-depth articles for scientific
journals. However, our experience indicates that it is possible to overcome these challenges.

For the collaboration to be effective, some non-scientific efforts need to be made, alongside common scientific efforts. Building a common conceptual framework with policymakers, ensuring ongoing dialogue between researchers and policymakers and creating trust between the two parties represent essential steps. Eventually, we considered the collaborative nature of this type of research not as a threat to scientific rigour, but rather as a powerful tool for increasing the grip we had on policy development in this field and thereby generating valid outcomes that could be generalised.

8.2 Methodological considerations

The specific limitations of the various studies have already been considered in detail in the separate chapters of this thesis. This section provides some general reflections on the design and methods that were used. We were prepared to address our research questions with quantitative as well as qualitative techniques. Eventually we used primarily qualitative methods; including interviews, document analyses and observations (see table 1.1). For the study of the Exercise Referral Scheme, we also used questionnaires.

The case in this thesis represents a programme ‘in action’. It described and analysed the programme as it occurred. Therefore we had no prior focus on an analytic model, but a more ‘open view’. We built a global conceptual framework which provided direction but left enough freedom and flexibility for exploration. Initially we aimed at studying the development of the three working principles: community participation, professional integration and intersectoral collaboration. However, when following the lead of the programme we came across research questions that, although related to the working principles, had a different focus to what we had foreseen. For example, the generation of political priority appeared to get a great deal of attention from the policymakers. Whereas as researchers we had first predicted being able to do an in-depth analyses of collaboration between municipal sectors. Also, given the time and resources spent on the process of generating political priority, the intersectoral collaboration got far less attention during the study period than we anticipated. The freedom provided by our ‘open design’ allowed us to refocus on what was beneficial to our aim of unravelling the black box of health promoting programmes. We considered our open design as a strong point in this research. This was in line with our principal aim to gain a deeper understanding of the mechanisms through which such a complex programme is developed.

In evaluating the programme, the two-fold goal of assisting the programme while producing scientific knowledge, posed some scientific challenges for us. In chapter 7 we concluded that it was possible to overcome these challenges, especially regarding internal validity.

In contrast to the internal validity of this research, the direct transportability to other settings is less self-evident. However, this is not so much related to the collaborative nature of the research, but rather to the single case study design. As a result, the findings cannot unreservedly be applied to other municipal programmes that aim at reducing health
inequalities. In contrast to survey studies that rely on statistical generalisation, case studies rely on analytical generalisation (8;9). Analytical generalisation concerns the contribution of the evaluation to developing theory more generally. We identified some elements in the programme that could be important in developing theory. One of these was the choice to embed the programme within the local authority. This provided support for the mobilisation of political priority but at the same time threw up difficulties in mobilising the other systems (community and local health system). Current theories about municipal policy processes still have some blanks on how to address the three systems together in one programme. On this point, further theory development is needed. Our observations of the policy processes in The Hague have contributed to this and are reflected upon in the following paragraphs.

8.3 Reflections on the results

In this section we reflect on the findings of this study by using our conceptual framework. Firstly, the consequence of the choice of the programme to get engaged simultaneously in three separate social systems, is discussed. Secondly, translation of the objectives into concrete activities will receive attention. Thirdly, the expected contribution of this whole programme to reduction of Health Inequalities is considered.

8.3.1 Tackling Health Inequalities by engaging three social systems simultaneously

In 2002, after the issue of tackling health inequalities received political priority and was allocated 1.9 million Euros, the programme had to be built from scratch. As elaborated in chapter 2 we developed a conceptual framework around the core themes and principles of the programme. When we contextualised these principles, three social systems appeared; (1) the local authority, (2) the local health system and (3) the local residents. By engaging simultaneously in these three separate social systems, the programme constituted a broad approach incorporating political, health care and social factors.

Engaging these social systems is considered vital for tackling health inequalities. Firstly, the local authority has to prioritise the health inequalities and allocate financial means and human resources in order to initiate a programme (10-13). Secondly, the local health system should be engaged to implement the programme. Thirdly, the participation of residents in developing and executing the programme is important. In contemporary public health policy this principle is considered a health enhancing strategy to reduce inequalities in health (1). Although all three systems were meant to be engaged, in practice the dynamics within the local authority dominated the development and execution of the programme. This system fully financed the programme and employed the manager and the members of the steering group.

The roots in the local authority (at the city level) had both its benefits and its shortcomings. The mere fact that the policymakers were physically located within the local authority enabled the anticipation of political ‘windows of opportunities’. In chapter 3 this was considered
beneficial for mobilising political priority for tackling health inequalities. However, in later stages the political processes and accompanying administrative procedures became a central tenet in the programme. During the development of the programme, political priority was increasingly perceived by the policymakers as vital for continuation of the programme. To this end it was conceived as a phase that precedes the working principle of intersectoral collaboration. Consequently, the policymakers’ focus changed from intersectoral policy-making to generating political priority.

Furthermore, the local authority became somewhat dominant in the programme’s course of action at the cost of the engagement of the local health system and the local residents. Shaping their own programme directions is important for communities in order to gain ‘ownership’ and to become actually empowered (1). The stated principles (resident participation and professional integration) had to contribute to this. Participation of residents that was aimed for via the neighbourhood health panels was only partially realised. Furthermore, the principle of professional integration in the local health system was paid only minimal attention. As the principles were only to a limited extent realised, the ownership over the programme remained with the local authority.

The dominance of the local authority over the course of the programme and the limited role of the other systems, could have been inherent to the initial stage of the programme. In the further development of the programme, the other systems should be engaged more in order to get the programme implemented and specific interventions initiated.

**8.3.2 From working principles to interventions**

Notwithstanding the limited elaboration of the working principles, many interventions were initiated on the four themes of the programme: physical activity and healthy nutrition,
pedagogical support, information on and access to health care and strengthening primary care. In the logic of the conceptual framework, these activities are assumed to improve the health of the residents by improving healthy lifestyle, healthy environment and improvement of primary health care. So, does this imply that these activities were chosen on the basis of their expected contribution to the ultimate aim of the programme for tackling health inequalities in the Hague? The answer is: yes, but to a limited extent. First, in the decision-making process with regard to interventions there was limited linkage with the previously established principles and stated goals. Second, information on their potential to effectively tackle inequalities in health hardly played a role in the selection of interventions.

Figure 8.3: Conceptual framework for evaluating the neighbourhood-based Programme for tackling health inequalities in The Hague

(1) The limited specification of goals
In the local authority goals that are globally formulated are common. In this programme, the goals were likewise broadly formulated. For example, there was no specification on the type of professionals who had to integrate. Nor were the expected number of professionals or the level of collaborative activities specified. Instead, ‘professional integration’ was just made one of the main global criteria of the micro grant financing scheme. Likewise, the number of residents who had to participate and in which stages of the programme was also not specified. This approach is in line with the literature about political decision making where broad formulation of goals is considered functional. The purpose of this is to mollify opponents and allow for reinterpretation over time and across contexts, facilitating a broad coalition of support (14-16). In this programme, the broad formulated goals were also in line with the neighbourhood orientation as it left room for professionals and residents to influence goals and objectives.
However, with the absence of structural development on the working principles, participation of residents and professional integration, a specific goal orientation also did not occur during the further development of the programme. Since effective implementation requires a clear and unambiguous policy framework (17) the non-specific goals hampered an efficient implementation process. For example, if the main aim of the micro grants would have been about planting ‘seeds’ in order to see what might be effective in health promotion, the municipality should have organised a ‘chain of research and development’ in which successful initiatives would have been identified and widely implemented. Other criteria such as ‘it should be financially sustained’ were then not considered important. Now, as concluded in chapter five, the micro grants financing scheme was not fully exploited, partly because of objectives that were ambiguous. Besides, the non-specific goals also left room for rationales other than the two working principles, to lead the implementation process, including municipal procedures as discussed in chapter 4. As a result, the plethora of interventions that were initiated appeared to be disconnected and were pragmatic responses to perceived opportunities.

(2) A minor role for evidence on effective interventions

Another way to make the implementation process of such a complex public health programme effective is to make use of scientific evidence on the effectiveness of interventions (18-24). To optimally develop the programme on health inequalities, the Hague deliberately involved researchers to bring in the latest insights on tackling health inequalities and by giving back meantime results. The programme could, if so desired, anticipate by adjusting the activities along the way. This initiative fits the contemporary attempts to committing evidence based policy where the most up-to-date findings from research are used to inform policy-making. During the last two decades, the uptake of research findings in policy development has drawn a lot of attention to the matter (22;25-28). However, observations show that policymakers rarely base new policies on findings from research (29;30). This has much to do with the so-called gap between researchers and policymakers and the different rationalities of both worlds. Both have different goals, different attitudes towards what constitutes evidence and have different work cycles (27;31)

However, in bringing in the scientific evidence in the programme development, policymakers saw themselves confronted with the other interests that were competing with the scientific rationale. The implementation of the exercise referral scheme is an example of such a competing interest. The scientific evidence of effectiveness of this intervention was limited. Nevertheless, this intervention was financed by the programme for tackling health inequalities. Financing this intervention was based on various rationales, including the need to finance existing projects that would otherwise have been stopped due to a shortage of funding. Furthermore, it played a role in the generation of political priority. The ERS in the Hague started in 2002, expanded rapidly and was considered a good intervention for tackling sedentary lifestyles by professionals and the responsible alderman. Since the alderman wanted noticeable projects, the investment in such an intervention could be considered a strategic step.
for the generation of political support. Although researchers added some evidence as rationale in the decision making process, the choice to finance this intervention was thus not based on evidence on its contribution to tackling health inequalities. The scientific rationale appeared to be one among many others that were guiding the implementation process. However, the policymakers stimulated researchers to execute an evaluation on this intervention (chapter 6).

In sum, scientific evidence on the effectiveness played a minor role in the programme development, despite the collaborative design of the evaluation. However, through the collaborative approach, the policy development and research are coming into closer convergence. In the long term this might contribute to evidence based practice where evidence is generated locally, as well as generated from the scientific literature.

### 8.3.3 Expected contribution to the reduction of Health Inequalities

When the programme started in 2002, the local authority requested its evaluation. In line with common evaluation research, evaluation questions tended to focus on impact measures. Impact refers to the results of the programme for the people it was intended to serve (32). An evaluation of the impact of the programme was however not possible. The series of assumptions that link what the programme does to what it is meant to accomplish, could not therefore be clarified. Hence, a programme theory could not yet be formulated. While thinking through the evaluation possibilities, the policymakers started to think that scientific support would help them develop their programme on tackling health inequalities. As a result, a process evaluation was born. The actual reduction of health inequalities has not been assessed because of the immature stage of the programme and the knowledge that the impact would be too limited to measure significant changes over the chosen time period. An adequate effect evaluation is only possible and useful when the expected health outcomes are clear and visible.

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![Conceptual framework for evaluating the neighbourhood-based Programme for tackling health inequalities in The Hague](image)

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**Figure 8.4: Conceptual framework for evaluating the neighbourhood-based Programme for tackling health inequalities in The Hague**

<table>
<thead>
<tr>
<th>Program</th>
<th>Systems</th>
<th>Principles</th>
<th>Interventions</th>
<th>Outcomes</th>
<th>Health</th>
</tr>
</thead>
<tbody>
<tr>
<td>Local authority</td>
<td>Intersectoral Collaboration</td>
<td>Physical activity and Healthy nutrition</td>
<td>Healthy lifestyle</td>
<td>Physical &amp; mental health</td>
<td></td>
</tr>
<tr>
<td>Local health system</td>
<td>Professional Integration</td>
<td>Pedagogical support</td>
<td>Healthy environment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Residents</td>
<td>Participation</td>
<td>Information on and access to health care</td>
<td>Improvement Primary health care</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tackling Health Inequalities Program</td>
<td></td>
<td>Strengthening primary care</td>
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within a reasonable amount of time. Nevertheless, in this short paragraph, some light will be shed on the plausible contribution to the reduction of health inequalities.

In the programme, four themes were formulated ranging from healthy lifestyle to healthcare accessibility. Ultimately, foremost lifestyle interventions, such as the exercise referral scheme and the HOPLA campaign were financed. These types of interventions treat the symptoms rather than the underlying cause of the problem (17). In particular interventions which tend to directly tackle some of the causes of the social gradient by improving, for example, living conditions (17) were not launched. Therefore, at short term it is questionable whether health inequalities are reduced by the programme in question. For example, the study of the exercise referral scheme demonstrated that it appealed to women from lower socio-economic groups, including ethnic minorities. Specific elements of the scheme enabled the women to start exercising and included supervision, low costs and the neighbourhood setting. Since this intervention focuses on promoting exercise behaviour by providing an opportunity to exercise, it is not unlikely that these women will stop exercising after the scheme has finished. Structural changes in the environment seemed to be needed so that participants can continue their physical exercise under supervision, at low costs and within their own neighbourhood. Since these environmental changes were not directly realised, big wins on health seem to be unrealistic.

However, as far as benefits and long term expectations are concerned, the programme for tackling health inequalities is promising in the city of The Hague. The policymakers were successful in gaining political support that resulted in more attention and funding for policies on tackling health inequalities. In the long run, further investment in coordinated actions will hold the potential of improving the health status of residents in deprived neighbourhoods. Therefore, attention is needed on further specification of the programme’s objectives in order to warrant an effective implementation of interventions that are proven effective. Last but not least, efforts should be made to upscale the involvement of the other two systems involved; the residents and the professionals.

8.4 Implications
8.4.1 Implications for policy
Tackling health inequalities poses particular challenges for policymakers. Since the causes of health inequalities are multifaceted, the solutions must be too (24;33). The collaboration of many different sectors and organisations and long-term policy is required. The programme described here can now be considered in an early stage of policy development for tackling health inequalities in the Hague. Both policymakers and the aldermen succeeded in mobilising more attention, financial means and human resources, so that tackling health inequalities continues to be a political priority in the Hague. This course of action is theoretically in line with Dahlgren and Whitehead’s model (2006) which includes seven stages towards action in a policy process, starting with measurement, recognition and raising awareness to taking
action, isolated initiatives and finally in a more structured development and comprehensive coordinated policy. In the present programme the early stages are passed through, giving way to a more comprehensive approach. In elaborating this next step in policy development, three points should be taken into consideration.

1. **Building supporting mechanisms to elaborate the working principles**

The conditions needed to develop a programme that is based on the working principles of intersectoral collaboration, professional integration and participation of residents requires support from the environment. When embedded in the local authority, the policy for tackling health inequalities has to deal with a municipal and political climate. It does not seem likely that the habit to formulate broad goals and the presence of competing rationales in the implementation of interventions – including the need of politicians for quick wins and visible results – is about to change. Policymakers should be aware of these factors and find ways to deal with them.

For the development of participation of residents, investments should be made for example, in educating professionals and community workers. These are investments for the long term and do not result in visible products and quick wins. An important step within the present programme was to initiate, besides the policy line in which structural interventions were developed, the micro grants funding scheme. Although this scheme should be further developed, local health professionals and community workers were able to start small scale initiatives without interference from the municipal climate (competing rationales and the need for big wins).

In order to be able to implement the programme in a coordinated and collaborative way (with various sectors and organizations) specific goals are required. If the power remains with the local authority then it seems advisable to divide it more formally into a policy development part, focussing on the political arena for generating political priority and an executing part focussing on the implementation. These two parts need to act together to tune the implementation on the policy developments. But, at the same time, they should operate independently so that the implementation is not hampered by global and non-specified goals that are typical for the local authority system. A strong coordination role external to the local authority might be fruitful to receive the support of all three systems instead of solely the local authority.

Examples of such an external committee can be found in other similar programmes in the Netherlands such as ‘Hartslag Limburg’. In the province of Limburg, community networks were initiated comprised of representatives of various organisations and residents. These networks were professionally supported by a health promoter for the municipal health service, a welfare worker and a local bureaucrat. Their most important task was initiating and implementing health promoting interventions. Beneficial to the success of this professional collaborative approach was the external sponsoring (34) which is in contrast with the case described in this thesis in which all financial means originated from the local authority.
2. **Start intervening on environmental level (and thus involving other sectors)**

To actually reduce inequalities in health, action is required across different organisations and sectors. At the start of the programme, intersectoral collaboration was formulated as a working principle. At the start in 2002, the programmatic approach seemed to be a fruitful mechanism. The local authority is organised vertically and a programme promised to go beyond these separate departments. In the end, there was hardly any involvement from other municipal sectors in the development of the programme. This can be easily explained by a shift in the efforts of policymakers, from elaborating the working principle of intersectoral collaboration to mobilising political priority (as a prerequisite to collaboration). So just using a programmatic approach does not appear to be sufficient and a more active approach to involve other sectors seems to be necessary.

Intersectoral collaboration is not just about getting the right people around the table. Moreover, the broader institutional context and work towards transforming existing organizational structures, processes, and cultures to better support intersectoral collaboration has to be addressed. To avoid the perception that Health inequalities are beyond their core purpose, sectors including education and work environment should become aware of their vital roles in tackling health inequalities. A strong coordination is required throughout the government, possibly not solely from the health department because it may be assumed that the problem is only in the health sector. The premise that a so-called health broker, institutionalised outside the health department and representing a cross-cutting team, might help to overcome a number of key barriers to intersectoral action and foster environments that are more conducive to cross-cutting work, is currently being researched by the AMC (35).

3. **Continuing collaboration with the scientific community**

It is important to continue collaborative activities between researchers and policymakers in order to bring the scientific rationale into the policy-making process. Although the scientific rationale will have to compete with many others, including the municipal climate, a collaborative design at least warrants its presence. This supports an evidence based practice. Furthermore, collaborative research provides meantime findings that are useful to shaping the programme. For example, feedback might help to adjust a policy when necessary. Finally, collaboration between policymakers and researchers appears to be supportive for generating political priority. In sum, it is important to continue collaboration between these two fields in order to develop a strong community that is vital to tackling health inequalities.

**8.4.2 Implications for Researcher**

In our study the research questions that arose were primarily exploratory in nature. Hence, as the findings are consequently theoretical assumptions, there is a need to further substantiate them. For example, does a micro grant funding scheme actually realise community participation if investments in governance are being made? Furthermore, we need to test the hypotheses that were produced by this study. For example, can we reject the fact that the identified mechanisms that explain the generation of political priority also clarify the mobilisation of
political priority elsewhere? The policy development for tackling health inequalities and the accompanying evaluation studies are complex. This poses an array of difficulties for researchers in performing an adequate evaluation. Notwithstanding these challenges, evaluating these policies remains of imminent importance since there is still a lack of evidence regarding which policies are effective (36).

Effect studies that are still the most common evaluation studies, should be enriched by process evaluations. Our study demonstrated the added value, not only in contributing to evidence based practice but also on the unravelling of the so-called black-box of interventions. Our suggestion would be to invest in both types of evaluations and to tune the evaluation questions to that particular stage of policy development. The use of both quantitative and qualitative techniques is self-evident and should of course be chosen depending on the nature of the research questions.

Some scientists find it crucial for policy to be designed thoughtfully in order to make an adequate evaluation possible. Although this may hold for experimental studies, there are certain other types of evaluations that can contribute to an evidence base. The development of a logical model underlying the interventions is rarely realised. We suggest not to concede the policy process as simply too messy and disjointed for evaluation. We argue that scientists who present the policy process as linear and rational – moving from identification of a problem to policy development and finally implementation – miss the point of policy development in a political arena. In this social system, the scientific rationale is just one among many others. The fuzziness is inherent to policy-making. We believe that collaborative research is a powerful tool for increasing the grip that researchers have on policy development. The major challenge for scientists is to gain a greater understanding of policymaking and programme implementation without losing sight of the scientific rigour of their research.

Finally, in alignment with the aforementioned ‘fuzzy’ policy process, our construction of a conceptual scheme in order to obtain a shared conceptualisation needs some attention. Our approach was in line with the “theory of change” approach developed at the Aspen Institute. In this approach, researchers and programme directors spell out the course of action and its underlying assumptions at a micro-theoretical level, so that expected outcomes are transparent and measurable. In doing so, we carefully urged the policymakers to formulate hypotheses and clarify their strategies and goals. However, the complexity of the issue of health inequalities made it difficult for policymakers to specify in advance in more detail how, the programme would influence population health. Given this, the basic principle of linking original problems and context to activities and intended outcomes was roughly adopted. We merely succeeded in creating a global conceptual scheme that provided shared conceptualisation. That it is difficult to implement the ‘theories of change’ has also been experienced by others, such as the evaluation of the HAZ (37). For now, we think that we still have much to learn about the policy process before we get a grip on the theories of change within. A broad conceptual framework can, however, be very helpful and function as a starting point. Efforts should be made to actually include more specifications. Therefore, a long-lasting collaboration between researchers and policymakers is needed.
8.5 General conclusions

Developing a comprehensive programme for tackling health inequalities takes much longer than generally is anticipated. Three years after the Hague programme on tackling health inequalities was launched, the three working principles (intersectoral collaboration, professional integration and participation of residents) were still in a developmental stage. As a result we were not able to reflect on the value of the neighbourhood-based approach for tackling inequalities in health. Our results cautiously suggest that the marginal effects of such comprehensive programmes, as often found by previous effect evaluations, might be due to the prematurity of these programmes. For example, in the Hague programme, generation of political support alone appeared to be far more time consuming than anticipated. This experience is relevant considering that generating political support, although a vital component of programmes aiming to tackle health inequalities, is not often stated as a goal of such programmes.

We concluded in this thesis that it seems possible to generate political priority at the local level, if accurately done. Generating political priority requires craftmanship and continuous attention. Since the local authority cannot achieve health inequality reduction on its own, the choice to engage the local health system and the local residents seems a legitimate, albeit difficult task. In The Hague, the development of a micro grant financing scheme is an example of how this can be realised. Here the local authority’s experiment with decentralising control was partly successful. Lessons drawn from this experience indicate that local authorities should invest in the development of new strategies to actually mobilise social systems and new theories on how to do that effectively should be developed.

The process of programme development and the choices for particular interventions is subject to many competing interests; scientific evidence on the effectiveness of interventions being just one among many. It seems that, in order to allow a greater input from the scientific rationale in the decision making process, the formulation of explicit programme goals might be helpful. This is not a simple task, as local authorities have their own dynamics and tend to more generic goals. Therefore engaging local health care systems and residents may form an important counter-balance for the influences of the local authority system. To this regard, collaboration with researchers might be useful in order to bring in the scientific rationale.

Nonetheless, even in the absence of a thorough mobilisation of the local health system and the local residents many interventions have been implemented. In The Hague, the exercise referral scheme was one of these interventions. In this particular case, we found that the elements that enabled the participants to start exercising, were specific to this intervention and concluded that we should become aware of whether participants continue with lifestyle changes after the intervention period. It seems necessary to remain focused on the contextual, economic and cultural needs of lower socioeconomic groups in deprived neighbourhoods. This stresses the importance of engaging local health systems and local residents in such programmes in order to ensure that desired activities are embedded structurally.
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