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Local health policy development processes in the Netherlands: an expanded toolbox for health promotion

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SUMMARY

Although much research has been done on the existence and formation of risk and issue based health policies, there is only little insight in health policy development processes in a broader context. This hampers intervention in these policy processes to adequately develop integrated and effective health policies.

Legislation in the Netherlands requires municipalities to develop and implement local health policies. These policies are supposed to aim at the promotion of health across sectors and with a strong community involvement. Health policy development processes have been studied in four Dutch municipalities. For each case, we identified a range of stakeholders and monitored the change or stability of their characteristics over 3 years. In addition, for each case, three overlaying maps of networks were made addressing communication and collaboration actions within the defined set of stakeholders. We point out a number of barriers which impede integrated policy development at the local level: the importance given to local health policy, the medical approach to health

development, the organizational self-interest rather than public health concern, the absence of policy entrepreneurial activity.

Furthermore, this article advocates the use of complementary theoretical frameworks and the expansion of the methodological toolbox for health promotion. The value of stakeholder and network analysis in the health promotion domain, at this stage, is two-fold. First, mapping relevant actors, their positions and connections in networks provides us with insight into their capacity to participate and contribute to health policy development. Second, these new tools contribute to a further understanding of policy entrepreneurial roles to be taken up by health promotion professionals and health authorities in favour of the socio-environmental approach to health.

Notwithstanding the value of this first step, more research is required into both the practical application as well as in the theoretical connections with, for example, Multiple Streams theory.

Key words: health policy processes; health promotion; network analysis

INTRODUCTION

In the Netherlands, local government is required by national law to develop health policy at the municipal level. Very few municipalities succeed in this mission. In this article,

we demonstrate why policy development at the local level fails and what can be learned from studying these policy processes by making use of stakeholder and network analyses. Under the Collective Prevention legislation, municipalities in the Netherlands are required to develop and

implement local health policies. These are supposed to be *policies for health*, as specified in the legislation itself, its background documents and evaluations of its predecessors (Lemstra, 1996; Ministerie van VWS, 2000; Ministerie van VWS et al., 2001; Wijziging van de Wcpv, 2002). Such policies aim at the promotion of health across sectors, with a strong community involvement, and based on available epidemiological information. Similar policy requirements are found elsewhere, for instance in Victoria, Australia (Department of Human Services, 2001) where an extensive consultation framework is in place to support municipal public health planning.

Such support in The Netherlands is supposedly provided through joint Public Health Services (PHS) that, generally, covers a service area comprising several local government authorities. In our inquiry, we looked at health policy development processes in four municipalities (9,000–50,000 inhabitants) within the larger region covered by the Central Limburg PHS (Hoeijmakers, 2005). At the start of the investigation, none of these four municipalities had a health policy, so policy development could be studied.

HEALTH POLICY DEVELOPMENT

Health is considered a multidimensional concept with a physical, psychological and social dimension (WHO, 1946). Health develops through interaction between individual and environmental health determinants (including the physical, social and economic environment) as described in a recently endorsed Health Development Model (Bauer *et al.*, 2006). Baum (Baum, 2003) argues that public health interventions have evolved from a medical and behavioural approach towards a socio-environmental approach to health. This approach offers a broad framework concerned with the totality of health experiences and the factors to maintain health, including those connected directly to people (behaviour, genes) as well as the environment (housing, income). The socio-environmental approach applies, in particular, to health policy in the public sector. Such policies are aimed by definition at groups or communities in their daily living circumstances. They should therefore address multiple

determinants with the participation of multiple sectors and actors including the population.

To get more insight in health policy-making processes, this study builds foremost on the policy literature and relates these concepts to the development of health policy in the cases studied.

Policy processes

The process of policy-making can be characterized by a rational approach or by an interactive approach. The rational approach assumes that going systematically and consciously through a number of phases is the most effective way of analysing problems and choosing from a number of alternative solutions in dealing with them (Hoogerwerf and Herweyer, 1998). This is a very instrumental view of policy. The rational approach seems to be based on the classical model of policy-making, in which a small number of people, mainly the civil servants and governor or administrator, form and decide upon a policy. It implies a rather top-down activity from government to society, mainly using regulations.

This ‘stages heuristic’ is profoundly criticized in contemporary political science (Sabatier, 1999). Sabatier, and colleagues such as (de Leeuw, 1989; Walt, 1994; Stone, 1997; Milio, 2001; Lewis, 2005b) conceive of the policy development process as a complex interactive process influenced by the various stakeholders involved. The type of rationality that (public) policymakers display differs from purely ‘scientific’ rationality (Weiss, 1979). This becomes apparent in the fact that objective knowledge developed by scientific research, although available, does not lead to congruent policy decisions (de Leeuw, 1993; Dean, 1996; Catford, 2003; Glouberman and Millar, 2003).

The grounds for criticism, and at the same time the reasons to assume the policy process to be interactive and dynamic, are summarized in what follows. The distinction made here, between complexity, politics and communication, is rather analytical because in reality these aspects are highly intertwined.

Complexity

Many contemporary health problems (e.g. health inequalities, ageing, deprivation) are complex. This complexity does not allow for a detailed problem analysis or for a correct estimation of the effects of a proposed solution to the problem

(Kenis and Schneider, 1991). It requires the consultation of various specialists, resulting in the increasing participation in public policy-making of actors outside the government and in mutual interdependency. Problems can take on another meaning for people with different backgrounds, interests or (power) positions (de Bruijn and ten Heuvelhof, 2000).

Politics

Concerning the formulation of policy issues Stone (Stone, 1997) argues that these are created in the minds of people by civilians, leaders, organizations and governments, and not through objective analysis. Walt (Walt, 1994) and Stone (Stone, 1997) further state that policy-making has less to do with problem solving than with political processes. Problem definition is always a strategic activity to gain support for a certain point of view or a particular position in a conflict; and from problem definition, flow other dimensions such as implementation and imputed significance of other particular policy initiatives.

Communication

The participants in the policy process affect policy-making, each with their specific interests in the matter at stake. The divergent interests of the numerous participants involved in the policy-making process result in a bargaining, negotiation and adaptation process among these participants. De Leeuw (de Leeuw, 2000) argues that the policy process has a complex character because policy-making is increasingly a matter of communication. The opportunities and abilities of participants in a policy network to communicate, and the factual communication and exchange of information, expertise and other resources that take place determine whether policy is made and what its content is (Laumann and Knoke, 1987).

THEORETICAL FRAMEWORK

To capture these central characteristics of policy processes, we built on the Multiple Streams (MS) theory (Kingdon, 1995; Zahariadis, 1999) and the network perspective on policy-making. MS addresses the complexity and unpredictability of (unstructured) policy processes. It differentiates

agenda setting from the specification of alternatives (policy proposals). Policy decision-making occurs at the interface of the development of three streams: problem, political and policy processes, which develop rather independently from each other. Furthermore, MS acknowledges the presence of stakeholders (politicians, media, civil servants, specialists) and emphasizes their roles and actions, in particular, those of policy entrepreneurs, within the problem, political and policy processes. An issue reaches the political agenda when the problem stream is coupled with the political stream. This can happen at a predictable occasion, for example, at annual budget debates, or after a high-impact event, such as a disaster. A decision is made to act on an issue (the issue has reached the policy agenda) when all three streams are coupled. Thus, a problem has been recognized, there is an acceptable solution available and the political climate is right. When this coupling of the three streams takes place, a so-called 'window of opportunity' is open. According to Kingdon, this is the most opportune moment for policy-making. A 'window of opportunity' is open only for a short time and needs the adequate intervention of a policy entrepreneur at that very point in time. Such an entrepreneur is, however, only able to intervene due to permanent readiness and activities in setting the agenda and the specification of alternatives. In this study, we focus on participants and entrepreneurship as central concepts for understanding policy processes.

Although MS points to the importance of individual actors and the interactive character of policy-making, it focuses more on the existence and emergence of *events* in the streams, rather than on the roles of actors in shaping such events. This gave reason to combine the above notions with a network perspective on policy-making.

Thinking about policy-making in terms of policy networks has been triggered by a number of changes in modern society and in concepts of governance and coordination. A highly organized and specialized modern society and government reflected in functional differentiation and 'sectoralization', and many interdependent actors working on common problems seem to have contributed to the fact that policies increasingly result from policy networks (Godfroy, 1993; de Bruijn and ten Heuvelhof, 2000). Also modern ideas about governance emphasize the need for participation and involvement from population or representative

stakeholders. According to Kenis and Schneider (Kenis and Schneider, 1991), contemporary policy arrangements emerge from complex actor constellations and resource interdependencies. The above leads to a discussion of complexity indicating a system of multiple components that cannot be understood by studying them in isolation (Lewis, 2005a).

Lewis (Lewis, 2005a) used the network concept in constructing an overarching framework for analysing health policy. She demonstrates, for example, the policy agenda to be a resultant of that particular network structures linking actors and their concerns. From a theoretical perspective, we used the network conceptualization to describe the interconnectedness of participants in the policy process and to explore their capabilities to influence policy development. In addition, we used network mapping as an analytical technique.

OBJECTIVE: IDENTIFY POSSIBILITIES FOR HEALTH POLICY CHANGE

Legislation in The Netherlands, as stated earlier, requires municipalities to develop and implement health policy. Almost a decade after the first incarnation of the law, however, only 17% of the Dutch municipalities had in fact formulated such policies (GGD-NL and VNG, 2003). As part of an effort by the Central Limburg PHS to establish comprehensive community-based health promotion programmes across the region, we were presented with an opportunity to investigate the drivers and barriers of health policy development at the local level.

Using the MS theory and a policy network perspective, we looked at the composition and change of policy networks and the presence of policy entrepreneurial activity in four municipalities in the region. We assumed that mapping these would enable us to identify patterns and connections in the local policy networks that would allow us to suggest pathways towards policy change and establishment.

METHODOLOGY

The study used qualitative research methods.

- Semi-structured *interviews* with stakeholders identified by snowball sampling and one

Delphi round¹ (health organizations, welfare service and social work, public health officers and aldermen, interest groups). We defined stakeholders as actors who have an interest in the issue under consideration, who are affected by the issue or who have or could have an active or passive influence on the decision-making and implementation processes (Varvasovszky and Brugha, 2000).

- Participative *observation* in meetings at different levels (regional level: the PHS, and municipal level: special organized meetings to discuss local health policy).
- *Document analysis* (long-term policies of the local administration and local health policy memoranda).
- *Stakeholder and network analysis*

Some further explanation on stakeholder and network analysis is necessary here as they are a relatively new addition to the health promotion toolbox.

Stakeholder analysis is popular in organizational analysis, policy analysis and programme development (Brugha and Varvasovszky, 2000). Stakeholders may include individuals, organizations and different individuals within an organization, as well as networks of individuals and/or organizations.

Stakeholder analysis is used as a tool to map the actors who have a stake in a policy, organization or programme and to describe the characteristics of these actors. For example, stakeholder analysis in policy-making is used to create support for policy decisions and commitment for the implementation of policy. This inquiry looked at the following characteristics of identified stakeholders: their ideas about local health policy, interests, collaboration with other actors in public health, influence and the contribution they made towards policy development. These attributes formed the principal constituents of the annual interviews with stakeholders and were also leading in participative observation. Over 3 years, we monitored the change or stability of the characteristics of stakeholders. We were interested in knowing how these characteristics related to the policy development process and whether stakeholders engaged in entrepreneurial activities for policy change.

¹ In each municipality, all stakeholders mentioned by snowball sampling were asked to list the 10 most important stakeholders.

Whereas stakeholder analysis provides information on the set of actors who have a stake in a certain issue, network analysis on the other hand, provides information on the interactions between these actors. In other words, stakeholder analysis describes the actor differentiation whereas network analysis describes the actor integration related to a certain issue.

Network analysis is a tool to describe and analyse the interactions between a defined set of actors. Network analysis considers the presence and absence of relations among actors (individuals, work units or organizations) more powerful in explaining social phenomena, than the attributes of these actors [see e.g. Brass *et al.* (2004) for an overview]. Consequently, actors are embedded within a network of interconnected relationships that provide opportunities and constraints on their behaviour.

In network analysis, first a specific interaction (such as communication or exchange of resources) is described for a specific set of actors (in our case the stakeholders identified). Subsequently, structural characteristics of the actors as well as characteristics of the overall network can be calculated. The most commonly calculated characteristics of the overall network are the *density*—describing the extent to which all actors in the network are linked to each other—and the *centralization* of the network. The most commonly calculated characteristic of an actor in a network is its *centrality*. It describes the extent to which an actor is linked to other actors in the network (Scott, 2000).

We mapped three networks for all four municipalities: communication, involvement in public health action and strategic collaboration (see Figure 1). The data on interaction between stakeholders in these domains were obtained from a structured questionnaire filled in during the interviews. We have calculated density, centralization and actor centrality of the above-mentioned networks, see Table 1. The density measure served our purpose because it gives information about the participation of specific stakeholders in policy-making, their relationships with other actors and their integration in the network. More specifically, it indicates whether the participative and collaborative character of policy processes advocated by health promotion specialists has materialized. The higher the density of the network, the more integrated the network is. That is, the

higher the number of actors in the network that is actually engaging with each other in communication, exchange of resources and other activities of the network. We measured *closeness centrality*, as this concept describes how ‘close’ an actor is to all other actors in the network. As such an indication is given on how centrally embedded specific stakeholders are in the network and, consequently, how they can influence policy-making. Moreover, we used closeness centrality to identify the policy entrepreneur in the network. From a network perspective we assume that the actor closest to all other actors functions as a potential policy entrepreneur.

In sum, we applied stakeholder and network analysis to study (i) the perceived substance of local health policy, (ii) the connectedness and centrality of stakeholders in the policy process and (iii) the presence of policy entrepreneurship.

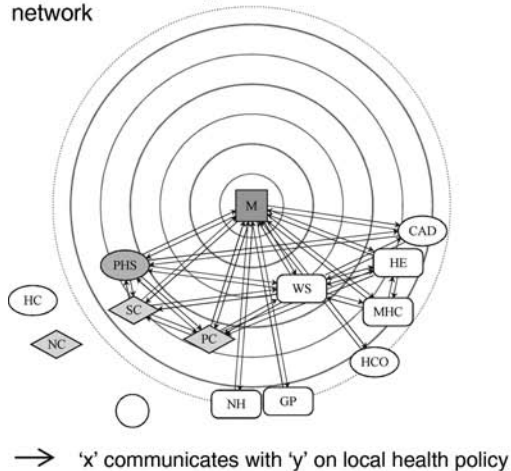
Data on the relations between stakeholders were imported in a series of matrices, used in a computerized statistical program, Visone (www.visone.info) and subsequently displayed in network graphs. Table 1 and Figure 1 show values and network graphs of one municipality. In each, the most central actor is situated in the centre of the graph. Other actors are situated at a relative distance to the most central actor in terms of closeness centrality. This position indicates their ability to easily reach the other actors in the network.

FINDINGS

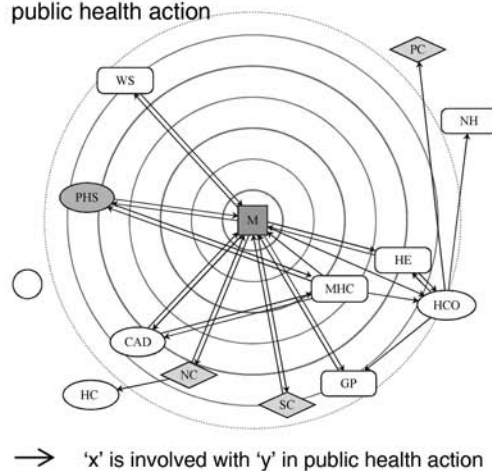
General

This section presents combined findings originating from the different data sources. Most stakeholders in the four municipalities said they participated in local health policy-making. The networks were found to include more (regional) professional organizations than non-professionals, with the professionals having direct access to the municipal authorities. The PHS, although from a managerial perspective very closely related to the municipal authorities, did not occupy a very central position in the networks. In all cases, the PHS provided epidemiological data and gradually became active as a policy advisor and coach. The municipal authorities occupied a central

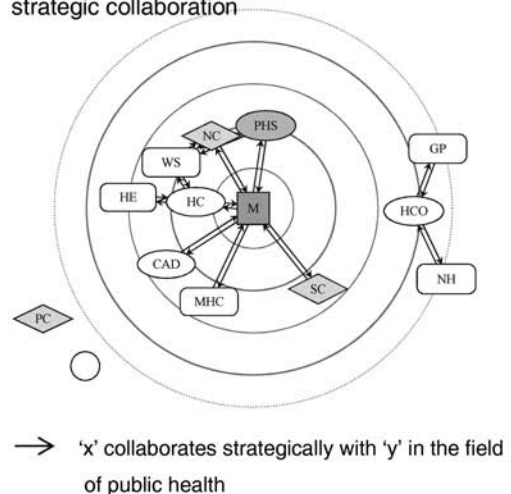
Closeness centrality in the communication network



Closeness centrality in the network of public health action



Closeness centrality in the network of strategic collaboration



LEGEND

- Municipality
- Local professional
- Regional professional
- Public health service
- ◇ Non-professional
- Non-respondent
- ↔ Link between two actors

- CAD Agency for care and treatment of addicts
- GP General practitioner
- HC Housing corporation
- HCO Home care organization
- HE Home for the elderly
- M Municipality
- MHC Regional centre for mental health care
- NC Neighbourhood council
- NH Nursing home
- PC Coordinating platform for health care consumers
- PHS Public health service
- SC Local sports council

Fig. 1: Three distinct networks around health policy development in one municipality.

position in all networks. Other stakeholders assumed that municipal authorities were to play a proactive and coordinating role in policy development. Community groups and organizations were regarded as less important and occupied peripheral positions in the networks, unless they had an official status as advisory committees.

Perceived substance of local health policy

Local health policy did not appear to be of pivotal importance to the operations of stakeholders or their organization. Their involvement in the policy process was reactive, inspired by self-interest rather than population health considerations. Stakeholders contributed their professional knowledge and

Table 1: Indices for three distinct networks around health policy development in one municipality

Indices	Communication	Public health action	Strategic collaboration
Density (0–1)	0.18	0.15	0.13
Actor centrality (%)	Closeness	Closeness	Closeness
Municipal administration	14.07	14.97	14.88
PHS	9.38	9.58	9.92
Welfare service	10.82	8.87	9.30
Centralization (%)	8.34	8.43	8.33

Density is expressed as the ratio of the number of observed relations to the potential number of relations.

Closeness centrality is the sum of the distances to all other actors divided by those actors that have the shortest path to all other members of the network.

experiences as professionals, health care consumers or residents. However, local health policy did not appear on the organizational agenda of participating stakeholders or on the agenda of their collaborative meetings. Their ideas about local health policy are an indication of the prominence of the medical approach to health development. The exception to this general pattern was found among stakeholders from the social sector. These patterns, demonstrating the dominance of the medical model, hamper the development of integrated health policies in view of the socio-environmental approach.

Networks

The pre-policy processes investigated can be best described as policy networks in which three different types of relationships are found to be relevant: communication, involvement in public health action and strategic collaboration. How the different actors are positioned in these three networks in one of the municipalities is exemplarily presented in Figure 1.

Findings were remarkable, particularly in light of pronouncements (by scientists, public health professionals and local authorities) in the area of intersectoral and community action. In communication networks, we found that communication took place among health and welfare sectors during formal meetings organized by municipal administrations. We found professional organizations to have generally more direct access to municipal actors than others. Clearly, in communication networks, municipal administrations occupy a central position. However, due to their operations and attitudes being facilitative rather than coordinative

(findings corroborated from the interviews and observation), they did not act on the prominence of this central position.

In the public health action networks, we found once again a central yet facilitative position of the municipalities, whereas those sectors and actors that supposedly shape important social determinants of health occupied peripheral positions, or were not involved at all. We also found that social work sectors (rather than health sectors) are in such network positions that they can act as effective conduits for network involvement of community groups.

We found actors not to engage in networking for a strategic interest in health issues, but for reasons that serve their primary organizational interests and domains.

The absence of a policy entrepreneur in any network mapped and analysed meant that the processes of alternative specification (presenting organizational benefits of engaging in a wider health policy making endeavour) had failed. This is surprising as the legal requirements and, in particular, the remit of the PHS would suggest that either municipalities or PHS should take up such engagement, being instrumental in health policy-making.

DISCUSSION

Opportunities for policy change

Health policy-making operates in a *complex 'fuzzy' domain* (Goumans, 1998). Health issues are highly connected and actors in health development are interdependent. None of the stakeholders, however, regarded themselves as pivotal in public health concerns, except for the

PHS. All stakeholders had carved out their specific territory in health matters and generally failed to connect towards a comprehensive community-based health promotion model. Participants' unique connections with specific organizational purposes (e.g. the delivery of home care) appear to conflict with the integrated character of health policy. Stakeholders conceived of local health policy as a broad and amorphous domain.

Public health, in our investigation, does not appear to be a public concern. None of the stakeholders we identified could be seen as champions of health policy development. Even the PHS identified itself as an agency primarily engaged in the delivery of technical support, rather than as a key player in policy innovation. Municipal authorities were found to struggle with the comprehensive scope of the legislative parameters for the development of health policy based on broad, social and environmental determinants of health. In spite of new ideas about governance and participative policy-making, integrated and intersectoral health policies are not easily realized.

Following the earlier empirical findings of the MS theory, the policy inertia we have identified can be attributed to (i) the absence of critical events and (ii) the absence of policy entrepreneurial activity that would lead to the opening of windows of opportunity and policy-making. We would postulate that the actions of a policy entrepreneur (Skok, 1995, p.326 establishes that others theorists have described similar roles under different names: 'social entrepreneur', 'issue initiator,' 'policy broker,' 'strategist' or 'caretaker') may enable the generation of such critical events. MS theory also asserts that such stakeholders would engage in strategies of alternative specification and 'softening up the system.' That is, they would liaise with stakeholders on their terms and endeavour to demonstrate organizational benefits in connecting with integrated local health policy development.

Multiple Streams, multiple networks

We have departed from common wisdom and convention in the policy network community (Brandes *et al.*, 1999), describing three distinctly different networks for one policy area. Following a more or less 'Grounded Theory' approach, we followed the lead of our research

population that their network engagement was different for communications, involvement in public health action and participation in strategic considerations. Indeed, the composition (in closeness centrality measures) for these three networks was different at the same point in time. For instance, in a communication network, we would see community groups closer to municipal authority than they would be in strategic considerations. This would lead us to believe that policy entrepreneurial activity should be responsive to such different constellations: interventions in communications networks would be qualitatively and substantively different from interventions in other types of networks.

Following this argument, the active manipulation of network constellations by policy entrepreneurs could be engaged in with much greater strategic foresight. Although in our study we have separated networks for conceptual and analytical purposes, in reality they always overlap. Thus, changing communication constellations would necessarily have an impact on action and strategic networks. For the policy entrepreneur, this would mean that engaging in change in the 'least resistant' network (likely to be a communication network) would result in constellation changes in 'more resistant' networks. From our empirical data, it appears, for instance, that the social work sector, through communicative intervention, would move into more prominent positions in strategic considerations. The 3-year time frame of our study has not allowed us to validate this potential shift; similar studies over a longer period would be able to shed further light on this hypothesis.

In retrospect, our study has failed to contribute more substantively to theorizing on policy development in general. Following the lead of our respondents to distinguish between communication, action and strategic networks has clouded a far more profound insight: Kingdon describes his MS theory in terms of events, and the presence of participants in those events, but not in terms of networks of actors engaging in or separating from events. Rather than distinguishing between communication, action and strategic policy networks, we might have conceptualized Stream Networks (problems–policies–politics). Further research would have to demonstrate whether such an approach would yield meaningful perspectives on the potential for policy entrepreneurial activity.

The promise of stakeholder and network mapping

As far as we know, this article is the first in the health promotion domain to employ stakeholder and network mapping as conceptual and analytical tools for understanding comprehensive health policy development, and the second after Lewis (Lewis, 2005b) to use these tools in the broader health promotion area.

We believe that these approaches should be an integral part of the health promotion development toolbox. Health promotion professionals are typically suited to engage in social and policy entrepreneurial roles; Catford (Catford, 1997) has described the health promotion social entrepreneur as a person that is capable ‘... to analyse, to envision, to communicate, to enthuse, to advocate, to mediate, to enable and to empower’ a wide range of disparate individuals and organizations. Stakeholder and network mapping and analysis would provide us with a relevant, responsive and powerful array of information to engage in such actions.

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