CHAPTER 1

General introduction
1.1 Background

1.1.1 Relevance of Health in All Policies (HiAP)

The publication in the early seventies of the Canadian Lalonde model, in which explicit attention was given to intersectoral action for health, has been an important stimulus to approaching health from a broader perspective [1]. After all, health is influenced by different factors, such as human biology, lifestyle, social and physical environment and health care organization [1, 2]. Factors that are found to have influence on health are called determinants of health [3, 4]. There are also important interrelationships between the different determinants. Dahlgren & Whitehead’s model (in Fig. 1) illustrates the interrelationships between the determinants of health [5]. The model distinguishes different categories of determinants: individual lifestyle factors such as smoking habits, diet and physical activity have the potential to promote or damage health; social and community network interactions with friends, relatives and mutual support within a community can sustain people’s health or well-being; wider determinants on health include living and working conditions, food supplies, access to essential goods and (health) services, and the overall economic, cultural and environmental conditions prevalent in society as a whole. Living and working conditions, or social and community determinants, may have effects on individual life style factors such as drinking habits, smoking and physical activity [3, 5]. The determinants of health can be influenced by policy from sectors and stakeholders both inside and outside the public health domain, including sectors such as public health, primary health care, spatial planning, education, safety, housing, social affairs and employment. Such input is particularly important in relation to complex (or wicked) public health problems [6]. Complex health problems that have been established for many years in the Netherlands include unhealthy lifestyle (e.g. smoking, lack of physical activity), overweight and health inequalities [7]. In order to adequately address these complex health issues the adoption of an approach based on Health in All Policies (HIAP) is required [4]. HIAP involves the collaboration of policy sectors inside and outside the public health domain aiming to positive influence the determinants of health and thus the health of the population [4, 6, 8].

The World Health Organization (WHO) uses the following definition: ‘Health in All Policies is an approach to public policies across sectors that systematically takes into account the health implications of decisions, seeks synergies, and avoids harmful health impacts, in order to improve population health and health equity’. A Health in All Policies approach improves accountability of policymakers for health impacts at all levels of policymaking (e.g. local, regional, national). It includes an emphasis on the consequences of public policies on health systems, determinants of health, and health, and well-being [9].
Fig. 1. Dahlgren & Whitehead’s model

1.1.2 The concept of Health in All Policies

Various similar terms and definitions of Health in All Policies (HiAP) are in use internationally and also in the Netherlands [10, 11]. Table 1 summarizes the main terms used in this thesis and that is Intersectoral Action (IA), Healthy Public Policy (HPP), Health in All Policies (HiAP) and Whole-of-Government (WoG). IA involves actions undertaken by sectors outside the health sector, possibly, but not necessarily, in collaboration with the health sector on population health or health equity [12]. HPP is characterized by an explicit concern for health and equity in all areas of policy and by an accountability for health impact. The terms intersectoral action and healthy public policy are often used interchangeably. However, intersectoral action does not necessarily include a policy component, and HPP does not necessarily require intersectoral action [4, 5]. HiAP builds on the concepts inherent to IA en HPP [4]. HiAP is a horizontal, complementary policy-related strategy with a high potential for contributing to population health (that means: multi-sectoral actions on health) [13, 14]. Intersectoral collaboration (IC) is an important prerequisite for HiAP [15]. IC focus on joint actions between sectors inside and outside the public health sector to promote population health or health equity [4, 15]. HiAP is in the Netherlands often used interchangeably with the term ‘integrated approach’. Integrated approach is a working method by which a public health problem is addressed by multiple sectors and stakeholders within various settings (e.g. neighbourhood) [16]. In recent years, the concept of HiAP has been part of a larger Whole-of-Government (WoG) approach [4, 17]. WoG denotes public health service agencies
working across portfolio boundaries to achieve a shared goal and an integrated government response to particular issues. Such strategies as above are closely related and based on the development of horizontal policy approaches (that is: between policy sectors inside and outside public health domain) and represents a continuum of degrees of policy integration \[18, 19\]. This continuum ranges from a one-directional (IA and HPP) to a multi-directional model (HiAP) \[4, 19\]. So, the concept of HiAP has evolved in the last decades\[12\].

Table 1. Terms of HiAP \[4, 15, 20\]

<table>
<thead>
<tr>
<th>Terms</th>
<th>Definition of strategies</th>
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<tbody>
<tr>
<td>IA</td>
<td>Intersectoral action refers to actions undertaken by sectors outside the health sector, possibly, but not necessarily, in collaboration with the health sector on population health or health equity.</td>
</tr>
<tr>
<td>HPP</td>
<td>Healthy public policy is characterized by an explicit concern for health and equity in all areas of policy and by an accountability for health impact.</td>
</tr>
<tr>
<td>HiAP</td>
<td>Health is All Policies is a horizontal, complementary policy-related strategy with a high potential for contributing to population health. Intersectoral collaboration (IC) is an important prerequisite for HiAP.</td>
</tr>
<tr>
<td>WoG</td>
<td>Whole-of-government denotes public health service agencies working across portfolio boundaries to achieve a shared goal and an integrated government response to particular issues.</td>
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</tbody>
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1.1.3 International developments involving HiAP

The concept of Health in All Policies was first introduced by the World Health Organization. In the Ottawa Charter for Health Promotion in 1986, it was referred to as Intersectoral Action (IA) and Healthy Public Policy (HPP). At subsequent global public health promotion conferences, attention was also given to HiAP, resulting in the Rome Declaration on Health in All Policies in 2007. Drawing on all the previous work, the Adelaide Statement was adopted at the 2010 International Meeting on HiAP. The statement emphasised that HiAP works best when: a clear mandate makes joined-up government an imperative; systematic processes take account of interactions across sectors; mediation occurs across interests; accountability, transparency and participatory processes are present; engagement occurs with stakeholders outside of government; practical cross-sector initiatives build partnerships and trust \[21, 22\].

Simultaneously to the developments regarding HiAP within the WHO, HiAP was placed on the EU policy agenda by the Finnish presidency in 2006. This resulted in the conclusion of the Council of the European Union on Health in All Policies, which reinforces the new Article 152 of the Amsterdam Treaty establishing the European Community, which states that “a high level of human health protection shall be ensured by all Community institutions in the definition of all Community policies and activities” \[23\]. HiAP was also one of the
four principles of the EU Health Programme 2008-2013 Together for health. The European Commission is funding several HiAP-related research projects, including Joint Action on Health Inequalities and Crossing Bridges. The Crossing Bridges project has developed practical tools, which are required to put HiAP into practice, thus advancing the implementation of HiAP in Europe [21].

The WHO Regional Committee for Europe endorsed the development of a new European health policy: Health 2020 [24]. The challenge was to promote health as a whole-of-government (WoG) responsibility. The key elements of the new policy were establishing a broad vision of health, encouraging sectors outside the public health domain to improve population health, providing support through a visible and approachable unit and using Health Impact Assessment (HIA) [25].

European regions and countries, like Finland, New Zealand, Norway, Sweden, United Kingdom (England) and Canada (Quebec), follow international recommendations on the application of HIAP and employ a ‘whole-of-government approach’. This approach means that intersectoral collaboration is defined at the highest policy level, especially in the field of mental health and socioeconomic health inequalities [21, 25, 26].

1.2 HiAP in the Netherlands

1.2.1 National developments involving HiAP

Policy documents and statements

In the Netherlands, there have been references to HiAP in policy documents going back to 1986. The developments regarding HiAP are summarised in Fig. 2, in relation to relevant international developments. The publication of the Nota 2000 (policy document 2000) in 1986 was the first explicit step to consider health in policy outside public health domain (‘facet policy’). In the following years this theme remained on the four-yearly national health policy documents (e.g. Gezondheid met beleid, Gezond en Wel) [27]. Since 2001 the term HiAP is being used (in Dutch: ‘Integraal Gezondheidsbeleid’). In 2007, the cabinet vision statement Being Healthy, Staying Healthy recommended tackling smoking, alcohol abuse, overweight and depression on the basis of HiAP [28]. The recommended approach involved focusing on both the individual and his/her environment: people’s environments should be designed to facilitate healthy choices. The importance of HiAP was also emphasised in the policy document ‘Policy plan targeting health differences through socioeconomic backgrounds’. In 2009, the Council for Public Health and Health Care (RVZ) advised the Ministry of Health, Welfare and Sport (VWS) to do more to promote HiAP in the period thereafter [25].
Fig. 2. Historical developments regarding HiAP

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**International highlights**

- **WHO: Ottawa Charter for Health Promotion**
  - Highlighted HiAP and IA for health (1986)

- **1990-1994**
  - **WHO: Ottawa Charter for Health Promotion**
  - **Article 152** highlighted HiAP in Public Health Action Programme (2001)
  - **WHO: Rome Declaration on Health in All Policies** (2007)
  - **WHO: Health 2020** highlighted whole-of-government responsibility (2010)

- **1994-1998**
  - **WHO: Ottawa Charter for Health Promotion**
  - **Article 152** highlighted HiAP in Public Health Action Programme (2001)
  - **WHO: Rome Declaration on Health in All Policies** (2007)
  - **WHO: Health 2020** highlighted whole-of-government responsibility (2010)

- **1998-2002**
  - **WHO: Ottawa Charter for Health Promotion**
  - **Article 152** highlighted HiAP in Public Health Action Programme (2001)
  - **WHO: Rome Declaration on Health in All Policies** (2007)
  - **WHO: Health 2020** highlighted whole-of-government responsibility (2010)

- **2002-2006**
  - **WHO: Ottawa Charter for Health Promotion**
  - **Article 152** highlighted HiAP in Public Health Action Programme (2001)
  - **WHO: Rome Declaration on Health in All Policies** (2007)
  - **WHO: Health 2020** highlighted whole-of-government responsibility (2010)

- **2006-2010**
  - **WHO: Ottawa Charter for Health Promotion**
  - **Article 152** highlighted HiAP in Public Health Action Programme (2001)
  - **WHO: Rome Declaration on Health in All Policies** (2007)
  - **WHO: Health 2020** highlighted whole-of-government responsibility (2010)

- **2010-2014**
  - **WHO: Ottawa Charter for Health Promotion**
  - **Article 152** highlighted HiAP in Public Health Action Programme (2001)
  - **WHO: Rome Declaration on Health in All Policies** (2007)
  - **WHO: Health 2020** highlighted whole-of-government responsibility (2010)

- **2014-2018**
  - **WHO: Ottawa Charter for Health Promotion**
  - **Article 152** highlighted HiAP in Public Health Action Programme (2001)
  - **WHO: Rome Declaration on Health in All Policies** (2007)
  - **WHO: Health 2020** highlighted whole-of-government responsibility (2010)

**National highlights**

- **Nota 2000**
  - First explicit step to consider health in policy outside health domain (1991)
- **Policy document Gezondheid met Beleid**
  - Emphasised Healthy Public Policy (1991)
- **Framework policy document Gezondheid en Welzijn**
  - Introduced HIA (1994)
- **The Council for Public Health and Health Care**
  - Advised on IA for health (2001)
- **The amended Public Health Act (WCPV)**
  - Encouraged municipalities to HPP (2002)
- **Vision Being Healthy, Staying Healthy**
  - Policy plan tackling health inequalities (2007)
- **National policy document Health close to people**
  - Recommended use of HiAP approach (2011)
- **National Programme Everything is Health**
  - By joint action (2014-2016)
- **VWS funded HiAP knowledge function through The Public Health Status and Forecast (2008-2014)**
- **The Council for Public Health and Health Care**
  - Recommended increased emphasis on HIA (2009)
- **Covenant on Combating Overweight by joint action (2010-2015)**
- **Healthy in the City Programme**
  - Aims at reducing health inequalities by HiAP (2014-2016)

**Fig. 2. Historical developments regarding HiAP**
In May 2011, the national policy document on health *Gezondheid dichtbij (Health close to people)* identified a number of national public health priorities and recommended addressing health on an integrated approach [29]. The National Prevention Programme (NPP) *Alles is Gezondheid (Everything is Health)* is based upon *Health close to people* [30]. Covering the period 2014 to 2016, the NPP is a programme through which the government, businesses, sport organisations, care sector organisations and community organisations work together to promote health and vitality in the Netherlands. The programme includes initiatives in the fields of care, education, neighbourhoods, work and health protection. The latest national health policy document on health was published in 2015, which emphasised the importance of an integrated local approach and preventive and lifestyle-related initiatives in all domains [31]. Such policy documents will help to keep HiAP on the policy agenda for a long time.

**Research and action programmes**

In 1995 a supportive function was deployed within the Netherlands School of Public Health (NSPH) for conducting Health Impacts Assessments (between 1996-2002). In 2003 this was housed in the National Institute for Public Health and the Environment (RIVM). Over time the responsibilities have gradually changed from a supportive function to a research function regarding HiAP (knowledge development and dissemination).

From 2008, more structural research into HiAP was carried out in the Netherlands, reflecting the fact that the importance of HiAP was increasingly emphasised in various policy documents. The Ministry of Health, Welfare and Sport (VWS) identified various focus topics for the development of HiAP knowledge at the national and local levels (at RIVM up to 2014). In addition, the Netherlands Organisation for Health Research and Development (ZonMw) funded various research programmes on HiAP, which contribute to the exchange of information, knowledge and examples of good practice. Between 2009 and 2013, LOCAL50 evaluated the ZonMw programme *Gezonde slagkracht (Healthy Capability)*; in this programme, integrated approaches used in thirty-four projects undertaken by Dutch municipalities to address overweight, harmful alcohol consumption, smoking and drug use were conducted [32]. Another relevant evaluation study is URBAN40, which ran from 2008 to 2012 in approximately forty deprived neighbourhoods in the Netherlands. This study evaluated the programme known as *Actieplan krachtwijken (Action plan deprived neighbourhoods)*: the aim of this programme was to realize healthy living, learning and working conditions in deprived neighbourhoods [33]. In addition, a number of consortiums were set up, including the Consortium Integrated Approach for Overweight (CIAO), active between 2010 and 2014, and the Consortium Instruments for Integrated Action (i4i), active between 2012 and 2014. CIAO is a consortium of five university research centres dedicated to supporting an integrated approach to reduce overweight through research [34]. The i4i consortium involved nine Dutch research teams working to collate HiAP-related knowledge
and develop new insights. Its fields of activity included theoretical frameworks and research tools for HiAP [35]. From 2014, emphasis has been placed on the implementation of an integrated approach to tackling health inequalities at the local level. This is supported by the programme Gezond in de Stad (Healthy in the City; Dutch acronym ‘GIDS’), and supports one of the goals of the National Prevention Programme (NPP) [30,36]. In addition to these initiatives, there were more (local and regional) Dutch projects and studies in the field of HIAP [6, 16, 26].

1.2.2 Local HiAP developments
Public health act and local policy
The national policy documents and studies mentioned above support the development and implementation of HiAP at the local level. Furthermore, under the Public Health Act (Wpg), municipalities have an obligation to promote and protect the health of the local population by HiAP strategies [25, 37]. Most Dutch municipalities focus mainly on addressing alcohol abuse, overweight and psychosocial problems [38]. Their priorities are mostly corresponding with the priorities of the ministry of Health, Welfare and Sport [39]. Municipalities focus also more and more on the health problems faced by low-educated people (health inequalities) [38]. HiAP appears to be most promising as a means of tackling such complex health problems (e.g. overweight and health inequalities) [4, 6]. That is, only joint efforts of multiple sectors (compared to only efforts by public health sector) could effectively influence the determinants that underlie complex health problems, such as unhealthy lifestyle and unfavourable social and physical environment (e.g. unemployment, low educational level, poor living and working conditions, accessibility of healthcare) [6, 40]. The number of municipalities that pay attention to HiAP in their local health policy document to improve the health or reduce health inequalities of their residents has risen in recent years (80% of the municipalities) [38]. However, developing and implementing HiAP has been found to be exceptionally complex in practice [8, 15, 25]. It has, for example, been found difficult to engage other sectors, to link problems and solutions for several sectors, and to coordinate the process [16, 41].

Decentralisation initiatives
Since 2015, a great deal has changed for the Dutch municipalities as a result of three decentralisation initiatives within the social domain. The national government has decided that care and support should be organised as close to the people (local citizens) as possible. This will give municipalities more say in issues that directly affect their local citizens. By the decentralisations municipalities are responsible for three specific areas the so-called 3D decentralization agenda: services for persons with disabilities (Wmo), youth policy and work & income. Before the introduction of the decentralisations, those areas were the
responsibility of the national government and the provinces [42]. The national government responsibility is to create a framework within which the municipalities can operate effectively, e.g. by making a single integral budget available to allow scope for customised solutions; by promoting an integrated approach to tackling problems in the field of care, support, work and income (e.g. central guide if necessary); and by facilitating close monitoring of the entire social domain [42, 43]. Decentralisation enables municipalities to play a directorial role and provides opportunities for the further development of (health) policies that are integrated at the local or regional level [44]. In the new decentralised landscape, municipalities can build bridges between key policy sectors: social support, care, housing, work and income [42, 43].

1.2.3 Supportive tools and knowledge for HiAP

In the Netherlands various instruments are available for the development of HiAP, such as Health Impact Assessment (HIA), Determinant Policy Screening (DPS) and the Facet Policy Quick Scan (FPQS), which were developed in 2004 [45-47]. HIA and its many variants are familiar in most other countries as well [48]. Each of these tools has its own purpose as presented in Table 2. However, most of these tools were developed a decade ago and are intended mainly for use in the development of HiAP, rather than its implementation or evaluation. Also international several tools were developed (e.g. variants on HIA) [48-50]. In 2012, the WHO concluded that insufficient tools were available complementary to HIA, such as tools for promoting collaboration between policy sectors inside and outside public health domain [51].

In recent years, also, more and more knowledge and information has become available in the Netherlands and internationally, which can be used to support the (local) development and implementation of HiAP. For example, theoretical knowledge is now available regarding the various possible strategies of policy integration (e.g. HiAP, HPP and IA), the strategic elements (e.g. broad vision on health, using HIA) and the key elements (e.g. clear mandate, finance) for developing HiAP [16, 19, 26]. Literature also showed that HiAP involves a number of relevant mechanisms, making implementation complex and diverse [52]. Such mechanisms include distributed agency amongst sectors and stakeholders, distributed knowledge amongst sectors, coordination amongst sectors in regimes with their own structures, cultures and practices, and divergent health issue interpretation by sectors (and thereby see other solutions) [53]. It is also well known from the literature that evaluation of the effects of HiAP is difficult. This is due to reasons such as being (un)healthy caused by multiple factors, absence of golden standard and broad concept of HiAP [25, 26]. Despite HiAP is for many years on the (local and national) policy agenda, a number of programmes and projects are in place, and supportive tools and knowledge are available, HiAP remains
difficult to develop, implement and evaluate in practice [16, 26]. Besides, knowledge on HiAP isn’t always sufficiently used or connected to practice [53].

Table 2. Tools that support HIAP

<table>
<thead>
<tr>
<th>Tools and instruments that support HIAP</th>
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<tbody>
<tr>
<td>Health Impact Assessment</td>
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<tr>
<td>Health Impact Assessment (HIA) is a technique for analysing the health effects of sectors other than the public health sector. HIA takes as its starting point policy that is under development and seeks to identify its potential health promoting and health protecting aspects with a view to making adjustments where appropriate. HIA is suitable for studying a ministry’s generic policy objectives or specific plans for a particular neighbourhood. There are numerous HIA variants, including HIA for city and environment.</td>
</tr>
<tr>
<td>Determinant Policy Screening</td>
</tr>
<tr>
<td>Determinant Policy Screening (DPS) defines the policy sectors that can influence an important public health problem. Steps are then taken to identify available policy options with the potential to positively influence the determinants of health and the sectors that are able to implement the necessary measures.</td>
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<tr>
<td>Facet Policy Quick Scan</td>
</tr>
<tr>
<td>The Facet Policy Quick Scan (FPQS) is a technique for assessing the substantive, political-administrative and instrumental feasibility of HIAP. Substantive feasibility is the degree to which policy is capable of influencing the health situation. Political-administrative feasibility is the degree to which policy has political-administrative and social support. Finally, instrumental feasibility is the degree to which the municipality has the means to realise the relevant goal.</td>
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1.3 Purpose of this thesis

1.3.1 Research questions addressed by the thesis

The general purpose of this thesis ‘Towards a HIAP cycle. Health in All Policies as a practice-based improvement process’ was to obtain more insight into the development, implementation and evaluation of Health in All Policies (HIAP) as practiced in the Netherlands, and to translate this knowledge to develop practical support for HIAP practice. On the basis of the general purpose, three research questions were formulated:

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?

The thesis draws on the findings of four Dutch studies at the national and local level, in which HIAP practices empirically were studied by using several available tools (e.g. HIA, DPS) and newly developed tools (e.g. integrated profiles, maturity model). These studies were performed in the period 2009 -2014. In order to categorize and interpret the results from
these studies on meta level the thesis introduces a HiAP cycle consisting of the process steps developing, implementing, measuring and improving (based on the Plan-Do-Check-Act cycle), as illustrated in Fig. 3. In that way, it has been possible to identify strategic building blocks and corresponding technical and practical key elements (actions) for HiAP practices. Moreover, knowledge was made directly applicable in the context of other practices (i.e. implementation knowledge development). The results of the Dutch case studies make it also possible to give future directions to (stimulate the) use (of) the HiAP approach.

![Fig. 3. Introduction of a HiAP cycle](image-url)
1.3.2 Outline of the thesis
The first part of the thesis (Development of HiAP) draws on two national-level Dutch case studies (studies 1 and 2). The second part (Implementation of HiAP) draws on two local-level Dutch case studies (studies 3 and 4). The third part (Evaluation of HiAP) draws on one local-level Dutch case study (study 4) and a synthesis of Dutch key publications on HiAP. The results of the individual case studies are referred to in the various sections of the thesis. The general discussion summarises and also integrates the main findings of the four Dutch HiAP studies (Improving HiAP). An overview of the thesis’s content is provided in Table 3.

Table 3. Outline of this thesis

<table>
<thead>
<tr>
<th>Part</th>
<th>Dutch case studies</th>
<th>Focus(^1)</th>
<th>Tools(^2)</th>
<th>Policy level</th>
</tr>
</thead>
<tbody>
<tr>
<td>Development of HiAP</td>
<td>Study involving seven Dutch ministries (study 1)</td>
<td>HiAP aimed at reducing health inequalities</td>
<td>Policy screening on the basis of the determinants of health inequality</td>
<td>National (health and non-health)</td>
</tr>
<tr>
<td></td>
<td>Study involving two Dutch ministries (study 2)</td>
<td>Healthy Public Policy aimed at health equity</td>
<td>Health impact assessment with equity focus</td>
<td>National (health and non-health)</td>
</tr>
<tr>
<td>Implementation of HiAP</td>
<td>Study involving seven Dutch neighbourhoods (study 3)</td>
<td>Intersectoral collaboration aimed at improving health of the local population</td>
<td>Stepwise approach with two central tools: district health profiling and policy dialogues</td>
<td>Local (public health and primary care)</td>
</tr>
<tr>
<td></td>
<td>Study involving sixteen Dutch municipalities (study 4b)</td>
<td>Intersectoral collaboration aimed at reducing health inequalities</td>
<td>Qualitative descriptive analysis of collaboration</td>
<td>Local (health and non-health)</td>
</tr>
<tr>
<td>Evaluation of HiAP</td>
<td>Study involving sixteen Dutch municipalities (study 4a)</td>
<td>HiAP aimed at reducing health inequalities</td>
<td>Maturity model with six maturity levels</td>
<td>Local (health and non-health)</td>
</tr>
<tr>
<td></td>
<td>Synthesis of Dutch core publications on HiAP</td>
<td>HiAP aimed at tackling complex health problems</td>
<td>Logic evaluation model</td>
<td>Local and regional</td>
</tr>
</tbody>
</table>

\(^1\)HiAP concepts = Health in All Policies (HiAP), Intersectoral Collaboration (IC), Healthy Public Policy (HPP) and Intersectoral Action (IA) \(^4\)  
\(^2\)Tools= tool, instrument, method or model
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