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

Citation for published version (APA):
Summary
Over the past three decades, health inequalities have emerged as an important theme in public health policy in the Netherlands and abroad. In this thesis, health inequalities refer to the systematic differences in health between different socio-economic groups within a society. The inequalities are mainly caused by a higher exposure of lower socio-economic groups to a wide range of unfavourable material, psychosocial and behavioural risk factors.

As in many other countries, health inequalities in the Netherlands are persistent. Nowadays, people with the lowest socio-economic status live six to seven years less and spend 16 to 19 years longer in poor health compared with those from the highest socio-economic group. The differences in health expectancies in the city of the Hague are among the highest reported in the Netherlands. In accordance with the national trend, The Hague’s health monitor showed, roughly ten years ago that morbidity is related to the socio-economic status of neighbourhoods. The mortality rates in the deprived areas are much higher than in the more prosperous neighbourhoods. These inequalities in health were confirmed in the 2002 health monitor. It was in this year that health inequalities first became a specific focal part of the local government coalition agreement. A sum of 1.9 million euros was made available for the period 2003 to 2006 for the purpose of tackling health inequalities. Subsequently, a programme for tackling health inequalities (PTHI) which aimed at improving the health of the residents in deprived neighbourhoods, was initiated.

Although a growing body of experimental studies have been evaluating these kind of comprehensive programmes, most of these studies have shown only marginal effects. This has led many people to conclude that there is little knowledge on what “works” in comprehensive programmes for tackling health inequalities. Generating such knowledge requires the formidable decoding of the “black box” of these comprehensive programmes and studying the mechanisms through which these programmes influence population health.

This thesis concerns the process evaluation of such a comprehensive programme for tackling health inequalities in the city of The Hague. First aim of the study was to assist the policy-makers by gathering information and generating findings they could use to shape the programme. The second aim of the study was to gain insight into the developmental process of the programme, producing valid and generalisable knowledge that would contribute to the international debate on tackling health inequalities. This thesis focuses on this second aim and reports the results of the developmental process of the programme. Although many parts of this programme are still going on in the city, the present report focuses on its initial phase (2003-2006).

The core working principles that were formulated by the policy-makers (intersectoral collaboration, professional integration and participation of residents), are linked to three separate social systems, the local authority (at city level), the local health system and the local residents. Not the working principles were leading in our research, but in stead the most salient processes in these three separate social systems. For evaluating PTHI, the main aim was to explore which processes are dominant in these systems during the development of the programme. In addition to the exploration of the three social systems, we explored the scientific consequences of our collaborative design.
The following research questions have been formulated:

1. What is the shared conceptualisation of the programme and its goals by the researchers and policymakers?
2. How does the programme mobilise political priority within the local authority?
3. How does 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 does the programme mobilise the residents through an exercise referral scheme?
5. How do the researchers unite the two diverging goals of the research (assisting the programme while producing scientific knowledge)?

To reveal the processes of the programme in its real-life context, a single-case study was undertaken. For four years the process, in which the city of The Hague unrolled the programme, was studied. To elaborate the process evaluation a collaborative research strategy was employed. Collaborative research, as a long-lasting partnership of researchers and policymakers, is by many assumed to result in better interpretation and use of research findings and produce policy relevant knowledge. This thesis reports the results of the process evaluation of the programme. By way of starting the collaboration with the policymakers we strived for a shared conceptualisation of the program.

**Obtaining a shared conceptual framework**

In chapter 2, we introduce and outline the conceptual framework that we as researchers co-constructed with policymakers in order to obtain a shared conceptualisation. 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 works along three lines in order to improve health: healthy lifestyle, healthy environment and improvement of primary health care. The following determinants of health are 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 comprehensive 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.
The mobilisation of political priority within the local authority

Chapter 3 provides an exploration of key factors for generating political priority. Political priority is vital for tackling health inequalities, in particular for investments in sustainable policies, actions and infrastructure. In The Hague, two generic processes were identified as key. 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 participation of residents. 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 policy-makers and aldermen and a favourable context seems vital.

The mobilisation of the local health system

The role of the local health system in the programme on tackling health inequalities is specified in two chapters (4 and 5).

In chapter 4, we explore how the local authority of the city of The Hague in general aimed to implement its programme by mobilizing the local health system. 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 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 continue the discussion on mobilising the local health system by exploring a specific activity taken up by the programme. To engage 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 for local organisations, and (2) neighbourhood health panels of health and community workers,
functioning as distributing mechanism. The scheme demonstrated the threefold role of micro grants as a vehicle to enable community action at an organisational level in terms of increased network activities between the local organisations, to set an agenda for the health topic in non-traditional health agencies and to enable a number of health promoting initiatives. Although these initiatives were attended by small groups of residents normally considered hard to reach, the actual public participation was limited. The results indicate that this limitation was related to the objectives of the financing scheme that were somewhat confusing. We concluded that making such micro grants available to the community is supportive but not efficient to enable community action. The scheme should be complemented by investments in infrastructure such as training of professionals.

The mobilisation of the residents
The role of the residents in the programme for tackling health inequalities in The Hague 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 participating in interventions. 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 of one of the subsidized interventions. Exercise referral schemes (ERS) have become a popular way of promoting physical activity. 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. Since these elements that enabled the participants to start exercising are specific to this ERS, we should become aware of whether this population continues to exercise after the end of the scheme. This implies that follow-up projects are needed to help participants to find activities suitable to them.

Dilemma’s of a collaborative researcher
After describing the main salient processes in the programme for tackling health inequalities in The Hague, we added reflection on the collaborative design we used for evaluation. In chapter 7 we reflect on the challenges we encountered in meeting the scientific standards and the strategies we employed in order to cope with them. The most important concerned (1) combining policy and scientific relevance in the research questions, (2) obtaining measurable objects, (3) evoking reactivity while trying to control for it, (4) warranting independency and
competing goals of reporting interim goals in short reports and writing in-depth articles for scientific journals. However our experiences indicates that it is possible to overcome these challenges with some generic investments. Building a shared conceptual framework and organizational arrangements represent essential steps. This study demonstrates that with these investments the collaborative nature of this type of research should not be considered to be a threat to scientific rigour, but rather as a powerful tool for generating valid and generalisable outcomes.

**Implications for tackling health inequalities on a local level**

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 during the evaluation period. 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 craftsmanship 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. In addition 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.