Case study:

Role of entrepreneurs in Health in All Policies – Lessons from a regional coaching programme in the Netherlands

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Produced by the UK Health Forum and commissioned by the Health Foundation.

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Summary

Limburg is the southernmost of the Netherlands' 12 provinces. In 2007, the South Limburg regional Public Health Service (PHS) developed a coaching programme and offered it to South Limburg's 18 municipal authorities. The aim of the programme was to upskill public health staff to facilitate intersectoral collaboration and develop Health in All Policies (HiAP) proposals to address obesity. The programme was developed with the National Institute of Health Promotion and Disease Prevention (NIHPDP). Nine South Limburg municipalities volunteered to participate in the coaching programme.

The coaching programme involved four main components:

- There were three conferences for elected councillors to highlight the urgency of intersectoral collaboration to tackle obesity; the need for a HiAP approach; and the need for strong leadership.
- A masterclass was held for the participating municipalities' public health civil servants and for staff in the regional PHS on how to stimulate intersectoral collaboration on obesity.
- Four training sessions were run for the regional PHS staff to develop their competency to advise their civil service counterparts.
- Action learning sets brought together a regional PHS staff member, a public health civil servant from a municipality and a health promotion specialist from the NIHPDP to develop cross-sectoral action plans on obesity over a 30-month period.

The coaching programme was evaluated through a combination of before and after surveys, in-depth interviews and log-books kept by the active learning set participants. All 32 of Limburg's municipalities took part in the evaluation. The coaching helped to raise awareness of the importance of intersectoral collaboration on obesity and six of the nine participating municipalities developed concrete HiAP proposals. The evaluation found that those municipalities that participated in the coaching programme did so because of established relationships with the regional PHS.

Framing the coaching around obesity failed to engage the other nine South Limburg municipalities because it was seen as a health issue and at the time other policy areas were taking priority. This framing also reduced the interest of the other sectors. The development of integrated obesity policies among the participating municipalities was limited. One explanation for this was that the civil servants lacked sufficient seniority or power to fully implement multisectoral action, and the programme failed to garner the necessary support from their managers to overcome this.

Lessons for UK public health include:

1. Frame health issues such as obesity in language that enables non-health actors to see the relevance to them and how collaboration will help meet their priorities.
2. Design coaching programmes to take account of, and address, power imbalances that might otherwise limit staff's authority to act.
3. Recognise that middle managers are a key enabler and engage them fully in organisational development programmes.

Introduction

This case describes a coaching programme delivered in the Netherlands province of Limburg that was designed to support intersectoral collaboration and the development of integrated policies for the prevention of obesity (see timeline below). It is informed by an interview with an employee from the South Limburg regional Public Health Service (PHS), and by correspondence with an academic researcher who studied Health Impact Assessment (HIA) in the Dutch context.

Timeline

Year	Event
1990s	HIA starts to be used in the Netherlands[1]
1995	HIA formally introduced in the Netherlands in a government White Paper[2]
1995–2003	HIA explored by government, which establishes the Intersectoral Policy Office at Netherlands School of Public Health to undertake HIAs and coordinate results[1]
2002	Publication of the Public Health (Preventive Measures) Act, handing responsibility for integrated health policy onto the municipalities[3]
2003	Intersectoral Policy Office integrated into the National Institute of Public Health and the Environment; funding for HIA of national policies ceased[1]
2007	Health in All Policies (HiAP) coaching programme begun in Limburg province:[4] • Three conferences held for elected councillors from the nine participating municipalities • A masterclass held for civil servants from the participating municipalities and for staff from the South Limburg regional PHS • Four training sessions held for South Limburg regional PHS staff
2007–2009	Action learning sets established, involving civil servants from the participating municipalities, staff from the South Limburg regional PHS and staff from the National Institute of Health Promotion and Disease Prevention, meeting seven times over 30 months
2007–2009	Evaluation conducted by the South Limburg regional PHS, in partnership with three departments of the Care and Public Health Research Institute of Maastricht University, and the Academic Collaborative Centre for Public Health Limburg
2009	The coaching programme ended
2012	Publication of the evaluation report[4]

Description of the policy

System of government in the Netherlands

The Dutch government consists of the King and his Cabinet, which initiates national laws and policy. The Dutch parliament, officially known as the States General of the Netherlands, comprises the House of Representatives and the Senate. Members of the House are elected every four years by the public and can propose or amend legislation. Members of the Senate are elected indirectly by provincial councillors every four years, and they debate the legislation that the House puts forward.[5]

The Netherlands is divided into 12 provinces that have devolved responsibility for a number of policy areas including health, spatial planning and recreation.[5] The provinces oversee the policies and finances of the municipalities. Limburg is the southernmost province and its capital is Maastricht.[6] Local government in the Netherlands is through 418 municipalities.[5] They are governed by the College of Mayor and Aldermen. The mayor is appointed by the national Cabinet and is responsible to the Minister of the Interior and Kingdom Relations. The aldermen are appointed by and responsible to the municipal council, which is elected by the public. The College of Mayor and Aldermen receives policy proposals for review before they are presented to the municipal council for a final decision.

The four-year term of elected councillors means policies that deliver visible results within the four-year period tend to be prioritised. Childhood obesity has been a neglected area of policy because a reduction in population body mass index will only be observed beyond this four-year timeframe.[7]

> *'Most council members are not terribly interested in health policy […] What they're interested in is housing, spatial planning. That's what they like. Because that's what citizens ask them about. They talk about the pavement being new, or grass not being mown in time, or a tree not being pruned in time. Those are the things they notice. But health policy, that's something citizens don't see… They're politicians. They want to score with the electorate…They want to be re-elected in four years' time.'*
>
> Source: Alderman responsible for public health and spatial planning[7]

25 regional PHSs, funded jointly by the municipalities and the state, support the municipalities with their devolved responsibility to develop and implement health policy.[4]

As part of this function, the regional PHS employs dedicated account managers who are tasked with developing and managing relationships between the PHS and the municipality.

> *'So [the account manager's] job was to make the connection between our organisation and the municipalities. Everything [PHS] wanted to talk about health with the municipalities, [PHS] first said, "Well, we have a big organisation with lots of people working. If you want to come and engage with the municipalities, we do it in one way". Four times a year, we have a meeting and we ask them what they want to know and we suggest subjects.'*
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> Source: Former South Limburg regional PHS account manager

HIA in the Netherlands

HIA was introduced in the Netherlands in the 1990s. According to Bekker,[1] HIA was initiated by a municipal health service director who perceived a specific need to review non-health policies for their health impacts at a time when Rotterdam Airport was being expanded in a densely populated area. The director urged the Dutch Minister of Health, Welfare and Sport to formally introduce HIA. The Minister was a medical doctor by background, with research papers to her name, and she was receptive to the argument. She recognised the need to have a tool that developed the scientific evidence of impact of non-health policies on health and she introduced HIA in a government White Paper in 1995.[2]

HIA was explored at a national policy level, and an Intersectoral Policy Office was established at the Netherlands School of Public Health to undertake HIAs and coordinate the results.[1]

The 2002 Public Health (Preventive Measures) Act

Unfortunately the HIA approach worked against the Dutch tradition of consensual politics.

> *'[HIA] was perceived as a rather naïve tool producing nasty side effects in negotiating processes within the Ministry as well as with other Ministries who in return wanted to conduct their Environmental, Social, Cost-Benefit, Educational, Business, etc impact assessments on healthcare policies. Not something high Ministry officials are keen on.'*
>
> Source: Academic researcher studying HIA

As a result, the Minister was forced to back down on HIA nationally.[1] A new Public Health (Preventive Measures) Act[3] was introduced in 2002 that gave municipal authorities the responsibility to develop cross-sectoral policies and to scrutinise non-health policies for their health implications. In 2003, the Intersectoral Policy Office was moved and integrated into the National Institute of Public Health and the Environment, and funding for HIA of national policy was ceased.[1]

> *'At the municipal level, there are many opportunities to exert a positive influence on health from within various disciplines, including education, environmental management, spatial planning and housing. Under the 2002 Public Health (Preventive Measures) Act, municipal authorities are obliged to pursue an integrated health policy. […] Central government has a role to play encouraging integrated policy planning, while the municipal executive must accept responsibility for identifying and exploiting the opportunities that exist.'*
>
> Source: Ministry of Health, Welfare and Sport, The Netherlands[8]

Despite the importance afforded by the 2002 Public Health Act to the development of integrated health policy at the local level, this approach was not enforced or incentivised and therefore the integration of health into wider public policy was patchy.[4]

Promoting HiAP in Limburg province 2007–2009

The province of Limburg is a former mining area occupying the southernmost area of the Netherlands. Limburg is made up of 32 municipalities.[6] Our key informant described how, as a result of its industrial heritage, the province now experiences high levels of intergenerational

unemployment and poor health outcomes including some of the highest rates of obesity in the Netherlands.

Recognising that cross-sectoral collaboration is critical for tackling issues like obesity, the South Limburg regional PHS, which provides support to the 18 South Limburg municipalities, secured research funding to deliver a participatory action research study exploring a new way to facilitate a HiAP approach. Together with the National Institute of Health Promotion and Disease Prevention (NIHPDP), they developed a coaching programme in 2007 for public health staff working in South Limburg's municipalities.[4]

The purpose of the coaching was to upskill the public health staff to facilitate intersectoral collaboration and to develop a number of cross-sector HiAP proposals. Obesity was chosen as the policy area to focus on. The sectors targeted included public health and welfare, sports and recreation, youth and education, traffic and transportation, spatial planning and environment, and social affairs. Nine South Limburg municipalities volunteered to participate in the programme.

In Dutch municipalities, policy development takes place at three levels:[4]

1. At the administrative or strategic level, elected officials and political appointees (aldermen, the mayor and the municipal council) agree the priorities and provide the political leadership and commitment to an issue.
2. At the tactical level, heads of municipal departments facilitate (or restrict) the civil servants in their activities, set organisational culture and identify the capacity and resources for delivery.
3. At the operational level, civil servants prepare policies and deliver programmes. Personal attributes such as knowledge and self-efficacy play their part.

The South Limburg regional PHS adopted a conceptual framework for the coaching programme that described the need to support effective vertical collaboration between the public health staff working at the three levels, as well as supporting the effective horizontal collaboration between public health staff and their counterparts in other sectors.[9]

The four components of the HiAP coaching programme

1. Three conferences were held for the elected councillors of the nine participating municipalities. These events were intended to reinforce the councillors' role as leaders, to achieve their buy-in to the political urgency of intersectoral collaboration to tackle obesity, and to gain their support for a HiAP approach.

   'We did it on high level for all aldermen, with speakers from all over the country to let them see why this was important and why it was important for this area to work on it. So we wanted to make it a priority for them and show them that we wanted to support.'

   Source: Former South Limburg regional PHS account manager

2. A masterclass was held for the public health civil servants from the nine participating municipalities and for their counterparts in the South Limburg regional PHS. The purpose was to increase their knowledge about different approaches for stimulating intersectoral collaboration on obesity such as HIA.

3. Separately, South Limburg regional PHS staff were given four training sessions to develop their competency to support and advise the municipalities about HiAP and cross-sectoral collaboration.
4. South Limburg regional PHS then established action learning sets, each comprising one of their own staff members, a public health civil servant from a municipality, and a health promotion specialist from the NIHPDP. These learning sets operated from May 2007 until November 2009. First, they analysed their local obesity problem, their existing community projects and the prevailing political and administrative powers. They then met with their relevant municipal councillors to discuss appropriate intersectoral collaborations that could tackle the obesity problem. Subsequently the trios formulated action plans and also met seven times with experts to develop further skills. It was envisaged that the learning sets would develop HiAP plans that would be agreed by the municipalities and be ready for implementation within the programme's timeframe.[(4)]

It should be noted that the regional PHS staff had no engagement with municipality staff at the managerial level.

> *'But I noticed in my research that our regional public health service also didn't talk with the managerial level. We did not have any connections. We had connections with aldermen and with civil servants, but not with the managers. We did not talk with them.'*
>
> Source: Former South Limburg regional PHS account manager

Information about the coaching programme was passed on to managers by the municipal councillors and the civil servants.[9] This information included the importance of HiAP, and the need to transition towards ways of working that facilitated intersectoral collaboration. Managers had to agree to allow their civil servants to spend a minimum of two hours per week on the programme.

Evaluation

An evaluation of the coaching programme was conducted between 2007 and 2009 by the South Limburg regional PHS in partnership with the Care & Public Health Research Institute of Maastricht University, and the Academic Collaborative Centre for Public Health Limburg.[4] The evaluation involved all 32 municipalities in the Limburg province.

Elected councillors, senior managers and civil servants across different policy sectors (public health and welfare, sports and recreation, youth and education, traffic and transportation, spatial planning and environment, and social affairs) were invited to fill in a questionnaire at the start of the coaching programme and 30 months later.

In the nine participating municipalities, all activities, contacts, time investment, resources, and barriers that influenced the process, were registered by means of a log-book kept by civil servants, regional PHS professionals and NIHPDP health promotion specialists.

In-depth interviews were held with 13 public health municipal managers, including eight managers from the coached municipalities, about their role in stimulating municipal intersectoral collaboration and the development of HiAP.

Outcomes

- Nine out of 18 municipalities chose to engage in the programme. Those that participated reported that this was largely as a result of their civil servants and/or elected councillors having been in post a sufficiently long time to have built up good working relationships with staff at the regional PHS.[4] They were therefore more open to collaborating with the public health body on a new approach.

  'I was one of the persons who went to the municipalities to speak about health policy, to speak with the aldermen about health policy. So if you have a good connection with the aldermen, if they feel connected with the regional public health service, then it's easier to announce this project and to announce that we want to do something new and we want to stimulate. Then they say, "Oh, yeah, let's try." […] Those nine that were people who were interested, working a little bit longer, wanted to do something new, something special, and that makes them more open for a new project.'

  Source: Former South Limburg regional PHS account manager

- Senior managers among those municipalities that did not engage in the project reported they did not feel that the merits of intersectoral collaboration had been sufficiently well demonstrated to make them want to invest their team's already stretched capacity in taking a HiAP approach.[4]
- The coaching positively contributed towards municipalities making obesity a priority and to the implementation of HiAP interventions targeting obesity.[4] Six of the nine participating municipalities developed concrete HiAP proposals:
  - In three municipalities, health promotion was included in non-health policy documents that were in preparation.
  - A fourth municipality included a health check for obesity in spatial planning and environment policy proposals.
  - In a fifth municipality a new policy procedure was accepted stating that the public health civil servant should participate in multisectoral consultations about environmental policy proposals. To support the civil servant in this municipality with knowledge and skills, a manual was developed in conjunction with the regional PHS.
  - The sixth municipality purchased an existing evidenced-based HiAP intervention for people in debt that could be implemented immediately.
- Among the three participating municipalities that did not develop concrete HiAP proposals, two withdrew from the coaching programme prematurely because of competing priorities, and one did not get as far as developing concrete proposals in the timeframe of the project.[4]
- The coached civil servants recorded that their perceived expectations and self-efficacy increased over the 30-month period.
- Over the 30-month period, the managerial support given to HiAP decreased among the participating municipalities. This lack of support from managers meant that the coached civil servants felt they had no authority to change their practice and influence others and this was a barrier to the programme's effectiveness.[9]

- The coaching programme modelled HiAP by taking obesity as a working example and supporting public health civil servants through the policy development process. However, high staff turnover meant that HiAP knowledge was quickly lost and with it the programme's momentum. Similarly, a turnover among portfolio holders at the leadership level impacted on the senior commitment to HiAP, which decreased over the coaching period.[4]

Lessons learned

The lessons from the case study based on what worked are limited.

Some valuable lessons can be drawn from what did not work, in particular other strategies that need to be in place in order for such an approach to be successful and sustainable.

1. The need to address leadership and performance.

   The lack of outcomes and the reducing attention on HiAP over the course of the programme were attributed both to the turnover among civil servants and leaders, and to a lack of engagement from managers.[4] The coaching programme may have had greater success if it had included a component that was focused on how HiAP could be embedded more formally into the organisations' ways of working to remove the reliance on key individuals.

   'They were interested when I did my promotion. They were interested and I got a lot of positive feedback. But those people are now already changed. Four years later, they have changed. So the knowledge of my research, maybe one in ten will know and the others, there is no history on it, the knowledge is gone.'

   Source: Former South Limburg regional PHS account manager

   It is clear from the programme's outcomes that future coaching programmes need to pay more attention to the managerial level, since managers have the power to set priorities, allocate resources and empower their staff. Senior leadership commitment could include making changes to management roles and responsibilities so that cross-sectoral working becomes a performance issue, both in terms of empowering and supporting civil servants to deliver HiAP, and also in driving the development of managers' own relationships with other policy areas and with regional PHS staff.[4]

   'And we still now, four or five years later, don't have a lot of efforts we do on that managerial level. So it's difficult to make connections and speak to them at the right level, because they don't work with the issue of obesity. They have a lot of things to manage and they don't want to go into the subjects.'

   Source: Former South Limburg regional PHS account manager

2. The importance of framing.

   Of the 18 South Limburg municipalities invited to participate in the coaching programme, only nine took up the offer and this was because of strong personal relationships with the regional PHS, rather than because they were persuaded by the topic or the approach.[4]

   At the time the coaching programme was introduced, there was greater focus in municipalities on other priorities such as tackling unemployment. By framing the coaching in health language (obesity), many of the municipalities were unable to see what was in it for them.

'Especially with respect to the political priority. Obesity was not a political priority. And managerial support, well, there was almost no support for obesity because we had other issues that were more and more important for the region.'

Source: Former South Limburg regional PHS account manager

Further, tackling obesity may have implied individual behaviour change approaches, which can be politically controversial because they interfere with people's private lives.[9] Changing the framing to describe nudge policies such as influencing the physical environment, or describing other outcomes like quality of life or social inclusion[7] may have led to greater take-up among municipalities and greater involvement among the non-health departments.

This framing was identified as something that the PHS would have done differently were it to do the process again, as is illustrated by the reflective quote below:

'We from the health sector, we wanted this priority. But I think, if I look back, I could say, well, in the health field there was a priority, but if I would do it again, I would research more on the priorities in the whole field. […] What are the priorities and is there a health issue that can influence that other priority? […] If you are able to let them see what health does in environmental things or in schools or in other work fields, if you can make sure what the effort is … If you do something good in health, what it will do for progress on the other fields. Then they are very interested.

'Don't call it health. You want better health, but don't always call it health in the first place. Call the other issues first and don't hesitate to do a step back and say, Well, we as health professionals, we wait and see where we can put things together.'

Source: Former South Limburg regional PHS account manager

3. The need to upskill the coaches.

As described by our key informant, the regional PHS staff relied on existing relationships with municipality leaders to get sign-up to the coaching programme. Where these relationships didn't exist, the staff lacked the influencing skills to persuade leaders of the relevance of the topic or the approach. The ability to reframe arguments and present data in different ways for different audiences is important: information for politicians should be simple and relate to their priorities, while civil servants need more in-depth information about the causes and solutions.[7]

'As health workers, we think we have to speak about health. And if you want to do integrated work, then maybe we should not speak about health […] I think we, as health workers, also make a problem ourselves, because we are not able to make the extra connection […] People in the regional health service can use some education on that part.'

Source: Former South Limburg regional PHS account manager

The coaches assumed that the process of cross-sectoral collaboration would lead to a consensus on the obesity reduction targets that each municipality wanted to achieve. However, this ambition was not realised and in hindsight, the setting of clear health targets and provision of instructions on how to reach those targets at the start of the programme might have helped to stimulate stronger intersectoral collaboration.[4]

Implications for the UK

Several of the issues highlighted in this case study share characteristics with parts of the UK, such as the increasingly devolved responsibility for improving health to the local level, and the need for public health actors to engage with non-health departments on the social determinants. The lessons for public health professionals in the UK include:

1. Health issues such as obesity need to be framed in language that enables non-health actors to see the relevance to them and how collaboration will help meet their priorities.
2. Coaching programmes need to be designed to take account of, and address, power imbalances that might otherwise limit staff's authority to act.
3. Middle managers need to be recognised as a key enabler and engaged fully in organisational development programmes.

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