Challenging Health in All Policies, an action research study in Dutch municipalities

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\begin{abstract}
The Dutch government encourages municipalities to develop ‘Health in All Policies’ (HiAP). The development of such a policy requires inter-sectoral collaboration, however municipalities show little initiative in this regard. Operating in an advisory role, the regional Public Health Service (PHS) has supported municipalities in South-Limburg in setting up inter-sectoral collaboration. A coaching program for municipal stakeholders was developed and implemented to improve HiAP, using obesity as an example.

To determine the effectiveness of this coaching program, civil servants, managers and municipal councilors were invited to fill in an Internet questionnaire prior to and at the completion of the program. By means of a log-book all activities were registered in coached municipalities and in-depth interviews were held with municipal managers. Outcomes were scored depending on the stage of HiAP proposals.

Six of the nine coached municipalities showed concrete outcomes in terms of HiAP proposals. The results show that more support and involvement at each system level stimulates the development of HiAP. The program contributed positively to the implementation of HiAP interventions targeting obesity. The pretest results for coached municipalities were better compared to non-coached municipalities. However, after 30 months of coaching this positive starting position faded away. We recommend that the municipal management become more involved in the development of HiAP and advise the PHS to increasingly demonstrate their expertise. Here lies a challenge for municipalities and their regional PHS.

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\end{abstract}

1. Introduction

1.1. Health in All Policies

In the Netherlands, as in many countries worldwide, local governments are held responsible for local public health policy by national law and are obligated to work together with a Public Health Service (PHS, in Dutch GGD) [1]. Municipalities have a central role in providing Public Health Services to improve health and to reduce socioeconomic health inequalities [2]. Lower educated people in the Netherlands live 6–7 years less than those who are highly educated, and they live 14 years longer in poor health [3]. This fact in combination with the high prevalence rates of chronic diseases, obesity and mental health problems implies the need for solutions outside the health domain, which has been cited as ‘Health in All Policies’ (HiAP) [4,5]. The complex policy challenges posed by obesity (40–50\% of the Dutch adult population is obese [3], for instance,
are a good example of the rationale underpinning the presumed need to work in policy networks to tackle this public health concern. Policy domains such as Spatial Planning & Environment, Social Affairs, Traffic & Transportation, Public Safety, Youth & Education, Recreation & Sports need to be involved [6]. So far, there is limited knowledge about how to organize these partnerships at the local level nor the outcome: obesity prevention [7].

The Dutch government encourages municipalities to develop HiAP. The development of such a policy requires inter-sectoral collaboration, however municipalities show little initiative with regard to inter-sectoral collaboration [8,9]. There are very few mechanisms that stimulate local policymakers outside the health domain to consider health determinants and health impacts. Usually each policy domain works to its own logic and own performance indicators without regarding the impact certain measures may have on health of the population. The method of Health Impact Assessment (HIA) provides an opportunity to discuss the health impacts of measures taken by non-health domains but recent research has indicated that this tool is not very effective in the Netherlands. The current emphasis of HIA on a technocratic and rational decision making design obstructs rather than facilitates the integration of health in public policy [10,11]. The evidence-based reasoning in HIA appeared to be not effective, so far. These negative results encouraged the emergence of a coaching program based on the principles of knowledge sharing and dialogue and creating the necessary white space conditions for further progress [12]. Municipal authorities have to define Public Health policy. In most policy plans since 2006 the importance of an integrated approach to, for instance, the obesity problem, is proposed [13]. Operating in an advisory role the regional PHS South Limburg together with the National Institute on Health Promotion and Disease Prevention (NIHPDP) developed a coaching program for nine municipalities in the region to collaboratively find ways to improve HiAP, using obesity as an example.

1.2. Conceptual framework

The process from policy preparation to policy decisions is a hierarchical process, with municipal councilors having the final say, managers or heads of departments in between and the civil servants at the bottom. Therefore, the coaching program distinguished between stakeholders at the strategic or administrative, tactical or managerial, and operational or executive level. A conceptual framework was developed based on theoretically essential determinants of inter-sectoral collaboration, marked in italics, to stimulate inter-sectoral collaboration within and between policy domains [14] (see Fig. 1). The logic behind it is that the realization of HiAP requires agenda setting of a special health concern at the administrative level to give the issue political priority [15,16]. Administrative commitment and leadership are both essential elements to propel an issue onto the political agenda of different policy domains [17]. When policy stakeholders at the administrative level consent to political priority setting, the policy preparation process can be initiated. The managers can facilitate or restrict civil servants in their activities at the executive level. They will have to facilitate the transition towards more collaboration between municipalities’ policy domains including their regional PHS. The transition poses challenges with respect to organizational culture, managerial support and policy capacity [18,19]. Policy capacity relates to available human resources in terms of time, competence, and capability i.e. the ability to adapt to change, generate new knowledge, and continuously improve performance with colleagues in other policy domains [20]. Having realized the preconditions for collaboration at the tactical level, the different executive professionals can initiate co-operation at the operational level. Knowledge, attitudes, perceived social and outcome expectations, and self-efficacy seem to be important personal determinants of both judging one’s own policy frame of reference and of entering another policy domain [19].

This constitutes a system level approach in which collaboration is viewed as a function of individuals and of the environments in which individuals operate. The various levels are viewed as embedded systems [21]. The conceptual framework illustrates the reciprocity between the stakeholders at each level within a municipality, i.e. municipal councilors, managers and civil servants. To create inter-sectoral collaboration the usual communication in a vertical, hierarchical direction needs to be supplemented with communication horizontally between the different policy domains at each system level (see Fig. 1).

1.3. Aim of the study

This study seeks to structurally map and explore the effectiveness of a coaching program which was implemented by the regional PHS South Limburg and the NIHPDP. The aim of the study is to see if municipalities are able to make progress in inter-sectoral collaboration at the strategic, tactical and operational level and in the assessment of HiAP proposals. Findings from this study could help policy makers and PHS-professionals understand how to more effectively develop HiAP proposals.

2. Methods

The development of HiAP is not a discrete event but rather part of an ongoing process in which different policy domains at the three system levels work together. Therefore a participatory action research design was chosen in which intermediary results were given as feedback to the stakeholders for direct broader use. The effect of the program in terms of municipal inter-sectoral collaboration and developing HiAP is evaluated by a pre- and post-test measurement.

2.1. The coaching program

The coaching program aimed to enable municipal inter-sectoral collaboration, and to build HiAP proposals, by addressing stakeholders at the three different system levels. For these aspects the following data is collected:

At the strategic level:
• Three regional conferences were held for municipal councilors with a Public Health portfolio. The conferences addressed the need for agenda setting and advocacy, showing visible commitment and leadership, and creating resources. Political urgency of inter-sectoral collaboration on the issue of obesity was clarified, the coaching program was explained and halfway through the program intermediate results were presented (e.g. agreements in each municipality, successes and problems, steps to continue).

At tactical level:

• The managers were informed by the municipal councilors and civil servants about the coaching program, the need for HiAP and organizational transition, in order to facilitate inter-sectoral collaboration. Managers had to agree to allow a minimal time expenditure of 2 h per week by the relevant Public Health civil servant.

At the operational level:

• A master class for regional civil servants and PHS-professionals on stimulating inter-sectoral collaboration was held. The application of policy instruments e.g. HIA, screening determinants of policy domains, and the quick scan for HiAP [22] on obesity were discussed. For PHS-professionals, four successive sessions were held to attain adequate competency to advise their civil service counterparts.

• Active learning was stimulated by the formation of a trio of the Public Health civil servant from the municipality, the PHS-professional and the health promoter of the NIHPDP. The trios operated from May 2007 until November 2009 and were actively involved in organizing inter-sectoral collaboration during this time. Firstly, they described the local public health status and forecasts, the prevailing political and administrative powers, and the existing community projects. Next, they had a meeting with their municipal councilor to elaborate on eligible inter-sectoral collaboration that could tackle the obesity problem. Subsequently the trio worked through the policy preparation process by analyzing the obesity problem, and formulating attainable goals in term of integrated policy, desired results, an action plan, policy domains to collaborate with, and the time frame. In between they could meet the stakeholders at other levels, on their own initiative. In seven meetings experts trained skills and reflected on new experiments. It was envisaged that the trios would end up with HiAP plans that would be agreed.
on in local government and would therefore be ready for implementation.

2.2. Data collection

In total, 32 municipalities in the Netherlands region of Limburg were involved in this research, including 9 municipalities that decided on voluntary bases to participate in the coaching program to encourage integrated health policy regarding obesity (from now on called the ‘coached ones’). Reasons not to join the coaching program were lack of time and no positive attitude to HiAP.

A mixed method design was used which consisted of an internet questionnaire, logbook registries, and in-depth interviews. A pre- and post-test Internet questionnaire at the start (T0) and 30 months later (T1) was conducted to measure the impact of the coaching program. Nine coached municipalities were compared to 23 non-coached municipalities. Municipal councilors (strategic level), managers (tactical level) and civil servants (operational level) of different policy sectors (Public Health & Welfare, Sports & Recreation, Youth & Education, Traffic & Transportation, Spatial Planning & Environment and Social Affairs) were invited to fill in the questionnaire which measured the relevant determinants of inter-sectoral collaboration at each level as formulated in the conceptual framework (see Fig. 1). These determinants were indirectly measured by means of a number of propositions (see Fig. 1) with an answer category agree/not agree [23]. The number of actual implemented interventions for obesity prevention were investigated as well as the intended interventions.

In the 9 municipalities all activities, contacts, time investment, resources, barriers that influenced the process, were registered by means of a log-book kept by civil servants, PHS-professionals and health promoters of the NHPPDP. In-depth interviews were held with thirteen Public Health municipal managers, including eight managers from coached municipalities, about their role in stimulating municipal inter-sectoral vertical and horizontal collaboration and the development of HiAP [24].

Outcomes were scored depending on the stage of HiAP proposals: score 0 when the coaching had stopped before final date, score 1 when no HiAP proposals had been developed, score 2 when it was in preparation, score 3 when the proposal was completed, score 4 when there was an administrative policy decision, and score 5 when the proposal was implemented [25].

2.3. Data analysis

For each cluster of propositions in the Internet questionnaire Cronbach’s Alpha (α) and scale averages were calculated. Scale averages of the pre-test were subtracted from the post-test results (T1 – T0). All statistical analyses were performed by using ANOVA analyzes (SPSS version 15.0) to check significant differences in sum scores of scale averages to zero (no change in time) and between professionals from coached and non-coached municipalities. Policy capacity is calculated in average available hours per week. Response at T0 was 70% (N=226) and at T1 67.1% (N=206). In total 119 respondents, municipal councilors (N=26), managers (N=35) and civil servants (N=58), filled in the questionnaire two times and these respondents are used in the analyzes. Not all respondents filled in all questions [23,26].

Log-book data was categorized in 24 activities divided in strategic, tactical and operational activities; e.g. to advocate HiAP by councilors, to discuss HiAP progress by manager, to participate in intervision meetings and write a HiAP proposal by civil servants. Each activity was given a score between 0 and 1; score 1 ‘realized’, score 0.5 ‘partly realized’ and score 0 ‘not realized’. Subtotal scores were counted at each system level with a maximum of 8 points at strategic, 7 at tactical, and 9 at operational level [25]. To see if there was a relation between impact and activities of municipal stakeholders on the strategic, tactical and operational level during the coaching program, the log-book scores of the 9 coached municipalities were compared. The assumption was that a higher log-book score i.e. activities at all system levels, would facilitate the development of HiAP proposals.

All in-depth interviews with municipal managers of the Public Health domain were recorded. The recordings were transcribed into key notes and the notes were then linked to the items in the conceptual framework. An independent researcher repeated the procedure: overall agreement was 87.1% [24].

3. Results

3.1. HiAP proposals

Six of the nine municipalities where the coaching program was delivered showed concrete outcomes of HiAP proposals. Two municipalities withdrew from participation prematurely (score 0). One municipality could not achieve any policy result (score 1). In three municipalities the issue of health promotion was included in policy documents that were in preparation (score 2). One municipality included a health check for obesity in spatial planning and environment policy proposals that were completed and ready for decision (score 3). In one municipality a new policy procedure was accepted stating that the Public Health civil servants should participate in multi-sectoral consultations about environmental policy proposals. To support the civil servants knowledge and skills, a manual was developed together with the regional PHS (score 4). Finally, one municipality purchased an existing evidence-based HiAP intervention for people in debt [27] which could be implemented immediately (score 5). Within coached municipalities the log-book score was positively associated with the outcome score: the higher the log-book score the higher the outcome score in terms of HiAP proposals (see Fig. 2). With regard to actual number of implemented interventions for obesity prevention, there was a significant increase in coached municipalities compared to the non-coached ones but the intention to implement new interventions in the future had decreased. Furthermore, there was a little, but not significant increase in political priority and frequency of consultation (see Table 1).
Table 1
ANOVA analyses pre- and post-test of determinants in inter-sectoral collaboration targeting obesity (N = 119).

<table>
<thead>
<tr>
<th>Integrated health policy on obesity</th>
<th>N</th>
<th>N</th>
<th>N</th>
</tr>
</thead>
<tbody>
<tr>
<td>Municipal priority obesity (average score; range: 0–3; $\alpha 0.817$)</td>
<td>119</td>
<td>0.32</td>
<td>42</td>
</tr>
<tr>
<td>Obesity in municipal consultation (average score; range: 0–3; $\alpha 0.783$)</td>
<td>119</td>
<td>0.14</td>
<td>42</td>
</tr>
<tr>
<td>Obesity interventions within municipality</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Obesity interventions implemented</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Only civil servants (average score; range: 0–12; $\alpha 0.736$)</td>
<td>31</td>
<td>1.10$^*$</td>
<td>11</td>
</tr>
<tr>
<td>Obesity interventions planned</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Only civil servants (average score; range: 0–12; $\alpha 0.736$)</td>
<td>31</td>
<td>$-0.52^*$</td>
<td>11</td>
</tr>
</tbody>
</table>

* Averages who significantly differ from zero = $p < 0.05$.

3.2. HiAP at different system levels

3.2.1. The strategic level

Comparing scores between coached and non-coached municipalities showed significant differences between pre- and post-test scores for political priority but not for administrative commitment. The political priority decreased in coached municipalities. During the intervention period two municipal councilors with Public Health in their portfolio changed their positions.

3.2.2. The tactical level

All 32 municipalities showed significantly higher scores on the issue of managerial support for HiAP at the first measurement compared to the measurement 30 months later (see Table 2). Comparing scores from coached and non-coached municipalities showed no significant differences between pre- and post-test scores for managerial support and organizational culture, although civil servants from coached municipalities judged the cooperation with the regional PHS more positive, both at the start of the coaching program and still 30 months later. In coached municipalities, managerial support decreased more compared to the non-coached municipalities (see Table 2). Compared to stakeholders at the other system levels, the managers were the least positive about the possibility of developing HiAP. In most municipalities the policy domain of Public Health is part of a department with a large scale of tasks. Only a very small part of the policy capacity of the department is available for Public Health (on average 8 h a week (range 4–32)). The average available hours of coached civil servants increased slightly from 11 to 16 h a week.

The in-depth interviews with managers of Public Health showed the importance of HiAP for their municipality. Managers stated that nobody should be against it. They said that HiAP and inter-sectoral collaboration requires an organizational change and emphasize that this is difficult to accomplish. Regarding the aspect of management support, only a few managers actively stimulated HiAP within their own department, experienced administrative support and they said that HiAP is translated in policy documents. At the tactical level collaboration with other policy domains is often absent, including collaboration with the PHS. Links to other policy domains are mainly forged at the level of municipal councilors and civil servants. Managers feel themselves hierarchically responsible for Public Health, but their involvement on content is very limited and delegated. Managers ask the PHS to be more proactive in making municipalities aware of their expertise in the area of inter-sectoral collaboration to support municipalities in developing HiAP.

3.2.3. The operational level

There were no significant differences in knowledge about HiAP, attitudes, self-efficacy and perceived expectations at the first measurement compared to the measurement 30 months later (see Table 2). Comparing scores between coached and non-coached municipalities showed no significant differences either between pre- and post-test scores, although the perceived expectations and self-efficacy of coached civil servants had increased, but not significantly due to low number of respondents (see Table 2).

Forty-six percent of the civil servants not working in the Public Health domain do not have any ground in common with the obesity problem. Only a few civil servants state that they have the intention to develop HiAP interventions targeting obesity, such as stimulating a healthy school canteen, no license for fast-food companies near schools, no dogs allowed on playfields and healthy food instructions for people in debts [23,27]. During the intervention period six of the nine coached Public Health civil servants changed their positions.

4. Discussion

This study provides insight into the effectiveness of a coaching program which was implemented in nine South
Table 2
ANOVA analyses pre- and posttest of determinants in inter-sectoral collaboration (N=119).

<table>
<thead>
<tr>
<th>Determinants on strategic level</th>
<th>Post minus pre</th>
<th>Coached municipalities</th>
<th>Non-coached municipalities</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N</td>
<td>N</td>
<td>N</td>
</tr>
<tr>
<td>Political priority (average score; range: 0–7; α 0.786)</td>
<td>119 −0.08&lt;sup&gt;a&lt;/sup&gt;</td>
<td>42 −0.45&lt;sup&gt;a&lt;/sup&gt;</td>
<td>77 0.12&lt;sup&gt;b&lt;/sup&gt;</td>
</tr>
<tr>
<td>Administrative commitment (average score; range: 0–3; α 0.713)</td>
<td>119 0.15</td>
<td>42 0.00</td>
<td>77 0.23</td>
</tr>
<tr>
<td>Determinants on tactical level</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Managerial support</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Only civil servants Public Health (average score; range: 0–2; α 0.775)</td>
<td>14 −0.29&lt;sup&gt;a&lt;/sup&gt;</td>
<td>3 −0.66</td>
<td>11 −0.18</td>
</tr>
<tr>
<td>Organizational culture</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Only respondents with PHS contacts (average score range: 0–7; α 0.732)</td>
<td>57 −0.23</td>
<td>23 0.09</td>
<td>34 −0.44</td>
</tr>
<tr>
<td>Determinants on operational level</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Attitude (average score; range: 0–4; α 0.831)</td>
<td>119 0.27</td>
<td>42 0.24</td>
<td>77 0.29</td>
</tr>
<tr>
<td>Knowledge (average score; range: 0–2; α 0.754)</td>
<td>119 −0.03</td>
<td>42 0.10</td>
<td>77 −0.10</td>
</tr>
<tr>
<td>Self-efficacy</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Only civil servants Public Health (average score; range: 0–4; α 0.790)</td>
<td>14 −0.14</td>
<td>3 0.67</td>
<td>11 −0.36</td>
</tr>
<tr>
<td>Perceived expectations</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Only civil servants Public Health (average score; range: 0–19; α 0.887)</td>
<td>17 0.77</td>
<td>10 1.60</td>
<td>7 −0.42</td>
</tr>
</tbody>
</table>

<sup>a</sup> Significant differences of averages with a column = p < 0.05.
<sup>b</sup> Significant differences of averages with a column = p < 0.05.
<sup>c</sup> Averages who significantly differ from zero = p < 0.05.

Limburg municipalities in the Netherlands. We answered the question of whether municipalities are able to make progress in inter-sectoral collaboration at the strategic, tactical and operational level and in the assessment of HiAP proposals. We found that the coaching did not contribute to improvements in the determinants of inter-sectoral collaboration at the strategic and tactical level (see Table 2). On the contrary, the determinants in coached municipalities got worse, especially with respect to political priority and managerial support. At operational level self-efficacy and perceived expectations improved in coached municipalities whereas these factors decreased in the non-coached ones. Concrete for the health problem obesity the effects are stronger and more positive (see Table 1).

The results of the study further showed that there is a relation between log-book scores and HiAP proposals. In other words, more support and involvement of the stakeholders at each system level is related to the development of HiAP proposals (see Fig. 2). Stakeholders at tactical level were difficult to involve and, in the eyes of coached civil servants the managerial support for HiAP decreased. Managers acknowledged this, simultaneously challenging the professionals of the regional PHS to show their expertise in HiAP and take the lead. Finally, we found that the coaching seemed to have positively contributed to the municipal priority setting of obesity and the actual implementation of HiAP interventions targeting obesity (see Table 1).

4.1. Improvements of coaching program

Looking back at the coaching program its final effect in general was very limited. There are different reasons for its failure. Firstly, our coaching program focused on stimulating the dialogue between different municipal policy domains, especially at the levels of civil servants and municipal councilors with Public Health in portfolio. They were coached to search for possibilities to participate in the policy preparation process of other policy domains. However, stimulating inter-sectoral collaboration requires involvement at the strategic, tactical and operational level, both vertically within a policy domain and horizontally with other policy domains [14]. We may have insufficiently focused on horizontally organized managerial support. An interface between managers from the municipality and managers from the regional PHS was not created, making it difficult to create a sense of urgency for HiAP and to capitalize on opportunities for management support.

Secondly, the in-depth interviews with municipal managers revealed that they were prepared to invest in time and personnel if the merits of collaboration with other policy domains were made clear. Apparently, neither the trio that coached the municipalities nor the regional PHS have been able to show the merits of inter-sectoral collaboration, so far. The PHS should take this advice seriously and invest in competency and capability improvements of their professionals with respect to HiAP. Moreover, the very limited capacity within the municipality makes support from the regional PHS inevitable.

Thirdly, we did not formulate clear targets beforehand as we thought we would set these targets along with all stakeholders during the training sessions. No municipality dared to set fixed goals during the policy preparation process. This is not so remarkable because policy proposals merely state these goals in ambiguous terms e.g. of maximizing well-being. The goal-seeking process serves consensus and cooperation, both in terms of party politics and with various external groups [15]. Recent literature however shows that clear health targets and instructions on how to reach these targets can stimulate inter-sectoral collaboration [28–30].

Fourthly, the Netherlands lacks a national strategy in which inter-sectoral collaboration is a formally established rule or law such as in the United Kingdom, Finland or Sweden [29,31,32]. There are no public bodies at the national level that make HiAP a requirement apart from the permissive legislation of the Ministry of Health, Welfare and Sport [1]. Therefore, at the local level HiAP is in its infancy and knowledge and skills improvements depend
on goodwill. Thus far, Dutch municipalities are confronted with inadequately and insufficiently developed expertise [8,9]. Municipalities are also not aware of the positive effects that health might have on the local economy and residents’ participation [31,33]. Our coaching program incidentally contributed to some progress in self-efficacy and perceived expectations among civil servants but cannot structurally support the development of HiAP-expertise as long as there is no national obligation delegated to local public health bodies.

Finally, professional discontinuity, especially at operational level made it difficult to raise knowledge and skills within the municipality. In the eyes of civil servants the support from their manager was inadequate. Without such support professionals at the operational level have no authority to change their practices, even if they themselves should prefer to work more horizontally. Therefore, managerial support is essential for innovations [34].

4.2. Opportunities to stimulate municipal inter-sectoral collaboration

Literature shows the complexity of developing HiAP. The process needs coordination, focus and a long term horizon [4,35]. Moreover, within Dutch municipalities, Public Health has not been a strong or dominant policy framework for very long. The local economy, employment, or social security, for example, are dominant policy frameworks in which public and private bodies more or less automatically invest without external obligation. Policy actions focusing on behavioral lifestyle determinants are considered moralistic and may be politically controversial because they interfere in people’s private lives [30,36,37]. For legitimization of public health, the environmental dimension of health should be more explicitly defined [38], thereby offering opportunities for HiAP proposals. This has to be explained by experts such as the regional PHS, because policy stakeholders often are not aware of the health impact of certain measures taken by, for instance, spatial planning [39]. To counteract the weakness of the Public Health policy framework, a strong and long term commitment is needed from mayors and municipal councilors including instituting decisive measures and resources regarding HiAP [30,40]. They should also enforce adjusted performance indicators at tactical level that go beyond one’s own policy domain [4,12,29]. The manager should ensure both vertical connections within their own policy domain and horizontal connections with other local policy domains and external partners [41,42]. Both the national government and local authorities should be aware that inter-sectoral collaboration, which is necessary to develop HiAP, is not realistic without strong guidance. The poor results so far in developing HiAP are perhaps not so much due to the reluctance of non-public health policy domains, but rather because of powerlessness and lack of expertise in the domain of Public Health. Crucial in this context is the recognition that health does not have to be a primary goal in itself, but a means to other, more overarching community goals such as promoting social security, social cohesion, social inclusion and quality of life.

4.3. Limitations of this study

It appeared difficult to determine the effectiveness of a coaching program and to measure progress in HiAP within local governments [43]. To our knowledge little research has been done nationally or internationally on HiAP by municipal stakeholders. The research is based on only 9 of the 418 municipalities in the Netherlands. There are no validated questionnaires to measure inter-sectoral collaboration. The Internet questionnaire developed for this study was based on theoretical insights and practical experience. The self-reported findings from the respondents can never completely rule out the risk of social desirability. Furthermore, the willingness to participate in this study fully depended on the delivery of email addresses by civil servants. The decision to participate in coaching was done on a voluntary basis, so municipalities that already had a positive attitude towards HiAP could have signed up for this program (selection bias). This better starting position may have influenced the results, because changes are then difficult to realize and coaching may have a negative effect because people realize how difficult HiAP is.

These results are a first indication of the possibilities for local government to participate in HiAP development. Future research is needed on how health can be connected to other policy domains, and what the positive and negative influences of health can be on the main targets of other policy domains.

5. Conclusions

The results show that the effects of the coaching program are in general very limited and uncertain although it had a small positive effect on HiAP proposals targeting obesity. Within municipalities HiAP proposals are not given a high priority, at the strategic level nor at the tactical level. The results of the study further showed that more support and involvement of stakeholders at each system level is related to the development of HiAP proposals.

Stimulating inter-sectoral collaboration in relation to specific health problems requires institutional involvement at all levels and not only with the Public Health sector. We therefore recommend to municipal management to get directly involved in the development of HiAP. With the energetic guidance on management level and input of knowledge and skills from the regional PHS, HiAP can perhaps be more successful than has been the case to date. Here lies a challenge for municipalities and their regional PHS.

Acknowledgements

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