
Summary

This study focuses on municipal health policy in the Netherlands. The objective of health policy is to maintain or improve the health status of (parts of) the population by means of measures, intervening in the determinants of health (Ministry of Health 1986). These policy intentions were made explicit in the Memorandum 2000 that distinguishes as determinants of health biological factors, physical environment, social environment, lifestyle, and the health care system. This health concept, except for the biological factors, was operated in this study.

The study is based on six research questions, extensively described in the summaries of chapters 2, 4, 7, 8, 9 and 10. First the history of health policy (research question 1, Chapter 2) and the policy background of local health policies (Chapter 3), as well as the legal space of a municipality for conducting health policy (research question 2, Chapter 4) is described. Next, the study concentrates on municipal activities or municipal intentions for developing health policy in the Netherlands. Activities of Regional Health Services have intentionally been omitted. At the start of this study in 1996 the general public opinion was that municipalities, without the activities of the Regional Health Services, had an underdeveloped health policy. The validity of this general opinion had never been empirically studied, a void that this study tries to fill in (research question 3, Chapter 7). Chapter 8 (research question 4) enters into the determinants of the differences in health policy among municipalities. Finally, the goal-orientedness of health policy (research question 5, Chapter 9) is discussed, as well as the determinants of the differences in the discussed goal-orientedness (question 6, Chapter 10).

Chapter 2 History of health policy

The research question about the history of health policy was, did operational health concepts from the ancient Greeks onwards include collective and preventive measures? Greek, Roman and Arab medical science was studied; subsequently the developments in Western Europe are described,

with an accentuation on the Netherlands after 1970. Greek, Roman and Arabian concepts of health and illness facilitated the reflection about influencing health other than by individual-oriented, therapeutic measures. Such collective measures, health policy, consisted for the greater part of individual-oriented advice about maintaining equilibrium, the then paradigm. Besides, other measures were taken, such as public hygiene and sewerage and obligatory isolation of patients considered to be infectious. From the Arab world the knowledge about health, and with it the concept of the theory of equilibrium, entered Western Europe about 1100. Increasingly discoveries were made that did not match the theory of equilibrium. In the eighteenth century the first important deviations of the strict definition of the humoral concept took place. Furthermore, health care itself was improved, social circumstances were taken into account, and lifestyles were influenced. In the nineteenth century there was a gradual transition from the theory of equilibrium to the present concept. Until the discovery of the bacterium as a cause for disease some scientists were openly sceptical about the role of social circumstances in the onset of disease. Others deemed those circumstances important, if not decisive. A plausible consequence of the discovery of the bacterium as a cause of disease was that all (scientific) attention was focussed on the bacterium and that social hygiene was neglected. In practice, however, the development of social hygiene did not come to a stand still: up to World War II nearly everywhere in the Netherlands waterworks and sewerage were constructed. The period after 1945 can be characterised on the one hand by a strong increase of the successes of curative medicine and on the other by the establishment and the extension of the welfare state in North Western Europe. In the seventies various authors formulated the complementary influences: next to health care biological factors, physical factors, social factors and lifestyle had their impact on the health status of the population. In the end this line of thought resulted in a number of policy documents in various countries, the start of health policy. The Netherlands started this development with the publication of the Memorandum 2000. On local level

this line of thought had rather an impact on putting the Healthy Cities Project on the agenda.

Chapter 3 Local health policy

In this chapter policy developments and reports about municipal health policies from 1980 onwards are discussed. A number of research reports are negative about municipal health policy. The report of the Reinforcement Collective Prevention Committee (1996) initiated a discussion that resulted in a platform Public Health, and a renewed focus of the Ministry of Health on municipal health policy. Ultimately, these developments resulted in the obligation for municipalities to publish a Health Policy Memorandum. Furthermore, in February 2001, the Ministry of Health, the Ministry of Home Affairs, the Dutch Municipality Association, and the Dutch Regional Health Services Association signed a National Public Health Contract. Health policy has become a subject for Dutch local politicians, and it has obtained a structural place on the agenda.

Chapter 4 Legal scope

What is the legal scope of implementing health policy in a Dutch municipality? That was the research question for this chapter. In the Netherlands the French occupation has ultimately contributed to the transition from the federal Republic of the Seven United Netherlands into the de-centralised unitary state. The 1851 Municipality Law created the present distribution of authority in the state.

The general specifics of the central-local relationship were laid out afterwards. There is the danger of seeing these general specifics as 'typically Dutch', which they are not. Everywhere in Europe there is a tension between the need of central control on the one hand and the seeking of local autonomy on the other. Regulation and distribution of means are the most important control mechanisms of the national government.

Legislation in the Netherlands, at present electronically stored in Kluwer's General Databank of Law and Legislation, is confronted with search parameters that on the one hand are related to municipal bodies and on the

other to the field to be studied, health policy. Regulations on health policy applicable on municipal level can thus be located. The results of the quantitative analysis of the regulations in the field of municipality and health show that the municipality, on first sight, has access to a multitude of regulations and is appointed task force for influencing, directly or indirectly, the collective health status of its citizens. The regulations thus obtained present a picture of what a municipality might implement in the field of co-administration; not presented is the filling in of the autonomous authority. The regulations are very heterogeneous and relate to a mixture of tasks and competencies. Among the regulations on municipal level that have relevant health aspects (283) 18 factors are determined as physical environmental factors, 103 social environmental factors, 2 lifestyle factors and 160 health care factors. The analysis shows clearly, in what co-administrative fields municipalities are completely absent, or hardly present. Three of the four themes of lifestyle (Nutrition, Alcohol, Smoking), have, in contrast to Physical Activity, hardly any regulations at all.

Chapter 5 Policy and research questions

The policy that ultimately comes about has survived the filter of the agenda building process. This chapter describes the literature about agenda building; furthermore, the determinants of policy are discussed. Finally, a model has been developed with which the differences in municipal policy can be explained. This model contains the variable urbanisation, in which municipal size, population density and income are combined. This variable reflects the general problem pressure in a municipality. In addition, the model contains three political variables, i.e. political colour (percentage left wing in the council), political stability (Herfindahl-index of the council [0-1]) and political participation (poll percentage in the 1994 council elections), as well as a policy area specific problem indicator. The dependent variable is the number of autonomous policy measures in a certain policy area.

Chapter 6 Study design, instrument used and operationalization

The study took place among a random sample of municipalities in the Netherlands that was stratified for size of municipalities and for province. The sample consisted of two municipalities per size category (< 20.000, 20.000-50.000, 50.000-100.000, >100.000) per province, 86 municipalities in total. These were requested to send in their Municipal Political Programmes '94-'98 and their Budgets '96. Out of the 86 municipalities 80 complied with this request (93%) with a feasible contribution. A new measurement instrument was developed to make the conversion from general and qualitative information in the Municipal Political Programmes and Budgets to health-related and quantitative data. This instrument made it possible to operationalize policy measures, to discriminate between target-related and non target-related measures, and to detect the prevalence of sectoral and inter-sectoral targets. The various policy areas relate to the Memorandum 2000 classification: Physical Environmental factors, Social Environmental factors, Lifestyle and Health Care. The cluster of Social Environmental factors is subdivided into Housing and Working. Lifestyle contains Nutrition, Physical Activity, Smoking, and Alcohol. Health Care is subdivided into General, Major Health Problems (Cancer, Cardiovascular Diseases, Traffic Safety, Social Security) and Risk Groups (Youth, Elderly, Handicapped, Refugees, Minorities, Addicts, Homeless).

Chapter 7 Extent and contents of health policy

The research question for this chapter was: what are the differences in extent and contents of health policy between municipalities in total, in policy sectors, in the subdivision Municipal Political Programme-Budget, in the subdivision co-administration-autonomy, in measure frequency, and in political attention for the various measures?

The analysis of the Municipal Political Programmes and the Budgets showed that municipalities on an average are active on the whole range of health policy, both in autonomous measures and in the total of measures. There are some blank spots, however: the lifestyle items nutrition, alcohol and smoking, the health care problem areas of cardiovascular diseases and

cancer, and the risk groups of addicts and the homeless. A comparison of the Municipal Political Programmes and the Budgets showed that the levels of activity in all sectors in the Municipal Political Programmes are lower than in the Budgets. Autonomous measures have the same score on activities as on total measures in analysis; low activity levels in the Municipal Political Programmes are scored by the items refugees and minorities, and in the Budgets only the item refugees scored low.

The division of the municipal measures into autonomous measures and co-administration measures made it possible for each policy area to calculate the 'degree of autonomy'; this degree of autonomy varies from 9.6% (Refugees) to 100% (Social Security). In addition, the political attention for a policy area was quantified. This varied, on a scale from 0 to 1 from 0.24 (Physical Activity) to 0.64 (Social Security). By means of a 'degree of political attention per individual measure'-index measures can be divided into 'high degree' of attention (= 0,75) measures, 'medium degree' of attention measures (0,25-0,75), and 'control measures', municipal measures without political charge (= 0,25).

Chapter 8 Determinants of extent and contents

This chapter discusses whether certain assumed structural determinants of policy influenced the amount of policy operationalized as the number of autonomous policy measures, and in addition the extent of this influence and the direction this influence took. The research question was, to what extent is the range of health policy measures of municipalities associated with socio-demographic and socio-economic variables, political variables, and the range of social problems?

Lisrel was used to represent a model of the simultaneous functioning of these structural determinants and their influence on each other. Previously, and with the help of a background model based on theoretical concepts, a model was developed and the relationships between urbanisation, political colour, political stability, political participation, and the magnitude of the policy-fitting problem were specified.

The data of the eleven policy areas were then entered into the model, which proved adequate for eight policy areas, based on p-value and explained variance, i.e. Physical Environment, Physical Activity, Health Care General, Traffic Safety, Youth, Handicapped, Elderly and Minorities. For Housing, Working, Social Security the model proved not significant and so the problem was taken out of the model.

The influence of urbanisation on the other model variables can be summarised as follows. There is a continuous significant and positive influence of urbanisation on political colour: a high degree of urbanisation is associated with a dominant left wing in the municipal council. In addition, there is a significant and negative influence of urbanisation on both political stability and political participation: a high degree of urbanisation is associated with an unstable municipal council and with lower poll rates. The influence of urbanisation on the problem is continuously significant and sometimes positive (Physical Activity, Health Care General, Elderly, Handicapped, and Minorities); these problems are larger in more urbanised municipalities. Sometimes this influence is negative (Physical Activity, Traffic Safety, Youth); these problems are smaller in more urbanised municipalities. The influence of the explanatory variables on the policy can be described as follows. The influence of political colour on the number of autonomous policy measures is significant and positive in the cases of Housing, Working, Health Care General, and Youth: the more left wing, the more policy measures. The influence of political stability is significant and negative in the cases of Housing and Minorities; that means that the more unstable a municipal council is, the more policy measures are being taken. Political participation showed a negative influence that is significant in the cases of Housing, Working, Social Security and Youth: a low poll rate is associated with more policy. In an urbanised municipality, having more left wing council members, a more unstable council and a lower poll rate, more policy is developed. In the case of Physical Activity, finally, the problem has a significant and positive influence: a higher mortality rate for cardiovascular diseases is associated with more policy measures. The relation between urbanisation and policy, absent in the main model, was studied separately:

in the cases of Housing, Working, Health Care General, Elderly, and Minorities the influence is significantly positive: a high degree of urbanisation is associated with more policy measures in the areas mentioned.

Chapter 9 Goal-orientedness

The research question about the goal-orientedness of policy was: what are the differences in the degree of goal-orientedness of the health policy of municipalities in total, as for sectors, distinguished for Municipal Political Programmes-Budgets, in frequency per target, and in political attention for the various targets?

The average number of sector targets per policy area is both in the Municipal Political Programmes and in the Budgets higher than one in the areas Physical Activity, Housing and Working. The areas Elderly and Addicts (and in the Budgets Physical Activity as well) have an average number of targets between 0.5 and 1. The other areas have a lower average, whereas Nutrition, Smoking (only in the Municipal Political Programmes), Social Security (only in the Budgets), Cardiovascular Diseases, Cancer, and Homeless (only in the Municipal Political Programmes) have no targets. The percentage of goal-orientedness of the policy, expressed in target-related measures, is 97.3 in the Municipal Political Programmes and 73.2 in the Budgets. Stratified into policy areas, the percentage of goal-orientedness of the total number of policy measures in the Budgets varies between 65 and 80.

Chapter 10 Determinants of goal-orientedness

Chapter 10 describes whether certain assumed structural determinants of goal-orientedness influenced the degree of goal-orientedness, operationalized as the percentage of autonomous target-related policy measures in the Budgets, and in addition the extent and the direction of the influence. The research question was, to what extent is the degree of goal-orientedness of the health policy of municipalities determined by socio-demographic and socio-economic variables, and political variables?

Lisrel was used to represent a model of the simultaneous functioning of these structural determinants and their influence on each other. Primarily the model as presented in Chapter 8 was used. This model proved not to fit to our data, and an adjusted model was developed, with urbanisation, stability of the Municipal Board (Herfindahl-index of the Municipal Board) and council support (percentage of council seats that may be supposed to support the Municipal Board, considering the Board's composition). Political attention for a policy area was added.

The relation between urbanisation and stability is continuously significant and negative, the more urbanised a municipality, the more unstable the Municipal Board. The relation between urbanisation and political support is continuously non-significant. The influence of political attention for a policy area on the degree of goal-orientedness of policy is significant and negative in eight cases (Physical Environment, Housing, Working, Health Care General, Traffic Safety, Youth, Elderly, Handicapped): the more attention for the policy area, the less argumentation. Which was contrary to our expectations. The influence of stability on the degree of goal-orientedness is significant and negative in one case (Working): the more stable, the less responsive, and the less the inclination to explain what has been done why. The influence of support on the degree of goal-orientedness of policy is significant and positive in three cases (Housing, Working and Handicapped): the more support for a Municipal Board, the more argumentation for its policy. This is contrary to what appears from literature: the more support, the less a council's need for justification.

The relation between urbanisation and the degree of goal-orientedness, absent in the main model, and between the three sub-categories of urbanisation, income, population density and municipal size and the degree of goal-orientedness of the policy have been studied separately: all these relations proved non-significant.

Chapter 11 Conclusions, discussion and recommendations

The majority of the conclusions have been discussed in the chapter summaries. The measurement instrument deviates from the usual: the

adding up of furnished means of estimation. We have chosen for developing a new measurement instrument: making an inventory of certain measures by a municipality, and furthermore using the sum-score of these measures within a policy area as the variable to be explained.

The role of the Regional Health Services has remained outside our study more or less necessarily. However, it is of major importance to analyse the activities of the Regional Health Services and to study the question to what extent these activities are complementary to those of municipalities. And, in addition, to do research in order to investigate the complementary relationship between activities of municipalities and Regional Health Services.

Stating that an analysis of the contents of the Municipal Political Programmes and the Budgets represent a reasonable picture of the municipal activities in the area of health policy but that this picture is rather incomplete, can be defended. A case study among a restricted number of municipalities is the means with which an additional immersion of the knowledge can be obtained about the existence of such further differences in health policy among municipalities.

Further research into how the intentions of municipalities with regard to health policy change in time necessitates a longitudinal follow-up study. Further research, after this study that is restricted to the phase of the policy-making, into the phase of the implementation of policy seems obvious: what exactly happens with the municipal expenditure estimations in the area of health care? A follow-up study as to whether the position of municipal authorities within the constitution of the state is a variable of its own, would make a similar study in other countries necessary.

One of the results of this study is that municipalities formulate a reasonable number of policy measures of which an effect on the health status of their citizens can be expected. In formulating a local health policy municipalities should be less concerned about the division into sectors of the official authorities. In fact, the nearly missing 'health policy' perspective is the most important blank spot in the municipal thinking about the health of the

municipal population. It should be possible to convince departments other than departments directly responsible for public health of the importance of this perspective. Next to this 'blank sectoral spot' there are also some 'white spots', the most important of which are in the area of lifestyles. More attention for lifestyles is of major importance for the health of the municipal inhabitants.

Perhaps the consultations between the Regional Health Services and the councils should be structured. A continuous 'health monitoring' in a municipality is advisable. The results of this monitoring should become a standard agenda item in the annual consultation between Regional Health Services and councils, in which priorities can be given with regard to problem approach. Where possible these problems should be approached inter-sectorally, preferably a 'community-based' approach. Municipal health policy is only then possible when the parties involved co-operate.

The Dutch Municipality Association and the Ministry of Health might be expected to come up with a substantial vision on municipal health policy. The National Contract is a first step. A substantial policy framework, such as e.g. the Fifth Memorandum, co-ordinates the health policy and provides as well the platform for less engagement free measures. Ultimately it all should be a matter of forcing back socio-economic health differences.

Ministry of Health	Ministerie van Welzijn, Volksgezondheid en Cultuur renamed: Ministerie van Volksgezondheid, Welzijn en Sport
Memorandum 2000	Nota 2000
Regional Health Services	GGD
Reinforcement Collective Prevention Committee	Commissie Versterking Collectieve Preventie
Health Policy Memorandum	Nota Gezondheidsbeleid
National Public Health Contract	Nationaal Contract Openbare Gezondheidszorg
Ministry of Home Affairs	Ministerie van Binnenlandse Zaken
Kluwer's General Databank of Law and Legislation	Algemene Databank van Wet- en regelgeving van Kluwer
Dutch Municipality Association	Vereniging Nederlandse Gemeenten
Fifth Memorandum	Vijfde Nota Ruimtelijke Ordening
Dutch Regional Health Services Association	GGD Nederland