Summary

Samenvatting (Summary in Dutch)
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In the Netherlands, Health in All Policies (HiAP) has been recognised by government as a promising approach for promoting or protecting the health of the population and addressing health inequalities. In addition, a considerable amount of research has been done with a view to developing and disseminating relevant knowledge regarding HiAP. Despite the recognition and the increasing academic insight, the development and implementation of HiAP in practice remains a complex process. Furthermore, the complexity makes HiAP difficult to evaluate. New insights are often not adequately utilised or aligned with what happens in practice. The objective of this thesis *Towards a HiAP cycle. Health in All Policies as a practice-based improvement process* is to provide greater insight into the development, implementation and evaluation of HiAP in the Netherlands, and to translate this knowledge to develop practical support for HiAP practice. The thesis draws on four Dutch studies, which involved the empirical observation of existing policy practices. In those studies, the focus was on reducing health inequalities or improving the health of the population by using a HiAP approach. In addition on these studies, a knowledge synthesis was performed, taking in a number of Dutch key publications on HiAP. The studies included in this thesis were conducted in the period 2009 to 2014. With a view to translating insights from the studies into practical support for HiAP, a Health in All Policies cycle (HiAP cycle) is introduced. The HiAP cycle has four process steps: developing, implementing, measuring and improving (based on the plan-do-check-act cycle). Within each step, building blocks and associated activities have been defined, reflecting the corresponding study findings.

Chapter 1, the general introduction, looks closely at the background to this thesis. HiAP can make an important contribution to efforts to address complex health problems, such as health inequalities and obesity. That is because the health of the population is influenced by numerous different factors (determinants), including lifestyle, physical and social environment, prevention and care. For example, health inequalities are associated with low levels of education, low income, unemployment, unhealthy lifestyles, poor housing and reduced access to care and other services. Exercising a positive influence on such determinants depends on the commitment of policy in sectors both inside and outside the public health domain. Relevant sectors include care, welfare, spatial planning, housing, social affairs and education. HiAP is intended to influence health or health determinants by means of an integrated approach. At its broadest, it implies multiple policy sectors collaborating to promote or protect health. However, HiAP has previously also taken narrow forms, such as intersectoral action or the integration of health within a single policy sector outside the public health domain (‘healthy public policy’). The importance of HiAP has been emphasised in numerous national documents and (research) programmes with a view to encouraging its application. Moreover, under the Public Health Act (Wpg), municipalities...
have a statutory duty to adopt HiAP (as a form of preventive policy). In addition, the
decentralisation initiatives pursued since 2015 provide clear opportunities for the realisation
of local collaboration between the public health sector and sectors within the social policy
domain and the physical policy domain.

The chapter ends by presenting the three research questions addressed by the thesis:
1. Which factors contribute to the development of HiAP in practice?
2. How is HiAP implemented in practice?
3. What information is needed to obtain insight into the progress of HiAP practice?

Structure of this thesis
The thesis has three parts, one devoted to each of the research questions. Table 1
summarises the studies used.

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¹The studies focused on the operational level (policy officers, professionals) and not explicitly on the tactical level (departmental managers) or the strategic level (political decision-makers) |
²Tools = tool, instrument, method or model

The first research question is addressed by using to two national-level studies (studies 1 and 2; see chapters 2 and 3). For the second research question, two local-level studies are used (studies 3 and 4b; see chapters 4 and 5). The third research question is addressed by using one local-level study and a knowledge synthesis (study 4a and synthesis; see chapters 6 and 7). In the discussion, the main findings of the various studies are reflected in the four process steps of the HiAP cycle (chapter 8). The various chapters are briefly summarised below.
Part 1 Development of HiAP

Chapter 2 describes research into how the policy sectors at seven ministries were able to contribute to a HiAP approach aimed at reducing health inequalities. All policy initiatives proposed by the ministries were screened to identify those targeting the determinants of health inequality (socioeconomic status, lifestyle, environment and housing, access to care). In addition, policy officers from the ministries in question were interviewed to identify critical factors that have a positive or negative influence on collaboration amongst the relevant sectors. The study identified thirty-eight policy initiatives (out of 153 screened), most of which were intended to improve socioeconomic factors (e.g. by increasing participation in education and employment) and the living conditions of disadvantaged groups. Where eleven of the thirty-eight initiatives were concerned, there was already collaboration between the health ministry and other ministries. The study also showed that most initiatives were not yet mutually coordinated. The challenge is therefore to influence the determinants of health inequality on a coordinated basis, to strengthen existing ties between policy sectors, to create a shared interest within the various policy sectors in securing certain goals and outcomes, and to obtain political support for coordinated action.

Chapter 3 describes (ex ante) research designed to determine how a policy on work-related learning proposed by the Ministry of Social Affairs and Employment would influence health (in)equality. A health impact assessment (HIA) was carried out to establish whether the learning policy for working people would influence the health of certain groups, or whether differences were unavoidable. To that end, a literature study was undertaken and various experts and stakeholders were interviewed. The chronically ill, the elderly, lower educated people, people working flexible hours/ self-employed people and lay carers were identified as being vulnerable groups. For example, people with chronic illness and the elderly are less likely to participate in work-related training. Training policies for working people are known to have a positive effect on health by influencing both employment-related factors and other factors, such as pay, employability, longer employment rate and participation in training. In order to encourage people in vulnerable groups to participate in training, it was recommended that work-related learning should be accessible, low-threshold and available when needed (e.g. early support or retraining). Training enables people in the relevant groups to participate in the labour market for longer, thus enhancing their health prospects. Both ministries supported the execution of HIA, because it shed light on the links between the social affairs and employment sector and the public health sector. It was regarded as a stepping stone to further collaboration on the basis of the ministries’ shared interest in helping vulnerable groups to remain in (healthy) active employment.
Part 2 Implementation of HiAP

Chapter 4 describes the results of the study in seven neighbourhoods, which investigated how the public health (prevention) sector and the primary care sector could collaborate at the local level to exercise a positive influence on the health of the population. A stepwise approach featuring two central tools (district health profiling and policy dialogues) was used to develop integrated plans and encourage collaboration. The steps in the approach were: 1) getting to know the neighbourhood, 2) assembling the workgroup, 3) analysing the neighbourhood, 4) developing a district health profile, 5) preparing a policy dialogue, 6) holding local policy dialogues, and 7) embedding integrated districts plans and collaboration. The process was coordinated by a core team. In the seven neighbourhoods, both the use of the two tools and the process were evaluated using documents, questionnaires, interviews and observations. The study found that the tools were used in different ways. For example, some neighbourhoods used generic profiles with a number of themes, while others used specific profiles with a selection of themes or target groups. The aims of the dialogue and the duration of the seven stages also differed from neighbourhood to neighbourhood. Consistent features of the way the tools were used included: the profile indicators adopted (e.g. population prognosis) and the themes selected on the basis of the dialogue (e.g. obesity, social cohesion). The strategy of working with local actors to integrate and interpret profile data contributed to integrated planning and (starting) collaboration between the prevention and care sectors. Where the process was concerned, it was found to be essential to involve the right actors in the network (e.g. GPs, local residents). The continuation of collaboration requires clear plans and agreements to be made. The core team felt that the stepwise approach did facilitate the process. The generic nature of the constituent steps means that the approach could be used in other situations as well. Important prerequisites for success included political support, the availability of resources and the involvement of people with the appropriate skills.

Chapter 5 describes the results of a study in sixteen municipalities, which looked at how the public health sector and both social policy sectors (e.g. youth affairs, education) and physical policy sectors (e.g. housing, spatial planning) collaborated in reducing health inequalities. To shed light on the collaboration, the study focused on a number of aspects: the involvement of the right sectors in the policy network, consensus regarding the objectives, coordinated use of policies and activities by relevant sectors, formalised collaboration and previous experiences within the sectors. To that end, policy documents were studied, digital questionnaires were conducted and policy officers working inside and outside the public health sector were interviewed. The study found that the social policy sectors were involved in the public health network with a view to reducing health inequalities and the associated
determinants more often than the physical policy sectors. Collaborative policies generally tended to be concerned with unhealthy lifestyles, social exclusion and the quality of care. There was less emphasis on improving housing or addressing socioeconomic factors (e.g. low income, unemployment). The conclusion was that, in both the social policy sectors and the physical policy sectors, more could be done to influence the determinants of health on a coordinated basis. It was also found that efforts to involve the physical policy sectors in the public health network could be facilitated by highlighting the relevant sectors’ potential for influencing health and by making political support more explicit. All policy sectors considered a systematic approach and the presence of a process supervisor to be essential for promoting collaboration. Important general prerequisites for success were support and the availability of adequate resources.

**Part 3 Evaluation of HiAP**

Chapter 6 describes the results of a study in sixteen municipalities, which considered how the progress of HiAP could be monitored. A maturity model for HiAP (MM-HiAP) was developed, featuring six stages and fourteen associated HiAP characteristics. In order to assess the utility of the model, data from local policy documents were analysed, digital questionnaires were carried out and policy officers working inside and outside the public health sector were interviewed. The study found that the maturity model was a viable tool for classifying the progress of HiAP within the sixteen municipalities. Six levels of maturity were defined: stage 0 (no municipalities), in which the problem is *unrecognised*; stage 1 (three municipalities), in which the problem and the importance of a HiAP approach are *recognised*; stage 2 (seven municipalities), in which HiAP is *considered* in policy documents and inter-sectoral collaboration is initiated; stage 3 (four municipalities), in which HiAP is *implemented* by getting multiple sectors to contribute to problem resolution on a structural basis; stage 4 (two municipalities), in which HiAP is *integrated* by operating on the basis of a shared vision; and stage 5 (no municipalities), in which HiAP is *institutionalised* by embedding systematic improvement of the approach within the culture of the organisation. The model can help municipalities to establish what stage of maturity they have reached and thus to determine what is required to progress to the next stage (e.g. invest in developing ties between policy sectors, develop clear integrated plans or secure management support for a HiAP approach). In order to further validate the maturity model’s HiAP characteristics, it will be necessary to gain (more) experience of the model’s use in the field and in association with local practice.
Chapter 7 describes the results of a synthesis of knowledge contained in Dutch core publications on the subject of HiAP. The study considered what conclusions could be drawn from existing HiAP practice regarding the monitoring and evaluation of HiAP. Relevant HiAP characteristics and associated practical tools were categorised on the basis of context, processes and impact. Relevant characteristics identified by the study included: theme and setting (context), linkage of policy and activities (process), collaboration between sectors (process), support and embedding within the organisation (process), and effect on health or health determinants (impact). The conclusion of the knowledge synthesis was that HiAP is too wide-ranging for generalised monitoring and evaluation. Monitoring and evaluation need to be more narrowly focused. It may therefore be advantageous for the toolbox to include tools suitable for use at various levels. For example, one tool might be used to assess a group of HiAP characteristics, e.g. a spider’s web model for monitoring the progress of integrated health programmes; another might be used to zoom in on a specific characteristic, such as the identification of links between policy sectors or collaboration amongst sectors. From the synthesis, it is also apparent that knowledge regarding the context and the processes is easier to generate than knowledge regarding health impacts. Moreover, it is apparent that, when knowledge about relevant HiAP characteristics is generated, confusion can arise concerning the meaning of some terms, such as ‘political support’. It is ultimately desirable to arrive at a set of validated tools for HiAP monitoring and evaluation. In that context, a theoretical basis is an essential precondition for the use of uniform terminology in HiAP practice.

General discussion

Chapter 8 provides an integrated summary of the main findings of the Dutch studies and translates those findings into a form usable in the field: a HiAP cycle. The chapter also includes a reflection on the methodological limitations and strengths of the studies. Finally, four dynamic changes or ‘shifts’ are identified, which are desirable in the context of HiAP practice in the Netherlands.

Practical translation to the field

Fig. 1 illustrates a HiAP cycle, with its four constituent steps: developing, implementing, measuring and improving. The HiAP cycle supports policy-makers, researchers and professionals gain insight into the approach’s practical significance and can be useful for bringing about improvements in the HiAP approach. The strategic building blocks and the associated technical elements (support tools) and practical elements (practical activities) needed at each step to promote a formal HiAP approach have been defined on the basis of
the empirical results from the supporting studies. The building blocks and elements are also shown in Fig. 1.

The strategic building blocks of the HiAP cycle are:
- Health and policy (joint policy-making)
- Collaboration and coordination (programme management)
- Research and evaluation (reflecting on progress)
- Learning and support (capacity building)

**Fig. 1.** The Health in All Policies cycle (HiAP cycle) and its building blocks
In practice, the HiAP cycle will not always follow the illustrated sequence, because HiAP is an iterative and complex process. Establishing or promoting a formal HiAP approach often involves identifying leverage points, and entering the HiAP cycle at the corresponding step. The context (e.g. the ambition or vision to address complex health problems) always plays a profound role. A definition of the HiAP cycle is provided in the following text box.

**Definition of the Health in All Policies cycle (HiAP cycle)**

*The Health in All Policies cycle (HiAP cycle) is a cycle of continuous improvement of the HiAP approach, characterised by a dynamic and systematic focus on four process steps (developing, implementing, evaluating and improving), in each of which particular strategic building blocks and associated technical and practical elements (actions) are used to support practice.*

**Methodological limitations and strengths**

One methodological limitation of the research presented in this thesis is that the number of case studies used was quite small. However, each study utilises a combination of data sources (e.g. literature and documentary research, digital questionnaire-based surveys and in-depth interviews) and all have been subject to multiple peer review. Furthermore, the studies were practice-based and involved practising policy officers and professionals. Another limitation is that the studies were based in certain selected ministries and municipalities in the Netherlands. Consequently, the results may not be transferrable to other settings. However, all the studies were primarily intended to shed light on ways of improving a HiAP approach. It is therefore likely that the support tools would be viable and the associated results valid for other settings with recognisable problems (e.g. health inequalities, obesity). A further limitation is that the studies were concerned with policy at different levels (national and local). Nevertheless, the similarity of the results from the case studies means that it has been possible to define transferrable building blocks and relevant elements for the various process steps in the presented HiAP cycle. Other Dutch and non-Dutch studies concerned with HiAP have yielded similar results. Finally, the relative immaturity of the HiAP discipline and the associated pioneering nature of many of the initiatives represent a limitation. In the case studies, the conditions were optimised by, for example, the presence of (proactive) researchers or process supervisors, who may not be present in the field. The introduction or promotion of a HiAP approach into a practical setting requires the systematic promotion of conducive conditions.

**The direction of future development**

Reflecting on the findings of the studies underpinning this thesis reveals that four shifts are desirable in the context of HiAP practice:
1 From a primary determinant-based approach towards a process approach
HiAP has for years been regarded and defined in terms of the determinants of health. While that is a good starting point for the development of a HiAP approach, the further development of such an approach requires that more attention is given to implementation (particularly collaboration) and evaluation (particularly progress). The HiAP cycle can serve as a basis for HiAP being regarded as a systematic process in the field.

2 From tools for policy-making towards tools for collaboration and evaluation
The support tools used for HiAP in practice still tend to be policy development tools. Nevertheless, in recent years, the studies considered in this thesis and other sources have introduced various additional tools for collaboration and HiAP evaluation. However, dynamic oversight and active management are needed to ensure that better use is made of the available tools in HiAP practice.

3 From emphasis on impact studies towards emphasis on case studies
The impact of HiAP is measurable mainly by looking at process outcomes, rather than health outcomes (e.g. reduction of health inequalities). It is therefore desirable to place more emphasis on generating knowledge about HiAP implementation from case studies, in which researchers and policy-makers collaborate to translate knowledge directly to the field.

4 From primary knowledge dissemination towards structural support
The distribution of knowledge and information about HiAP that has been taking place in recent years needs to continue. However, there is also a need for structural support to promote the adoption of the available tools, the internalisation of working methods, the development of specific skills and the organisation of inspiring interaction, in the context of which HiAP-related experience can be shared.

Finally
The objective of this thesis was to provide greater insight into the development, implementation and evaluation of Health in All Policies (HiAP) in the Netherlands. To facilitate the translation of that insight into practical support for HiAP in the field, a HiAP cycle is introduced, with four process steps and associated actions. The further implementation of HiAP can be facilitated by regarding the approach as a process, by making better use of (new) tools, by conducting case studies to generate knowledge about implementation, and by providing structural support in the field. Continued progress towards those aims can ultimately help to improve the health of the population and reduce health inequalities. Ongoing decentralisation initiatives and the focus on implementation in the context of nationwide programmes mean there are ample opportunities for getting HiAP established in practice.