CHAPTER 8

General discussion
8.1 Introduction

The aim 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. The thesis draws on four Dutch case studies at the national and local level, in which HIAP practices were subject to empirical analysis using various theoretical models and tools. The case studies focused on the use of HIAP to reduce health inequalities or to improve public health. In addition on these studies, a knowledge synthesis was performed, taking in a number of Dutch key publications on HIAP. The studies within this thesis were performed in the period between 2009 - 2014.

As a basis for organising and interpreting the results of the studies used, a HIAP cycle was introduced. The HIAP cycle consists of four process steps: developing, implementing, measuring and improving (based on the Plan-Do-Check-Act cycle). Within the HIAP cycle, common strategic building blocks (and associated key elements) have been formulated for each of the four steps, on the basis of the research outcomes in the used studies. The cycle and the building blocks are intended to support people working in practice to introduce or extend the application of HIAP.

Three questions were derived from the general aim of this 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?

In subsection 8.2, the results of the Dutch case studies are summarised and discussed in the light of the HIAP cycle. The results with regard to the three research questions are linked to the ‘development’, ‘implementation’ and ‘measurement’ process steps, focusing on both the technical elements (supportive theoretical tools and models) and the practical elements (action perspectives in practice). Where the ‘improvement’ process step is concerned, consideration is additionally given to the technical and practical elements that supplement the three research questions (as derived from the results of the Dutch case studies). In subsection 8.3, the research outcomes from the studies are placed within the HIAP cycle as building blocks for giving (further) support to the HIAP approach in practice. In subsection 8.4, the limitations of the case studies are discussed. Finally, in subsection 8.5, ways in which the HIAP approach could be further promoted in the future are explored.
8.2 Summary and reflection on research outcomes

8.2.1 Which factors contribute to the development of HiAP in practice?
Dutch case studies 1 & 2 on national level identified the factors that contribute to the
development of HiAP practices aimed at reducing health inequalities and improving public
health (chapters 2 & 3). In case study 1, qualitative (determinant) policy screening (DPS)
was used to assess how policy sectors within seven different ministries (including Health,
Social Affairs and Education) could contribute to the reduction of health inequalities in the
population. Study 2 used Health Impact Assessment (HIA) to investigate the impact of the
Ministry of Social Affairs’ proposed work-related learning policy (ex ante) on certain groups
of workers and their health, and whether the differences were avoidable (i.e. whether health
inequalities could be prevented). A reflection on the main findings made in connection with
research question 1 is presented below.

Tools for the development of HiAP
For the development of a HiAP approach, it is useful to identify how sectors inside and
outside the public health domain can contribute to public health and health equity [1, 2].
Both DPS and HIA proved to be viable tools for systematically expanding knowledge and
assessing the impact of policy on health and health equity. However, the tools require
adaptation to the particular priorities of the situation to which they are applied [3-5]. For the
screening of the seven ministries’ policies in study 1, the determinants of health inequality
within the theoretical model for reducing health inequalities (Albeda model) were used to
identify the sectors that (could) contribute to the reduction of health inequalities [6]. For
the HIA in study 2, an equity focus was specifically introduced to the tool to assess the
impact on health inequalities of the proposed policies of one other ministry. The relative
abstract formulation of the policies and measures made it difficult to find evidence in the
literature for these policies [5]. Input from Dutch documents and interviews with experts and
stakeholders were therefore used as additional sources of input for estimating the policies’
impact on health. The studies were undertaken under optimal circumstances, in terms of
the clear mandate from the Ministry of Health, the structured process, the composition
and experience level of the support team, and the availability of the resources needed
for researchers to make effective use of the tools. HIA appears useful mainly as a tool for
realising Health Public Policy (HPP) in a single sector outside the public health domain (i.e.
ensuring that policies take explicit account of health). DPS is a useful tool for starting from
the determinants of health (inequality). This starting point results in the identification of the
sectors outside the public health domain where Intersectoral Action (‘IA’, i.e. collaborative
efforts of one sector to improve health outcomes) is taking place, and where there are
perspectives for action in terms of reinforcing collaborative efforts of multiple sectors to
improve public health or health equity (i.e. multi-sectoral policy collaboration contributing to public health). The casuistics are described at the national level, but the tools can of course be used perfectly well at the local level. Research nevertheless indicates that only 15 per cent of Dutch municipalities use such tools, because of unfamiliarity with the tools or lack of support [7].

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<tr>
<th>Technical key elements for the development of HiAP</th>
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<tr>
<td><strong>Insights</strong>: the systematic (centralised) collection and analysis of data on the impact that policies in sectors outside the public health domain may have on population health or health equity contributes to the development of a HiAP approach.</td>
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<tr>
<td><strong>Tools</strong>: Determinant Policy Screening (DPS) and Health Impact Assessment (HIA) are useful tools for clarifying recognised relationships between sectors and realising integrated policy development (but adaptation to particular priorities is necessary)</td>
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**Action perspectives for the development of HiAP**

The insights from the two studies provide action perspectives for policy-makers and professionals for developing a HiAP approach in practice. Study 1 identified thirty-eight policy resolutions at seven ministries, which addressed the determinants of health inequality (mainly socioeconomic status and the living conditions of vulnerable groups). In eleven of the thirty-eight policy resolutions, evidence of collaboration between the public health policy sector and other policy sectors was observed. The study showed that most policy resolutions were not used in a comprehensive approach with respect to reducing health inequalities, and that there were opportunities for strengthening existing links between ministries and for re-using existing policies, objectives and groups. The results of the study served as input for development of the national ‘Policy plan targeting health differences through socioeconomic backgrounds’ published by the Ministry of Health [8]. Study 2 also showed that the policies of different sectors (in this case, work and health) can be interlinked with a view to addressing (health) inequalities. The study showed that work-related learning has a positive influence on (the determinants of) (work-related) health through factors such as pay, employability, longer employment and training participation. With a view to reducing avoidable inequalities in work-related learning, it is recommended that early, low-threshold, accessible opportunities are made available to vulnerable groups. The results of the study could support the development of HPP and enhance further collaboration between the relevant policy sectors. The results of the study have been fed back to the Ministry of Health and the Ministry or Social Affairs [9].

The determinants serve as a good starting point for getting various sectors to focus on objectives and groups, but it remains challenging to translate that into a HiAP approach. Another Dutch study of the HiAP approach (Local 50) also showed that health determinants were not always explicitly used as a starting point for integrated policy-making [10]. Studies
1 and 2 also show that high-level agreement (or a clear mandate) and coordination (with a directive role for the health sector) are critical factors for the ultimate realisation of a HiAP approach [11, 12].

**Practical key elements for the development of HiAP**

**Address determinants in a balanced way** on the basis of information about health determinants.

**Involve multiple policy sectors** outside the public health domain in the pursuit of (health) objectives and visible results (activities).

**Reinforce cross-links between policies** inside and outside the public health domain where there are recognized relationships and impact (IA or HPP).

**Create shared-interest goals or groups** can yield win-win situations for participating policy sectors.

The two national studies referred to show that the emphasis in the ‘developing’ process step is mainly on revealing opportunities for policy work by various sectors (development ‘in word’) and less on the collaboration process or the conditions for collaboration (development ‘in deed’). It may be concluded that, in practice, a HiAP approach can be developed by focusing on agenda-setting and policy preparation in collaboration with policy sectors inside and outside the public health domain (joint policy-making on health). The central concepts in that context are ‘health’ and ‘policy’. The implementation of a HiAP approach in practice requires a further step.

**8.2.2 How is HiAP implemented in practice?**

Dutch case studies 3 & 4b on local level show how HiAP is used in practice to improve public health or to reduce health inequalities. Case study 3 looked at seven neighbourhoods in which a stepwise approach based on two central tools (district health profiling and policy dialogues) was used, to develop integrated district plans and promote collaboration between public health and primary care to improve public health. Case study 4b considered how the public health sector and both social policy sectors (e.g. youth affairs, education) and physical policy sectors (e.g. housing, spatial planning) in sixteen municipalities collaborated in reducing health inequalities (via collaboration networks). A reflection on the main findings made in connection with research question 2 is presented below.

**Tools for the implementation of HiAP**

The implementation of a HiAP approach in practice requires structural collaboration between sectors inside and outside the public health domain: ‘intersectoral collaboration’ (IC) [1, 3, 13]. IC goes beyond IA and HPP (IA en HPP focus mainly on recognized relationships or impacts between policy sectors). The two studies on local level show that integrated district health profiles, policy dialogues with sectors inside and outside the public health domain and collaboration in policy networks are workable strategies for implementing a
joint diagnosis or approach with a view to improving public health or health equity [14, 15]. Such tools have been developed or refined on a practical basis, drawing on local experiences (by regional public health services, regional primary care support structure, municipalities). The studies show that, in the local setting, the tools are used in various ways, depending on local circumstances. For example, the seven neighbourhoods considered in study 3 differed in the way that the two tools (district health profiles and policy dialogues) or the stepwise approach (with seven steps to develop integrated plans and to promote collaboration) were used: general versus focused profiles, the actors involved, the aims of the dialogues or the intensity of the steps. There were also similarities in all neighbourhoods, including profile indicators (e.g. population prognosis, vulnerability) and dialogue themes (e.g. obesity, social cohesion). Besides, the seven steps of the stepwise approach were the same in all the districts involved. The conditions for use of the tools were optimal in the study, because local practice was supported by action-focused researchers and 'inspiration days' (training).

In study 4, various strategies were used for collaborating in policy networks: harmonization of objectives, use of policies from multiple sectors, formalised collaboration and previous experience (i.e. collaboration conditions between policy sectors inside and outside the public health domain). Study 3 showed that district profiles were useful mainly as a starting point for discussion, but that a district profile should not be regarded as an end in its own right [15, 16]. The study also found that dialogues were indispensable to the process, as a vehicle for integrating stakeholders’ knowledge and experiences. Studies 3 and 4 showed that collaboration was encouraged simply by bringing people from the various sectors into face-to-face contact and letting them get to know each other [16]. Promoting the development of strong policy networks therefore also contributes to the implementation of HiAP, although the process must be led by the content [17]. The casuistics were described on the basis of local practice and are applicable to other local situations.

**Technical key elements for the implementation of HiAP**

**Insight:** working on a joint diagnosis or a joint approach to public health or health equity contributes to the implementation of a HiAP approach.

**Tools:** district profiles, policy dialogues and policy networks appear to be useable tools for realising integrated decision-making and collaborative implementation

**Action perspectives for the implementation of HiAP**

The insights from the two studies on local level provide action perspectives for policymakers and professionals in terms of implementing a HiAP approach in practice. Study 3 showed that the strategy of integrating data to build a district health profile and interpreting that profile with local actors leads to the integrated planning of health activities aimed at improving local population health and strengthening collaboration (e.g. closer involvement, consensus about focus). It is essential to invest sufficiently in the integration of district
profile data (e.g. population prognosis, vulnerability) and in involving appropriate actors in the dialogue (e.g. municipalities, GPs and residents) [15, 16]. The study also showed that clear arrangements (plans) were needed to get the right sectors and actors involved and to keep them involved. Otherwise, there was a danger that ties would not be forged and that collaboration would not follow. After all, collaboration is characterised by the maintenance of multilateral relations amongst stakeholders and by positive experiences [18, 19]. Efforts to promote collaboration between the public health and primary care sectors in the seven districts examined in study 3 led to agreement on themes (e.g. obesity, social cohesion and loneliness of the elderly) and on collaboration methods (e.g. workgroups, follow-up meetings). Study 4 found that the issue of health inequality reduction received more attention from social policy sectors, even though the physical policy sectors studied by the researchers devoted attention to improving public health. More is done to influence the determinants of health inequality through policies aimed at lifestyle and social setting than through policies aimed at socioeconomic factors and the physical environment. The study also showed that, where the physical policy sectors are involved in the network to reduce health inequalities, the collaboration follows a very similar pattern to the collaboration with social policy sectors. Ways in which improvement of collaboration could be realised include involving physical policy sectors in the network (e.g. investments in relations), pursuing widely supported policy goals, and making balanced efforts to influence public health determinants. The value of a structural approach and a process supervisor for maintaining the momentum of the HiAP process is apparent from both study 3 and study 4 [15, 20]. Similar findings have been made in other studies of HiAP [21-23]. Study 4 highlighted opportunities for improvement on HiAP, and the relevant findings have been fed back to the sixteen municipalities collectively, but not individually [17].

Like studies 1 and 2, studies 3 and 4 found that a clear mandate and the availability of resources (e.g. to appoint a process supervisor or coordinator) were preconditions for HiAP implementation. Other research shows that collaboration is often confined to temporary (subsidized) projects and that attention needs to be given to avoiding that pitfall [24, 25].

**Practical key elements for the implementation of HiAP**

**Invest (and continue investing) in networks** is necessary for the integration of data and involvement of sectors (social and physical) and actors (citizens included)

**Make clear plans and agreements** on public health or health equity with the relevant sectors (using profile data, dialogues).

**Promote structural collaboration** to defined themes, objectives and activities.

**Appoint a process supervisor** (typically from the public health sector) to coordinate the process.
From the two studies described above, in which collaborative relationships were investigated, it appears that the ‘implementing’ process step mainly involves the establishment of new collaborative relationships and that work therefore still has to be done to ensure the continuity of the collaboration. It may be concluded that a HiAP approach can be implemented in practice by working on integrated decision-making and policy implementation, so that collaborations between sectors become more structural and more formal (programme management). The central concepts in that context are ‘Collaboration’ and ‘Coordination’. The next step is to reflect on and evaluate intersectoral collaboration in order to continue improving the HiAP practice.

8.2.3 What information is needed to obtain insight into the progress of HiAP practice?
Dutch case study 4a on local level and the knowledge synthesis (of several Dutch key publications on HiAP) identify the information needed to obtain insight into the progress of HiAP practice. Case study 4a applied a maturity model (with six maturity levels) to a group of sixteen municipalities to shed light on the progress measurement in situations where HiAP is used to reduce health inequalities. The knowledge synthesis investigated how HiAP can be monitored and/or evaluated in practice (using the logic evaluation model). A reflection on the main findings made in connection with research question 3 is presented below.

Tools for the evaluation of HiAP
In order to manage or control the development and practical implementation of HiAP, it is useful to reflect on those processes through research and evaluation [26, 27]. Evaluation of HiAP is difficult, because in practice it has a variety of different forms and characteristics and because the terminology used in the field is not standardised [28, 29]. Study 4a showed that the maturity model for Health in All Policies (MM-HiAP), in which six stages of maturity and fourteen associated key characteristics are defined, is a viable tool for measuring HiAP progress. Each stage has its own characteristics: Unrecognised (stage 0), Recognised (stage 1), Considered (stage 2), Implemented (stage 3), Integrated (stage 4) and Institutionalised (stage 5). The model can help municipalities to recognise the stage they are in, and also may help them to progress to the next stage. From the knowledge synthesis it is also apparent that various tools can be useful for generating information about HiAP key characteristics. In the interest of clarity, a classification system based on an existing logic evaluation model has been used [30]. The three categories in the classification system are: context (e.g. HiAP type), processes (e.g. policy interlinkage, intersectoral collaboration, satisfactory support) and impact (e.g. effect on health or its determinants) [31]. It helps to divide HiAP into ‘bite-size chunks’. However, tools sensitive enough for the evaluation of such HiAP key characteristics are not always available [32, 33]. Moreover, it is apparent from both studies that when knowledge about relevant HiAP characteristics is generated, confusion can arise...
concerning the meaning of some terms, such as ‘political support’ [34]. Other researchers studying HiAP have made similar observations [35] [36]. The importance of being able to gauge HiAP progress is recognised within central government as well. That was one of the reasons for funding the consortium Instruments for Integrated Action (i4i), which works on measurement tools for HiAP (e.g. HiAP checklist, Responsive Evaluation of Integrated Action Method) [33, 37, 38]. Like the maturity model, such tools have been developed in the Netherlands over recent years and are potentially useful additions to tools such as HIA and DPS. However, they are not often used in local practice and require further validation [25, 34].

**Technical key elements for the evaluation of HiAP**

**Insights:** the systematic study of HiAP key elements and the associated characteristics (individually or collectively) supports the process of gauging the progress of the HiAP approach.

**Tools:** MM-HiAP appears to be a usable tool for monitoring and evaluating HiAP levels and characteristics, and the logic evaluation model appears to be a useable tool for identifying which tools are needed for HiAP evaluation and assessing their availability in practice (but exact meaning of the characteristics is necessary).

**Action perspectives for the evaluation of HiAP**

The insights from the study 4a and knowledge synthesis studies provide action perspectives for policy-makers and professionals to measure (or commission measurement of) the HiAP approach in practice, and to use the findings to improve the approach’s practical implementation. The lack of (implementation) knowledge might be one of the reasons why HiAP is often considered insufficiently mature [25, 39]. Study 4a showed that it was possible to classify the stage of HiAP growth processes in sixteen municipalities: recognition of the importance of HiAP (Stage I: three municipalities), HiAP described in policy documents and project-based collaboration (Stage II: seven municipalities), concrete collaboration and structural consultation forms (Stage III: four municipalities), and a broad, shared vision on HiAP (Stage IV: two municipalities) [25]. In order to move from Stage 0 to Stage I, it is important to raise awareness. To go from Stage I to Stage II, it is important to invest in personal commitment (e.g. pay attention to positive experiences). Progression from Stage II to Stage III depends particularly on process direction (e.g. making agreements, securing management support). In order to move from Stage III to Stage IV, or even Stage V, it is important to focus on results and continuous improvement. The results show that there are sufficient leverage points to steer on the HiAP approach, but this generated knowledge to steer and to growth is not being actively utilised in the sixteen municipalities considered in the study (this falls outside the scope of this study) [17]. However, the MM-HiAP is after development used in practice by the Province of Brabant to monitor HiAP growth processes in multiple sectors (e.g. environment, spatial planning, sport) [37].
The practice-based exploration contained in the knowledge synthesis shows that scope for knowledge generation exists mainly in relation to processes (input and output), rather than impact (outcomes). Other research has shown that the impact of the HiAP approach on public health or health equity remains very difficult to quantify and therefore longer term studies are needed [40]. It is inherently easier to gauge the impact of a standalone policy measure than the impact of a mix of policy measures on (determinants of) health [41]. It is also apparent from the knowledge synthesis that it was necessary to carefully match the tooling to the diversity of HiAP key characteristics. In other words, consideration must be given to what is appropriate in each practical situation and to what management information is needed (objectives and abstraction level).

From both study 4 and the knowledge synthesis, it is also apparent that satisfactory management support and resources are required for the generation of management information on the progress of HiAP.

| Practical key elements for the evaluation of HiAP |
| Measure key characteristics | are needed for effective control and application of the HiAP approach. |
| Place emphasis on process outcomes | of the HiAP approach. |
| Use the right tools | for evaluation of the relevant elements and characteristics (individually or collectively) of the HiAP approach. |
| Match to the practical situation | using tools appropriate to objectives and abstraction level. |

From both studies on evaluation of HiAP, it is apparent that the emphasis in the ‘measuring’ process step is mainly on generating information about HiAP practice, thus yielding action perspectives for steering the HiAP approach. It may be concluded that, if the right tools are used, the HiAP approach (or components of it) can be evaluated in practice, but that (new) tools for HiAP need to be utilised and refined in the field and in collaboration with practitioners [42]. The central concepts in this process step are ‘reflection’ and ‘evaluation’. The following step is the (further) improvement of HiAP in practice by building on the experience gained in the preceding steps.

8.2.4 What additional factors contribute to further improvement of the HiAP approach in practice?

In addition to the research findings relating to the specific research questions, the Dutch case studies contain a number of common findings. Case studies 1, 2, 3 and 4 produced consistent observations regarding the improvement of HiAP in practice. A reflection on the main findings made (insofar as additional to those linked to the other three research questions) is presented below.
Tools for the improvement of HiAP

The results of the four Dutch case studies demonstrate that knowledge, experience and (a combination of) tools contribute to the improvement of a HiAP approach. In all studies, previous experience amongst policy-makers and professionals was found to have a positive effect on the HiAP approach [15, 20, 25]. Research also shows that, where HiAP is practised in the Netherlands, numerous questions always arise, such as how support can be generated, how collaboration with other sectors can be realised and progress with an integrated policy or plan can be measured [42, 43]. Furthermore, although tools are increasingly available, they are not being utilised sufficiently in practice, due to lack of awareness amongst practitioners, or because tools appear complex to use in practice [42]. In the four studies, the conditions were highly conducive to the use of tools, insofar as finance and satisfactory support were available (e.g. the presence of researchers to generate knowledge and training in the use of tools for professionals). In many practical settings, the conditions will be less conducive to tool use [44]. The four studies show that, for the improvement process, it can be useful to use (or learn to use) existing or newly developed tools to develop, implement and evaluate the HiAP approach and to gain positive experiences. That implies adopting or continuing to use well-established tools, such as HIA and DPS, but also making more use of tools for collaboration and evaluation (‘tool combinations’). However, in the Netherlands, practising professionals have little experience of working with those tools [33]. The use of tools will therefore require a cultural shift in the field [42]. Moreover, tools should not be seen as ready-made solutions. Rather, users should adapt tools to the setting and process in which they will be used, or work more closely with knowledge suppliers (e.g. researchers or advisors) [42].

Technical key elements for the improvement of HiAP

Insights: using knowledge and tools and gaining experience contribute to improvement of the HiAP approach.

Tools: combining multiple supportive tools for HiAP appears to be useful for the further extension of HiAP in practice.

Action perspectives for the improvement of HiAP

The insights from the four studies provide action perspectives for policy-makers and professionals to improve HiAP in practice by developing appropriate skills and continuing to build on previous (positive) experiences [15, 20, 25]. In study 3, the process supervisors in the seven districts were trained (e.g. in tool use, collaboration and networking, embedding integrated plans or activities) and were given advice on the use of HiAP by action-focused researchers [15]. In another Dutch study, a concept-map for HiAP was developed. It was found that – along with themes such as health (e.g. addressing determinants) and integration (e.g. promoting ties) – capacities (e.g. learning process, boundary work) was also a key theme for HiAP [36].
Along with developing the right skills and building on previous (positive) experiences in HiAP, it is apparent from the four studies that support (e.g. clear mandate, managerial support) and resource availability (e.g. personnel capacity for process supervision) are also advantageous to a HiAP approach. Such support promotes the use of knowledge, the acquisition of experience and the use of appropriate tools and thus contributes to improvement of the HiAP approach. From the domain of policy science, it is known that policy cannot be introduced unless there is a recognised problem, a policy solution to that problem and political support for that solution [45]. The prevailing mood, the political culture and traditions, and the available funds are all influential [46]. Other research into HiAP in Dutch municipalities has also shown that HiAP cannot become established without tactical and strategic support [39, 47].

**Practical key elements for the improvement of HiAP**

- **Secure support** by a clear mandate, high-level agreement and management support to get HiAP formally established.
- **Secure (financial and human) resources** for coordination of the HiAP approach (usually with direction from the health sector).
- **Improve capabilities and skills** of professionals, enabling them to forge ties, collaborate in networks and make use of tools.
- **Build on previous (positive) experiences** to continually improve the HiAP approach.

From the four studies, it is apparent that, in the ‘improving’ process step, progress can be made by using knowledge, building on experience, using (multiple) tools and securing satisfactory support. It may be concluded (in addition to the conclusions presented in the context of other steps) that a HiAP approach can be improved in practice by focusing on capacity building. In that context, the central concepts are ‘learning’ and ‘support’. The process steps may be implemented cyclically and dynamically to bring about continuous improvement of the HiAP approach in practice.

### 8.3 Strategic building blocks of the HiAP approach

Fig. 1 illustrates a Health in All Policies cycle (HiAP cycle), with its four constituent steps: developing, implementing, measuring and improving (or: plan, do, check and act). 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. On the basis of the empirical results from the four Dutch case studies and the knowledge synthesis, the strategic building blocks for constructing a formal HiAP approach (as described in subsection 8.2) have been defined on a step-by-step basis. The HiAP cycle can be useful to professionals, but should not be used in the absence of a general vision or ambition for addressing complex health problems on the basis of HiAP.
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)

The HiAP cycle will not in practice always follow the illustrated sequence, because HiAP is an iterative and complex process [33]. Policy processes are capricious and therefore often unpredictable [45]. In practice, therefore, it is often a question of identifying the appropriate approach path for HiAP (where are the leverage points?), and one may enter the HiAP cycle at various stages. For example, a HiAP approach may start with addressing the determinants of health or health equity; but it may equally well start with collaborative ties and policy decisions.
networks or with reflection on existing HiAP practices with the aim of promoting or protecting health. Hence, the HiAP cycle is applicable to any practical situation and provides leverage points for the (further) promotion of a formal HiAP approach at various junctures. The four studies considered in this thesis also confirm that it is not possible to provide a specific blueprint for the HiAP approach, but that the use of generic process steps (e.g. plan, do, check and act) with associated building blocks can facilitate the improvement of a HiAP approach. Within each process step, there are of course subordinate steps (e.g. preparation, implementation and evaluation), as demonstrated by various tools and methods in the four studies. The HiAP approach may therefore be described as a continuous, practice-based improvement process. 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.

### 8.4 Limitations and strengths

#### 8.4.1 Methodology

The insights provided by this study need to be considered in the context of the methodological limitations. First limitation is that the study was based on a small number of Dutch case studies with exploratory practices, and practices were difficult to compare with other scientific research. A strength is that various tools and models were used, including mixed data collection, such as literature study, digital questionnaires, interviews and document analyses. The tools were based on existing theoretical tools, models or strategies. However, for all four studies, the tools had to be adapted for use with HiAP or health inequalities as casuistics. The tools were suitable for use in practice and the theories supporting them are well documented, but further practical application and evaluation is needed. Because the case studies focused on actual practice and made use of input from practising professionals, they yielded useful information about the HiAP approach and led to more tools becoming available for use in HiAP practice [33]. From the literature, it is apparent that cases studies can also make a valuable contribution to scientific research [48].

#### 8.4.2 Study design

The second limitation is that the research focused on particular ministries and municipalities in the Netherlands. Where the two national studies were concerned, the determinant policy screening was performed at seven ministries, while the HIA was restricted to the Ministry
of Social Affairs and Employment. In the two local-level studies, research focused on sixteen of the Netherlands’ municipalities (roughly four hundred in total) and seven districts in the province of Brabant respectively. In the local studies, the location and size of the municipalities or districts were taken into account as far as possible, but the fact remains that the studied municipalities and districts were merely convenient samples. A strength is that the tools used in case studies 3 and 4 were developed or refined on the basis of practice and involve generic process steps and characteristics for HiAP. Furthermore, neither case study observed anything to suggest that the size or location of the studied municipality or district had any influence on the extent to which intersectoral collaboration was realised; factors specific to such collaboration (e.g. consensus on objectives, commitment from sectors) appeared to be more influential [15, 25]. The expectation is also that the tools and associated results will be recognisable and transferable to other ministries, municipalities and districts, because of the recognized complex health problems (health inequalities, overweight). Moreover, the results from the studies have been compared with those from other HiAP studies and found to be consistent [39, 40, 49].

8.4.3 National and local levels

The third limitation is that the studies took place at different levels and were placed within the HiAP-cycle. Some of the studies’ findings regarding the approach taken to health inequalities were mutually contradictory. For example, the national study 1 indicated that policy outside the public health domain was concerned mainly with socioeconomic position and the living conditions of vulnerable groups; by contrast, the local study 4 found that policy outside the public health domain was less likely to address living conditions and socioeconomic position. That contradiction may reflect the existence of national objectives for influencing the relevant determinants, such as reducing the number of people who choose not to continue their education, reducing traffic accidents and improving air quality. One possible explanation is that the focus is linked to national regulations, in the context of which municipalities play a more limited role than they do in, for example, the promotion of healthy lifestyles and the prevention of social exclusion. For this thesis, however, the HiAP approach was the primary study focus, albeit with the ultimate aim of promoting public health or reducing health inequalities. In the context of the HiAP cycle, a more abstract approach was used to identify opportunities for HiAP’s development, implementation or tool-assisted evaluation and to identify leverage points (‘action perspectives’) for practice. The leverage points are the results of the various studies and are presented as strategic building blocks. However, a HiAP cycle was introduced after the case studies had been performed and reflects advances in understanding secured by bringing together the Dutch HiAP practices [28, 29, 33, 42]. It is therefore desirable to place further studies within the HiAP cycle and thus to refine the strategic building blocks for HiAP.
8.4.4 Young field
The fourth limitation is that the work being done in the field of HiAP is relatively young and to a large extent pioneering work. In the case studies, the conditions were generally optimal, insofar as (action-focused) researchers or supervisors were available for coordination. There was sufficient time and opportunity to develop knowledge. In case study 3, the newly developed knowledge could also be translated directly into local practice. In normal practice, there is no guarantee of similar human and financial resources being available. Furthermore, development and implementation are often handled exclusively by policymakers, and the involvement of a structural knowledge provider (e.g. a researcher or a policy assistant) is relatively uncommon. In practice, such involvement can be a restrictive factor, since it implies an additional collaboration partner. A solution is that regional public health services could perhaps act as low-threshold research partners (as an extension of the local authority) and provide policy support for HiAP in practice [42]. National grant programmes can aid practical application of the HiAP approach and collaboration with academic centres can also be useful. Further research should therefore focus on fleshing out and following the various process steps. Funding practices, such as integrated budgets and joint accounting, are vital for the application of HiAP [22, 50]. After all, there remains significant room for improvement of HiAP approach in the Netherlands.

8.5 Directions for future HiAP practices
Reflection on the findings of the studies described in this thesis reveals that four shifts are taking place. It is desirable that these dynamic processes are encouraged, with a view to taking HiAP practices in the Netherlands to the next level. The shifts in question are:

1. From a primary determinant-based approach towards a process approach;
2. From tools for policy-making towards tools for collaboration and evaluation;
3. From emphasis on impact studies towards emphasis on case studies;
4. From primary knowledge dissemination towards structural support.

8.5.1 From a primary determinant-based approach to a process approach
HiAP has for years been regarded and defined in terms of the determinants of health (inequality). In Dutch and international literature, that is apparent from various health models, such as the Lalonde model, the Dahlgren and Whitehead model and the theoretical model for reducing health inequalities (Albeda model) [51-53]. However, HiAP may also be seen more as a dynamic and iterative process [54]. For example, the consortium i4i showed that HiAP involves a number of relevant mechanisms (e.g. distributed knowledge,
coordination amongst sectors, divergent health issue interpretation by sectors) [33]. That implies that, as well as being focused on the content (as in a determinant-based approach), attention is focused on processes in the context of improving HiAP practices (process-based approach). A HiAP cycle introduced in this thesis provides leverage points for treating HiAP as a process. In Dutch and international literature, the importance of addressing processes is of course recognised, but, as far as the author is aware, process-based working has not previously been put forward as a systematic approach for use in HiAP practice [1, 4, 54].

In the ‘developing’ process step, the emphasis is on defining the determinants of health and policy (IA and HPP strategies). That can serve as a starting point for discussions with other sectors and parties. However, continuation of a HiAP approach requires that attention is also devoted to the ‘implementing’ (IC strategies), ‘measuring’ and ‘improving’ process steps. Thus, Dutch practice can ultimately make the transition from HiAP on paper to HiAP in action (and continuation). At the moment, HiAP in the Netherlands is often not beyond the development of an approach [28, 29]. There is, however, increasing appetite for implementation and collaboration at the local or regional level. Moreover, developments such as decentralisation and implementation programs are making collaboration an increasingly topical issue in the Netherlands [54-56].

8.5.2 From tools for policy-making towards tools for collaboration and evaluation

In the Netherlands and around the world, HIA is the tool most closely associated with HiAP. In the Netherlands, DPS is also widely used for HiAP [3]. The only support tools used for HiAP in practice tend to be policy development tools (on basis of recognized relations between policy sectors), but a migration can be discerned towards the use of practical tools for intersectoral collaboration between policy sectors (as a condition for HiAP). The WHO commented on the importance of tools for stimulating intersectoral collaboration in 2012 [39, 54]. In this thesis, the available HIA and DPS tools are used for policy development. For collaboration, tools and strategies described in the literature are refined and adapted for use to support implementation of HiAP. Furthermore, the increasing emphasis on the evaluation of HiAP is creating a need for specific evaluation tools. This thesis accordingly puts forward the possibility of measuring HiAP using the specially developed maturity model HIAP (based on other maturity models). Other evaluation tools are also identified by the Consortium Instruments for Integrated Action (i4i) and the Consortium Integrated Approach Overweight (CIAO) [57]. In each step of the HiAP cycle, various tools can be used. As more and more tools become available, a dynamic overview is needed if the tools are to be properly utilised in Dutch practice [42]. In late 2015, the RIVM therefore made available a toolkit for integrated working in order to support the various steps of the process. Implementation of several tools requires more attention, however [33, 42].

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8.5.3 From emphasis on impact studies towards emphasis on case studies

From Dutch and international literature, it is apparent that HiAP’s effectiveness as a means of addressing health or health inequalities is difficult to verify scientifically [26, 27]. In that context, distinction may be made between HiAP’s effect on outcomes (health outcomes), HiAP’s effect on health determinants (intermediate outcomes) and HiAP’s effect on processes (process outcomes). Most of the measurable effects are on intermediate outcomes or process outcomes; few are on health outcomes [31]. This thesis demonstrates that that is due to HiAP’s complexity and diversity (e.g. multifactorial health causes, palette of measures, no blueprint, terminology). Furthermore, data from which effects might be discerned are rarely available from the literature or from data sources. The complexity of HiAP is highlighted in other studies as well [28, 29, 58]. Research focusing on HiAP practice can also be useful in providing evidence, with the focus on either ex ante evaluation (e.g. goals or strategy) or ex post evaluation (e.g. target attainment, process evaluation). It can help to work towards knowledge that is immediately usable within the HiAP process (action-focused researchers can also play a role). Kickbusch speaks of knowledge-based societies [54]. It would therefore appear desirable that in future greater emphasis is placed on case studies, while researchers and policy-makers make better use of each other to transfer knowledge directly to practice. The direct transfer of knowledge (and tools) to the HiAP process will help to keep the HiAP approach operating in Dutch practice. Of course, it remains important to continue striving to measure the impact of HiAP on health (inequalities) through long-term research programmes [4].

8.5.4 From primary knowledge dissemination towards structural support

In Dutch and international literature, much has been written about HiAP in recent years, covering its terminology, mechanisms and characteristics [54]. While the distribution of knowledge and information about HiAP remains necessary, there is also a need for structural support to assist HiAP practice. In the Netherlands, national support and research programmes are focusing increasingly on implementation, as in the national support programme entitled Gezond in de stad (Healthy in the city), through which advisors are made available [59]. Such initiatives bring knowledge within easy reach of practising professionals. Support programmes are temporary, however. It is therefore ultimately desirable to work towards more structural support for HiAP. In some other countries, there are special HiAP units, as in Quebec, Norway, Finland and Sweden [26]. A HiAP unit is often a discrete unit within the health ministry or the national public health institute, which has at its disposal resources for supporting and facilitating HiAP, not only within national government, but also at the local and regional policy levels [27]. The responsibilities of such a unit are: providing reliable health information; educating and advising policy-makers; developing tools such as HIA and providing information and knowledge about the health effects of policies.
outside the public health domain [26]. There is no specific HiAP unit to provide support in the Netherlands, but the National Institute for Public Health and the Environment does distribute health information and knowledge about HiAP via websites (e.g. Centre for Healthy Living, Public Health Forecast). Nevertheless, more support is needed to help practising professionals learn to use tools, internalise working methods, develop specific skills (e.g. building relations with sectors, involving citizens in policy) and organise inspiring meetings at which experiences can be exchanged [42]. Academic workshops and national training organisations can also play a clearer role in that context [42]. Such structural support can contribute to levelling up the HiAP approach in the Netherlands facilitated by the national government.

8.6 Concluding remarks

The general purpose of this thesis was to examine Dutch case studies with a view to gaining insight into the development, implementation and evaluation of Health in All Policies (HiAP) in Dutch practice. The knowledge obtained has been rendered explicit and utilisable for other practices by introducing a Health in All Policies cycle (HiAP cycle) and placing the research findings of the Dutch case studies in the cycle. The HiAP cycle involves continuous improvement of the HiAP approach through dynamic and systematic focus on a series of process steps (‘developing’, ‘implementing’, ‘measuring’ and ‘improving’). Each process step involves specific strategic building blocks and associated key elements (actions) that support practical application of the HiAP approach. The strategic building blocks in the HiAP cycle are: Health and Policy (policy-making), Collaboration and Coordination (programme management), Research and Evaluation (reflection), Learning and Support (capacity building). The HiAP cycle can support practice, but ambition is needed for complex health problems to be addressed using HiAP (strategy in context). HiAP practices can be further encouraged in the future by regarding HiAP as a process approach, by making better use of tools and strategies that support the process steps in practice, by making more use of case studies (with close collaboration between researchers and policy-makers), by generating implementation knowledge, and by providing structural HiAP support to practising professionals. Progress on the path towards the HiAP approach will ultimately improve public health or reduce health inequalities.
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