CHAPTER 2

Opportunities to reduce health inequalities by
‘Health in All Policies’ in the Netherlands:
An explorative study on the national level

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Abstract

Objectives: In the last few years the Dutch ministry of Health has been searching for a renewed Health in All Policies (HiAP) strategy. This study analyses the Dutch practices and explores opportunities to reduce health inequalities by HiAP.

Methods: A qualitative screening on the Dutch national budget was performed to explore ongoing policy resolutions of ministries inside and outside the public health domain. Additionally, semi-structured (group) interviews were conducted with 19 policy officers of seven ministries to identify critical factors for intersectoral collaboration.

Results: Using the Dutch model on health inequalities 38 policy resolutions were selected: 15 on improving the socioeconomic position of people; four on improving participation of people with health problems; 19 on improving living and working conditions and lifestyle; and four on accessibility and quality of care. To improve intersectoral collaboration, policy officers suggested to strengthen existing links between the ministries, create common interest of objectives as well as visible results, approach this theme in a coordinated way, and to achieve broad political agreement.

Conclusions: The main challenges for a formal HiAP strategy are to (a) cover the determinants of health inequalities in a balanced way linked to concrete objectives and visible results, (b) enhance high level agreement and coordinated mechanisms from the government in general and the ministry of Health in particular.

Keywords: Health in All Policies, Socioeconomic health inequalities, Intersectoral collaboration, Government
1. Introduction

In many Western countries lower-educated people do not live as long as their better-educated counterparts and they also experience more health problems [1-3]. In the Netherlands, the life expectancy of people with a low socioeconomic status is six to seven years lower than the life-expectancy of people with a high socioeconomic status. The difference is even greater for healthy life expectancy, namely 14 years [4]. In addition, people with a low socioeconomic status as well as ethnic minorities are more likely to suffer from chronic diseases such as diabetes, depression and overweight [5]. Socioeconomic health inequalities are persistent and apparently not affected by the Dutch national policy in recent years [6]. As a consequence the Dutch ministry of Health, Welfare and Sport has been looking for a renewed strategy to reduce health inequalities by Health in All Policies (HiAP) in the last few years.

National and international studies have revealed a wide range of determinants of health inequalities [7], including: low education level, low income, unfavourable living conditions (e.g. noise, social problems, moisture and cold in house, lack of green), an unhealthy lifestyle (e.g. smoking, unhealthy diet, low physical activity), relatively unhealthy working conditions in low paid jobs, social exclusion and suboptimal quality of care. Many of these determinants can only be tackled by policy resolutions outside the public health domain [8].

It is assumed that HiAP, in which policies from ministries inside and outside public health domain are contributing to persistent public health problems, is effective [9]. HiAP is a ‘horizontal complementary policy-related strategy with a high potential for contributing to population health [10, 11]. The HiAP strategy was formally legitimated as a European Union (EU) approach in 2006 [12]. It is suggested that intersectoral collaboration is an important prerequisite for HiAP [13]. Despite the fact that HiAP is recommended in several Dutch policy documents [14], there is yet no formal HiAP strategy to tackle health inequalities in the Netherlands. This is in contrast to other European countries, like Sweden, Finland, Norway and the UK, in which the government already explicitly addresses health inequalities through HiAP. These countries employ a ‘whole-of-government approach’ on this theme, which includes elements such as providing broad vision of health (e.g. commitment from high level), exerting influence (e.g. coordination and collaboration mechanisms), support on intersectoral action (e.g. concrete objectives and visible results), capacity building (e.g. development and transfer of knowledge on HiAP), and evaluation (e.g. formal control mechanism and procedures) [15]. This means that these countries collaborate on health inequalities at the highest level of government.

However, like in the Netherlands, other countries still have difficulties in developing and implementing HiAP [16]. Based on this, and the fact that health inequalities have not decreased in recent years in the Netherlands [17], the Dutch ministry of Health has
commissioned the National Institute for Public Health and the Environment to analyse opportunities to reduce health inequalities in the Dutch population by a HiAP strategy. Therefore, the aim of this study was to identify ongoing policy resolutions in the Netherlands inside and outside the health domain with potential impact on health inequalities (and their determinants), and to identify critical factors (e.g. drivers and barriers) with regard to collaboration between various ministries as a prerequisite for HiAP. In order to provide useful directions for formal HiAP on national level in the Netherlands, the Dutch situation is also discussed in comparison to some other countries with a ‘whole of government approach’. The insights of this study may be useful for other Western countries that are aiming at reducing health inequalities.

2. Methods

The study comprised a document analysis of policy resolutions with an impact on health inequalities as well as face-to-face (group) interviews with policy officers of different ministries. To guide the data collection in this study, the four action points described in the Dutch model on health inequalities were used as a theoretical framework.

2.1 Theoretical framework

In 2001 a Dutch Programme Committee on Socioeconomic Inequalities in Health developed a theoretical model for reducing health inequalities in the Netherlands. This model, which is depicted in Fig. 1, constitutes four action points [18]:

1. To reduce socioeconomic inequalities (i.e. reduce differences in education, occupation and income level).
2. To reduce negative effects of health on socioeconomic inequalities (i.e. prevent that poor health leads to low education and income levels).
3. To reduce negative effects of socioeconomic inequalities on health (mediated by lifestyle, and living and working conditions).
4. To improve accessibility and quality of healthcare services for socioeconomic disadvantaged groups.

The basic assumption underlying this model is that policies and interventions focusing on each separate point are not sufficient to reduce health inequalities; the best strategy combines policy and interventions related to all four action points [19].
Fig. 1. Theoretical model for reducing socioeconomic health inequalities (derived from the Programme Committee on Socioeconomic Inequalities in Health, 2001).

2.2 Document analysis of policy resolutions

In order to make an inventory of policy resolutions inside and outside the public health domain targeted at health inequalities by the four action points, a qualitative descriptive screening was performed of the ‘Dutch 2008 national budget’. This policy document consists of 20 policy chapters corresponding with the different individual ministries and gives an overview of all proposed policy resolutions of the Dutch government in the coming years. In general, policy is continued for the duration of a government’s term of four years. Seven of the 20 policy chapters were selected based on their potential relevance with regard to health inequalities: (a) Housing, Communities and Integration; (b) Housing, Spatial Planning and the Environment; (c) Transport, Public Works and Water Management; (d) Social Affairs and Employment; (e) Education; (f) Youth and Families; and (g) Health, Welfare and Sport. In total, these seven chapters yielded 153 policy resolutions which were subsequently analysed with regard to their potential impact on: the socioeconomic position of people (action point 1); participation in the labour market and education of people with health problems (action point 2); the living and working conditions and lifestyle of people with a low socioeconomic position (action point 3); and the accessibility and quality of healthcare for people of low socioeconomic position (action point 4).

In addition, it was assessed if the policy resolutions were intentional or unintentional used to reduce health inequalities. Also, both the overarching objectives as well as the specific policy objectives of these resolutions were analysed.
2.3 Group interviews

In order to identify opportunities with regard to collaboration between various ministries semi-structured face-to-face (group) interviews were conducted with representatives of the seven selected ministries. In these interviews we specified the respondents’ attitude towards HiAP and perceived critical factors for collaboration between various ministries. In total 19 policy officers of the seven ministries mentioned above were approached for an interview and all agreed to participate. Interviews were conducted in the period April – June 2009 separately for each ministry (one interview per ministry with one or more policy officers of the same ministry per interview) by one of the researchers and had an average duration of 60 minutes. To ensure that respondents were completely at ease to speak about collaboration with their colleagues from other ministries, the interviews conducted in this study were not audio-taped. Instead, extensive notes were taken during the interviews in order to correctly reproduce the content of the interviews. As member verification, notes of the (group) interviews were sent to the participants for their agreement. An overview of the respondents is given in Table 1. Respondents were asked for their opinion about (1) the involvement of their ministry with regard to health inequalities; (2) the perceived importance of HiAP and intersectoral collaboration; (3) suggestions to improve HiAP (e.g. drivers and barriers); (4) the preferred way of organizing collaboration for HiAP; (5) the role of the ministry of Health in the approach to reduce health inequalities. Based on these interviews possible improvements for HiAP on the topic of health inequalities were identified.
Table 1. Overview of respondents

<table>
<thead>
<tr>
<th>Ministry (Dutch initial)</th>
<th>Respondent’s position</th>
<th>Respondent’s gender</th>
</tr>
</thead>
<tbody>
<tr>
<td>Housing, Communities and Integration (WWI)</td>
<td>Policy officer integration</td>
<td>Male</td>
</tr>
<tr>
<td>Housing, Spatial Planning and Environment (VROM)</td>
<td>Policy officer urban policy and housing production</td>
<td>Male</td>
</tr>
<tr>
<td>Transport, Public Works and Water Management (V&amp;W)</td>
<td>Policy officer traffic policy</td>
<td>Female</td>
</tr>
<tr>
<td>Social Affairs and Employment (SZW)</td>
<td>Policy officer employment conditions</td>
<td>Male</td>
</tr>
<tr>
<td>Education, Culture and Science (OCW)</td>
<td>Policy officer inequalities policy and language delays</td>
<td>Female</td>
</tr>
<tr>
<td>Youth and Families (J&amp;G)</td>
<td>Policy officer youth lifestyle and living environment</td>
<td>Female</td>
</tr>
<tr>
<td>Health, Welfare and Sport (VWS)</td>
<td>Policy officer social support</td>
<td>Female</td>
</tr>
<tr>
<td></td>
<td>Policy officer public health</td>
<td>Female</td>
</tr>
<tr>
<td></td>
<td>Policy officer drugs policy</td>
<td>Female</td>
</tr>
<tr>
<td></td>
<td>Policy officer health insurance</td>
<td>Male</td>
</tr>
<tr>
<td></td>
<td>Policy officer financial policy and management</td>
<td>Male</td>
</tr>
</tbody>
</table>

Since October 2010 the Dutch government counts fewer ministries: the ministry of Transport, Public Works and Water Management (V&W) and the Ministry of Housing, Spatial Planning and the Environment (VROM) have become the Ministry of Infrastructure and the Environment (IM); the program ministry of Housing, Communities and Integration (WWI) is hosted by the ministry of the Interior and Kingdom Relations (BZK); the program ministry of Youth and Families (J&G) is reunited with the Ministry of Health, Welfare and Sport (VWS); and the ministry Agriculture, Nature and Food quality (LNV) is integrated into the Ministry of Economic Affairs, Agriculture and Innovation (ELI).

Because this respondent was not present during the (group) interview of the ministry, an additional individual interview with this respondent was conducted by telephone.

3. Results

3.1 Policy resolutions

Based on the data derived from the document analysis, 38 out of 153 policy resolutions were identified to have a potential impact on (the determinants of) health inequalities (i.e. one of the four action points). Often, these resolutions consisted of a combination of policy measures, projects and programs. Table 2 shows the distribution of these 38 policy resolutions over the different ministries and the action points that they address. Most policy resolutions were aimed on action point 1 (socioeconomic disadvantage) or action point 3.
Fifteen policy resolutions had a potential impact on the socioeconomic position of people (action point 1, Table 3a). Analysis of these policy resolutions revealed that there were three overarching objectives: (a1) to increase education opportunities for children from vulnerable groups; (a2) to create employment opportunities for vulnerable groups; (a3) to provide financial support to low income households. Policy resolutions were, for example, high quality language and math education or an intensive training program for young people leading to work/school or financial support for raising and maintaining children.

Four policy resolutions were identified that may increase the participation of people with health problems in either the labour market or in education (action point 2, Table 3b). Two overarching objectives were derived from the analysis of these policy resolutions: (b1) to improve education opportunities for children from disadvantaged backgrounds in combination with health problems; (b2) to improve employment of vulnerable groups. An example of a policy resolution was the removal of factors that hinder employment of disabled people.

Nineteen policy resolutions had a potential impact on living and working conditions and lifestyle of people with a low socioeconomic position (action point 3, Table 3c). These resolutions contained four overarching objectives: (c1) to improve physical living conditions of vulnerable groups; (c2) to improve social conditions of vulnerable groups; (c3) to improve working conditions of vulnerable groups; (c4) to improve the lifestyle of vulnerable groups. Examples of such policy resolutions were to ensure and promote sustainable quality of housing or to stimulate people to participate in sport activities, which also increases social participation and teaches people to respect each other.

Finally, four policy resolutions were identified with potential impact on the accessibility and effectiveness of healthcare for people of low socioeconomic position (action point 4, Table 3d). Analysis of these policy resolutions revealed that there were two overarching objectives: (d1) to realize citizens’ desired care; (d2) to ensure an effective system of public health facilities contributing to public health. An example of a policy resolution was, for instance, proper prevention and care for specific populations, such as residents of deprived neighbourhoods.

Looking at the 38 policy resolutions we also identified 11 existing links (that means intersectoral collaboration on these policy resolutions) between the ministry of Health and other ministries. These links were for instance found for policy resolutions that focussed on objectives to improve education opportunities for children and living conditions of vulnerable groups (e.g. Housing, Education, Youth and Families). No such links were present for policy resolutions addressing objectives like the creation of employment opportunities and the improvement of working conditions for vulnerable groups (e.g. Social Affairs and
Employment). The links that were present concerned major programs (e.g. Action plan deprived neighbourhoods, custom urban program) as well as measures and projects (e.g. increase social participation with specific focus on ethnic minorities, stimulating an active and healthy lifestyle among children while being actively involved in their environment).

However, most policy resolutions were developed and implemented in isolation (that is within one ministry) and not intentionally conducted on (determinants of) health inequalities (as one of the overarching objectives).

Table 2. Identified policy resolutions across sectors by four action points to reduce health inequalities.

<table>
<thead>
<tr>
<th>Ministry</th>
<th>Policy resolutions (n=38)</th>
<th>Action point 1: Socioeconomic inequalities</th>
<th>Action point 2: Effects of health on socioeconomic inequalities</th>
<th>Action point 3: Lifestyle, living and working conditions</th>
<th>Action point 4: Accessibility and quality of care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Housing, Communities and Integration</td>
<td>7*</td>
<td>2</td>
<td>0</td>
<td>5</td>
<td>2</td>
</tr>
<tr>
<td>Housing, Spatial Planning and Environment</td>
<td>4</td>
<td>0</td>
<td>0</td>
<td>4</td>
<td>0</td>
</tr>
<tr>
<td>Transport, Public Works and Water Management</td>
<td>3</td>
<td>0</td>
<td>0</td>
<td>3</td>
<td>0</td>
</tr>
<tr>
<td>Social Affairs and Employment</td>
<td>6</td>
<td>4</td>
<td>1</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Education, Culture and Science</td>
<td>8*</td>
<td>7</td>
<td>2</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Youth and Families</td>
<td>4*</td>
<td>2</td>
<td>1</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Health, Welfare and Sport</td>
<td>6</td>
<td>0</td>
<td>0</td>
<td>4</td>
<td>2</td>
</tr>
<tr>
<td>Total</td>
<td>38</td>
<td>15</td>
<td>4</td>
<td>19</td>
<td>4</td>
</tr>
</tbody>
</table>

* A number of policy resolutions are applicable to multiple action points to reduce inequalities.
Table 3a. **Action point 1**: fifteen identified policy resolutions with potential impact on the socioeconomic position of people.

<table>
<thead>
<tr>
<th>Overarching objectives</th>
<th>Policy resolutions of national policy chapters</th>
<th>Specific policy objectives</th>
<th>Policy domain/Type of Ministry</th>
</tr>
</thead>
</table>
| A1. To improve education opportunities for children of vulnerable groups | **Harmonizing rules childcare and playgroups (e.g. language delays)**<sup>a</sup>  
**Better supply of comprehensive facilities**<sup>b</sup>  
**Learning provision aimed at social skills**<sup>a</sup>  
High quality education (language and math education)  
Reduction of amount of early school leavers  
Intensive training program for young people leading to work or school  
Appropriate education in special needs | Reaching all children with language problems as early as possible (early childhood education)  
Increasing development opportunities of pupils (10-12 years) with learning delays  
Encouraging pupils to get a diploma, but also to develop as mature and independent people  
Applying for high quality education, with specific focus on language and math improvements on vulnerable groups  
Halve the annual number of new early school leavers in 2012 compared to 2002  
To offer an intensive training program for young people who are not attending school or work (for a reason other than disease or care)  
Maintain special schools and education for children with learning difficulties and large learning gaps | Education  
Health, Welfare and Sport  
Education, Health, Welfare and Sport  
Education  
Education |
| A2. To create employment opportunities for vulnerable groups | **Maintaining and improving financial incentives for work acceptance**  
Support in reducing the distance to regular work of persons who do not on its own force | Promoting employment of groups with low income and thereby improve their income  
Reintegration policy focus on outflow from unemployment to regular employment of beneficiaries with a large distance to regular work | Social Affairs and Employment |
| A3. To provide financial support to low income households | **Affordable rental housing supply and balanced distribution**  
**Housing affordability for groups with low income**  
**Achieving a balanced distribution of income**  
**Ensure adequate resources for supplementation of income to a minimum level**  
**Financial support for raising and maintaining children** | Guarantee for affordability of housing and balanced distribution of scarcity rent  
Guarantee affordability of independent living for all people and restricting rising house costs for specific groups  
Achieving a balanced distribution of income and protect the income position of vulnerable groups  
Combating poverty and encourage children to participate despite poverty  
Supporting families with financial compensation for raising and supporting children | Housing  
Social Affairs and Employment  
Social Affairs and Employment  
Youth and Families |

<sup>a</sup> Policy resolutions and objectives in the tables are translated as literally as possible from the national policy document.

<sup>b</sup> Existing link on these resolution between the ministry of Health, Welfare and Sport and the ministry of Education.
### Table 3b. Action point 2: four identified policy resolutions with potential impact on participation in the labour market and in education of people with health problems.

<table>
<thead>
<tr>
<th>Overarching objectives</th>
<th>Policy resolutions of national policy chapters</th>
<th>Specific policy objectives*</th>
<th>Policy domain/Type of Ministry</th>
</tr>
</thead>
<tbody>
<tr>
<td>B1. To improve education opportunities for children from disadvantaged backgrounds</td>
<td>Less early school leavers*</td>
<td>Reduce the number of early school leavers due to absenteeism</td>
<td>Education</td>
</tr>
<tr>
<td></td>
<td>Intensive training program for young people to lead to work or school*</td>
<td>To offer an intensive training program for young people who are not attending school or work (e.g. in relation to alcohol abuse)</td>
<td>Youth and Families</td>
</tr>
<tr>
<td>B2. To improve employment of vulnerable groups</td>
<td>Encourage and support emancipation process in society</td>
<td>Achieving equality of men and women in all areas of society, like employment</td>
<td>Education</td>
</tr>
<tr>
<td></td>
<td>Removal of factors that hinder employment of special groups</td>
<td>Prevent that special groups remain in employment (in addition to general labor)</td>
<td>Social Affairs and Employment</td>
</tr>
</tbody>
</table>

*Policy resolutions and objectives in the tables are translated as literally as possible from the national policy document.

*These policy resolutions are also applicable on reducing socioeconomic disadvantage (see Table 3a).
Table 3c. Action point 3: nineteen identified policy resolutions with potential impact on living and working conditions and lifestyle of people with a low socioeconomic position.

<table>
<thead>
<tr>
<th>Overarching objectives</th>
<th>Policy resolutions of national policy chapters*</th>
<th>Specific policy objectives*</th>
<th>Policy domain/ Type of Ministry</th>
</tr>
</thead>
<tbody>
<tr>
<td>C1. To improve physical living conditions of vulnerable groups</td>
<td>Action plan deprived neighbourhoods*</td>
<td>To realize vital pleasant living and working environment in the next eight to ten years</td>
<td>Housing, Communities and Integration Health, Welfare and Sport</td>
</tr>
<tr>
<td></td>
<td>Custom urban policy*</td>
<td>To improve subjective and objective safety, quality of the environment, social quality of society, bond of middle and high income to the city, and increasing economic strength</td>
<td>Housing, Communities and Integration</td>
</tr>
<tr>
<td></td>
<td>Ensure and promote sustainable quality of housing</td>
<td>Ensure minimum construction requirements and quality of housing in safety, health, usefulness and energy efficiency</td>
<td>Housing, Communities and Integration</td>
</tr>
<tr>
<td></td>
<td>Urban development</td>
<td>To improve living conditions of cities and the socio-economic position of cities, to strengthen accessible and accessible recreation facilities in and around cities, to strengthen economic areas and urban networks</td>
<td>Housing, Spatial Planning and Environment</td>
</tr>
<tr>
<td></td>
<td>Reduce road / traffic victims</td>
<td>To improve road safety for reducing road and traffic victims</td>
<td>Transport, Public Works</td>
</tr>
<tr>
<td></td>
<td>Decentralized/regional network transport</td>
<td>Better accessibility / infrastructure of cities for improving access from door to door</td>
<td>Transport, Public Works</td>
</tr>
<tr>
<td></td>
<td>Improve local air quality</td>
<td>Improving local air quality through prevention of harmful effects of air pollution</td>
<td>Housing, Spatial Planning and Environment</td>
</tr>
<tr>
<td></td>
<td>Quality environment highways</td>
<td>To reduce emission of harmful substances, to improve local air quality and to reduce high noises by traffic</td>
<td>Transport, Public Works</td>
</tr>
<tr>
<td></td>
<td>RemEDIATE contaminated soils</td>
<td>Elimination of health risks and rehabilitation of contaminated soils with specific focus on deprived neighbourhoods</td>
<td>Housing, Spatial Planning and Environment</td>
</tr>
<tr>
<td></td>
<td>Reduce noise</td>
<td>To reduce high levels of noise</td>
<td>Housing, Spatial Planning and Environment</td>
</tr>
<tr>
<td>C2. To improve social conditions of vulnerable groups</td>
<td>Increase social participation with specific focus on ethnic minorities</td>
<td>To reduce economic, social and cultural distance between immigrants and natives through increased economic, social and cultural participation</td>
<td>Housing, Communities and Integration, Health, Welfare and Sport</td>
</tr>
<tr>
<td>---------------------------------------------------</td>
<td>---------------------------------------------------------------</td>
<td>-----------------------------------------------------------------</td>
<td>---------------------------------------------------------------</td>
</tr>
<tr>
<td><strong>Active participation of citizens in social relationships</strong></td>
<td>To stimulate participation of citizens in society. Citizens making connections with each other, and making social connections arise</td>
<td>Health, Welfare and Sport, Housing, Communities and Integration</td>
<td></td>
</tr>
<tr>
<td><strong>Stimulate people in sport, social networks, and be respectful to each other</strong></td>
<td>Sport is the binding factor in the society, whereby health, safety, develop of mutual respect, integration and social development come together</td>
<td>Health, Welfare and Sport, Housing, Communities and Integration</td>
<td></td>
</tr>
<tr>
<td>Complete integration paths to promote social integration</td>
<td>Active involvement of new and old Dutch in the society through improving Dutch language and knowledge of the Dutch society</td>
<td>Housing, Communities and Integration</td>
<td></td>
</tr>
<tr>
<td>Accessible support on growing, educating and caring</td>
<td>Accessible family support on growing, educating and caring at the moment that a family and social environment sufficiently capable to answer education questions and to solve health of safety problems</td>
<td>Youth and Families</td>
<td></td>
</tr>
<tr>
<td>C3. To improve working conditions of vulnerable groups</td>
<td>Promote that workers and employers in firms have effective and efficient working conditions and prevent absenteeism</td>
<td>Promote that workers and employers in firms have effective and efficient working conditions, but also encourage their own responsibility</td>
<td>Social Affairs and Employment</td>
</tr>
<tr>
<td>C4. To improve the lifestyle of vulnerable groups</td>
<td>Children have a healthy lifestyle and are actively involved in their environment</td>
<td>To promote healthy living by powerful prevention of smoking, alcohol abuse, and stimulate healthy eating and physical activity</td>
<td>Youth and Families, Health, Welfare and Sport</td>
</tr>
<tr>
<td><strong>Choose a healthy lifestyle by more people</strong></td>
<td>To promote healthy living by discouraging smoking, use of alcohol and promoting healthy eating and physical activity</td>
<td>Health, Welfare and Sport, Youth and Families</td>
<td></td>
</tr>
<tr>
<td>To sport and to be physical active by more people</td>
<td>Encourage people to sport and to be physical active in a responsible manner</td>
<td>Health, Welfare and Sport</td>
<td></td>
</tr>
</tbody>
</table>

* Policy resolutions and objectives in the tables are translated as literally as possible from the national policy document.
* Existing link on these resolution between the ministry of Health, Welfare and Sport and the ministry of Housing, Communities and Integration.
* Existing link on these resolution between the ministry of Health, Welfare and Sport and the ministry of Youth and Families.
### Table 3d. *Action point 4*: four identified policy resolutions with potential impact on the accessibility and effectiveness of healthcare for people of low socioeconomic position.

<table>
<thead>
<tr>
<th>Overarching objectives</th>
<th>Policy resolutions of national policy plans</th>
<th>Specific policy objectives</th>
<th>Policy domain/Type of Ministry</th>
</tr>
</thead>
<tbody>
<tr>
<td>D1. To realize the citizens desired care</td>
<td>Providers achieve the desired care of citizens</td>
<td>Ensure that citizens will receive care according to the insured package which encourage providers to provide a high-quality health care (safe and accessible)</td>
<td>Health, Welfare and Sport</td>
</tr>
<tr>
<td>D2. To ensure an effective system of public health facilities for a better health</td>
<td><strong>Effective system of public health facilities that contributes to a better health</strong>&lt;sup&gt;a&lt;/sup&gt;</td>
<td>Contribute to good health en anticipate on health problems by an effective system of public health (connecting chain prevention and care)</td>
<td>Health, Welfare and Sport, Housing, Communities and Integration</td>
</tr>
<tr>
<td></td>
<td><strong>Action plan deprived neighbourhoods</strong>&lt;sup&gt;b&lt;/sup&gt;</td>
<td>Proper prevention and care for specific populations, such as residents of deprived neighbourhoods</td>
<td>Housing, Communities and Integration Health, Welfare and Sport</td>
</tr>
<tr>
<td></td>
<td><strong>Custom urban policy</strong>&lt;sup&gt;b&lt;/sup&gt;</td>
<td>Proper prevention and care for specific populations, such as residents of deprived neighbourhoods</td>
<td>Housing, Communities and Integration Health, Welfare and Sport</td>
</tr>
</tbody>
</table>

<sup>a</sup>Policy resolutions and objectives in the tables are translated as literally as possible from the national policy document.

<sup>b</sup>These policy resolutions are also applicable on improving living conditions (see Table 3c).

<sup>+</sup>Existing link on these resolution between the ministry of Health, Welfare and Sport and the ministry of Housing, Communities and Integration.
3.2 Critical factors for intersectoral collaboration

As mentioned before, intersectoral collaboration is regarded as an important prerequisite for HiAP. Based on the data from the (group) interviews we identified critical factors for collaboration as listed in Box 1.

Box 1. Critical factors for intersectoral collaboration to reduce health inequalities mentioned by 19 policy officers

1. Involvement of partners
   • Ministries temporally collaborate on strategic plans, an act or a program of action
   • To collaborate with both core partners (e.g., Housing, Communities and Integration, Social Affairs and Employment) as well as other relevant ministries, but it is the individual ministries’ choice to be involved

2. Perceived importance of HiAP and intersectoral collaboration
   • It decreases an overkill of measures targeted at lower-educated people
   • To have a common interest of goals can yield win-win for both ministries
   • It has value to be aware of each other’s issues and to reach alignment on an activity level
   • To cover the theme health in other areas

3. Suggestions to improve HiAP
   a Drivers for intersectoral collaboration on health inequalities
      • To strengthen existing links between the ministries and re-use existing policies, objectives and groups
      • To clarify in what way policies of other departments can be supportive in the reduction of health inequalities
      • To formulate overarching governmental objectives (and related activities).
      • HIAP strategy to reduce health inequalities should be a political choice (government priority)
   b Barriers for intersectoral collaboration on health inequalities
      • Collaboration should not lead to mandatory meetings and more administrative burdens
      • Own political priorities are most important and other objectives are complementary
      • Objectives at an operational level may vary, whereby tensions can arise on political level
      • Different ambition levels between ministries and funding streams may hinder collaboration

4. Preferred way of organizing HiAP on health inequalities
   • To address health inequalities in a programmatic and coordinated way
   • To improve collaboration through (existing) interdepartmental working groups or a program committee
   • Secondments of staff (at other ministries) will contribute to increased attention for health issues within other ministries

5. Suggested role of the ministry of Health
   • Establish a directive role with regard to the reduction of health inequalities, but it is required that the government sees it as a priority
   • To invest in other ministries to facilitate a complementary policy-related strategy (on reducing health inequalities)
   • To inform other ministries about the process with regard to the HiAP strategy in a way that other ministries will be inclined to engage in action
With regard to the involvement of partners most respondents indicated that in general ministries do not have problems in ‘finding’ each other for collaboration (that is: between the ministry of Health and another ministry). Respondents stated that there were sometimes temporarily forms of collaboration during the development of a strategic plan, an act or a program of action. When it comes to intersectoral collaboration to tackle health inequalities, the ministry of Housing, Communities and Integration (e.g. healthy neighbourhoods) was mostly involved (as was shown earlier in the identified policy resolutions). Regarding improving health, also other ministries (e.g. Social Affairs, Education, Youth and Families) were involved. Examples of (successful) intersectoral collaboration were observed in the prevention of smoking, alcohol and overweight (e.g. Covenant on Overweight and Obesity) [20].

Concerning the perceived importance of HiAP, respondents communicated a positive attitude towards intersectoral collaboration, while being aware of how their sector contributed to health inequalities (unintentionally). It was for instance outlined that, although health was not a major theme, the policies of their own ministry could probably impact inequalities of health. Common interest of issues was perceived as having the potency to yield win-win for both ministries, and being aware of mutual issues was seen as contributing to reaching alignment on activity level. The underlying assumption is that it is important to align on activity level and to diminish an overkill of measures targeted at lower-educated people. Although policy officers emphasized the importance of HiAP, in practice they found it difficult to realize intersectoral collaboration with regard to health inequalities.

With regard to suggestions to improve HiAP, an often mentioned driver for intersectoral collaboration was the re-use of existing policies, objectives and groups. In that respect, HiAP was regarded as being feasible from every thematic perspective. For example, alignment on objectives among the ministry of Social Affairs with the ministry of Health would be possible by connecting policies on reducing poverty and tackling health inequalities. As there were already many cross-sectoral links available, making use of these links was seen as more important than adopting a new approach (again and again). The interviewees also pointed out that the potential for collaboration would increase if the relation between policy outside the public health domain and health effects would be made more explicit. For instance, a healthy schoolchild has an increased chance of better school performance than an unhealthy child. It was however also noticed that it would be difficult to estimate the possible contribution of such policies to healthy life expectancy of lower-educated people. The respondents furthermore stressed the necessity of formulating overarching government-wide objectives (and related activities). Many respondents suggested that the ministry of Health should articulate a shared ambition to reduce health inequalities, based on a sustainable, broad, political agreement within the Dutch government. The government priority (e.g. urgency and political interest) would ultimately determine the further development of collaboration on inequalities of health.
With regard to barriers most respondents noted that collaboration should not lead to mandatory meetings and that the sector’s own political priority was most important. It was for instance mentioned that if an issue was not perceived as being urgent, than it would quickly receive a lower priority. Differences in ambition levels and funding streams between ministries were also perceived as possibly hindering collaboration.

Towards the preferred way of organizing HiAP, the respondents suggested that the ministry of Health should put forward a programmatic and coordinated strategy to reduce health inequalities. They also suggested to build on existing interdepartmental working groups, program committees or secondments of staff (at other ministries). In the program ‘Action plan deprived neighbourhoods’, for instance, ministries are already working well together, with one policy officer of the ministry of Health posted at the ministry of Housing to strengthen cross-sectoral links.

With regard to the role of the ministry of Health, respondents indicated that if there is broad and political support, this ministry should have a directive role and should invest in other ministries to facilitate a policy-related strategy on reducing health inequalities. It was for example stressed that it would be important to have a responsible person present for contact and to clearly explain process and planning in the HiAP approach. Respondents indicated that this would be also important towards local authorities (e.g. municipalities).

4. Discussion

In the last few years the Dutch government has been looking for a renewed strategy to reduce health inequalities by formal HiAP on national level. In this explorative study, opportunities for HiAP were investigated by analyzing possibilities for amending health inequality determinants on the one hand, and by analyzing critical factors for intersectoral collaboration on the other hand.

A qualitative descriptive screening of the Dutch national budget was performed to identify policy inside and outside the public health domain targeted at health inequalities. We identified 38 policy resolutions with impact on (the determinants of) health inequalities. Most of these policy resolutions focused on objectives to improve education opportunities for children and living conditions of vulnerable groups. Only few policy resolutions addressed objectives like the creation of employment opportunities, the improvement of working conditions or the improvement of the quality of healthcare for these groups. Remarkably, for only 11 of the 38 policy resolutions we identified intersectoral collaboration between the ministry of Health and other ministries (e.g. Housing, Education and/or Youth and Families). This means that most of the policy resolutions with a potential impact on (determinants of) health inequalities were developed and implemented in isolation. This indicates that
these policy resolutions were not intentionally conducted on government-wide objectives and visible related activities to reduce health inequalities.

Unlike Norway and the UK, the Dutch government does not have a ‘whole of government approach’. Such an approach, as described by the European Observatory on health systems and policies in 2009, suggests that a country has a national strategy with commitment from high level, collaboration and coordination mechanism to influence other ministries, concrete objectives and visible results (supported by various ministries), and formal control mechanism and procedures on the theme health inequalities [21]. In the UK, for example, the programme ‘Tackling Health Inequalities: a programme for action’ proposes 80 commitments on concrete objectives from various ministries to a very clear common goal on health inequalities [22]. The presence of tangible objectives may create the opportunity to show which related policy resolutions have contributed to a reduction of (determinants of) health inequalities. Such formal elements play an important role in countries with a government-wide HiAP strategy on tackling health inequalities and may be useful in the Netherlands as well [23].

In order to analyse critical factors for intersectoral collaboration (as a prerequisite for HiAP) we conducted semi-structured (group) interviews with policy officers from various ministries. Generally, most respondents acknowledged that their policy resolutions could (mostly indirectly) contribute to the reduction of health inequalities, and most of them had a positive attitude towards intersectoral collaboration as well. This indicates that amongst policy officers there is a basis for a formal HiAP approach. When asked for opportunities to collaborate on HiAP, the respondents reported several critical factors. They suggested to strengthen existing links between ministries, to increase the re-use of existing policies, to create common interest of goals, to approach the theme in a programmatic and coordinated way, and to achieve broad political achievement. Also, most respondents of ministries underlined that clarifying the relation between policy outside the public health domain and health effects might build a strong case for HiAP. Therefore, it is essential for the ministry of Health to invest in relationships with other ministries with regard to health inequalities and to coordinate HiAP between ministries in a programmatic way. Coordination and collaboration mechanisms are also recommended by a recent study of the Dutch Council of Public Health and Health Care and are one of the relevant elements within a whole of government strategy [24].

In literature the role of the ministry of Health has been pointed out as a key for HiAP [25]. For example, the ministry of Health in Norway plays a central role in coordinating and supporting HIAP. However, this is not explicitly the case in the Netherlands. Institutional features of Dutch ministries may probably hinder HiAP as well as intersectoral collaboration [23]. Dutch ministries have their own governance, which implies that one ministry has little control over policy-making within other ministries. This means that the Dutch ministry
of Health has only limited influence on many health-related issues (e.g. determinants of health inequalities that are the responsibility of other ministries). Furthermore, the Dutch health insurance system provides the ministry of Health with indirect rather than direct opportunities to influence health. Hence, these Dutch institutional features could constitute an additional challenge in pursuing HiAP and intersectoral collaboration compared to other countries [21, 23].

Therefore, broad political agreement on reducing health inequalities seems to be an essential next step for the Netherlands ministry of Health. In Norway, for instance, reducing health inequality is a whole of government challenge, and the government is committed to action for a society in which there is equal opportunity for healthy life for every individual [26].

Overall, most of the drivers mentioned by Dutch national policy officers are also important strategic elements in countries that show formal HiAP on the national level through a whole of government approach. However, although HiAP is recommended in Dutch policy documents, policy resolutions of various ministries are available, key partners appear to be already involved in several health problems, and policy officers are positive about intersectoral collaboration, deploying a formal HiAP approach to reduce health inequalities requires additional strategic action. Examples of the way this could be realized are: reaching commitment from a high policy level, influencing other ministries by putting forward coordinated and collaborated mechanisms, focusing on concrete objectives to reduce health inequalities in a balanced way, and developing more knowledge on this topic for underpinning this strategy [21].

Finally, although, a HiAP approach in itself is still in its infancy in most countries, a HiAP approach to reduce health inequalities is, in particular, suitable for different sectors to participate and collaborate. Previous international studies emphasize the impact of policy outside the public health domain on health inequalities (and their determinants) [27]. Nevertheless, the implementation of a HiAP strategy on health inequalities is difficult and will remain a challenge [28].

There are a few limitations and strengths of this study to address. A first limitation is that not all ministries and stakeholders at the administrative and the political level were involved. Previous findings indicate that horizontal as well as vertical collaboration is required to achieve intersectoral action and HiAP [29], future studies on this theme should preferably include a wider range of both ministries and stakeholders (e.g. administrative and political level). A second limitation is that in October 2010 a new Dutch Government has come into office. For this government, reducing health inequalities is no explicit priority, although this theme is indirectly addressed by policy objectives on other themes (e.g. safe sport and exercise in the neighbourhood and making the healthy choice the easy choice) [30]. Therefore, this study on HiAP to reduce health inequalities has become less relevant
for actual policy practice in the Netherlands. However, relevance remains for other Western countries with a focus on health inequalities. Besides, also for other themes this study provides interesting points of departure for enhancing a formal HiAP strategy.

5. Conclusion

In conclusion, with regard to current HiAP practices in the Netherlands, there is room for improvement to reduce health inequalities by formal HiAP. The main challenge aimed at reducing health inequalities is on the one hand to cover the determinants of health inequalities in a balanced way linked to concrete (overarching) objectives and visible results. On the other hand it is necessary to enhance high level agreement as well as coordinated and collaborated mechanisms from the government in general and the ministry of Health in particular.

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