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## Chapter 10

# **The conditions and contributions of ‘Whole of Society’ governance in the Dutch ‘All about Health...’ programme**

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### ***Editors’ summary***

This chapter is about a programme called “All about Health...” the programme aims at improving health by engaging all members of society in a social health movement, which greatly resembles a whole-of-society approach. The country chosen for this case study is the Netherlands, as the government and numerous organizations have engaged in collaboration. There are various CSOs, commercial partners, municipalities and government agencies and services involved. While there are many concrete health related “pledges” made between the partners of the programme, the overall aim is to move from government to governance and to involve many more stakeholders in policy making and implementation at all levels. Most prominently, partners organised events and provided services to the public. Additionally, they provided evidence, contributed to policy developed, exercised advocacy, helped consensus building, acted as watch dogs, provided services and acted as self-regulators. Strong government support, a small programme office and an ongoing programme evaluation have been instrumental to the progress of the programme. The authors conclude that the first three years of “All about Health...” seems to provide

an early backing of the hypotheses that CSOs contribute to health though it is too early for a final assessment.

*The editors*

## 10.1 Introduction

This chapter will describe and analyse a particular example of a governmental programme enhancing collaborative public, private and CSO initiatives for health: “All about Health...” (2014–2016). Interestingly, in this programme the Dutch government recognizes the potential these organizations have to offer in increasing the reach, acceptance and impact of targeted groups. Early experiences in this programme can help us to analyse conditions and challenges for sustained CSO initiative and their early contributions. In 2015 and 2016 Maastricht University and Radboud University conducted a qualitative monitoring study into the governance aspects of this programme. In this chapter we will address the following questions:

1. Which **activities** do CSO partners of the “All about Health...” programme contribute?
2. How do governments and CSOs develop **dialogue and collaboration** in practice?
3. Which **conditions** emerge for developing further the “All about Health...” programme as a ‘whole of society’ approach, and for achieving its health goals and ambitions?

Before we address these questions, we start with a contextual exploration of historical trends and current challenges in Dutch state-society relationships to understand how these may or may not shape or contribute to the role of CSOs in public health in the Netherlands. This section ends with a description of the current challenges in public health with regard to the potential role of CSOs. The third section is devoted to the general framework, research methods and findings of the “All about Health...” programme. In this section the three questions above will be answered.<sup>1</sup> We end with conclusions about the move from government to health governance, and the conditions for engaging with CSOs.

## 10.2 State-society relations and public health challenges in the Netherlands

In this section we investigate the relationships between the state and organized

<sup>1</sup> Parts of this analysis were discussed during workshops with the European Observatory on Health Systems and Policies and the WHO Office for Europe at the EPH conferences in 2015 (Milan) and 2016 (Vienna).

civil society, between the state and the market, and between the state and the community, ending with the specific public health challenges.

### **10.2.1 Trends in the relationship between the state and organized civil society**

The Netherlands is a decentralized unitary state. It has a long-standing tradition of well organized CSOs sharing responsibility with the state for policy-making and service delivery in a wide variety of policy domains, such as open water management, spatial planning and social services (Hemerijck, 1992; Brandsen & Pape, 2015). The Dutch private health care system, for example, has been built upon *corporatist arrangements*, whereby the state shares its public regulatory authority with the various associations of providers, insurers, trade unions and employers (Helderman, 2007). The *public health sector*, however, has never been part of these well established corporatist institutions and practices in the Netherlands. Article 22 of the Dutch Constitution stipulates that the government shall take measures "for the promotion of the health of the public", but it led to two discrete and only loosely coupled policy circuits (Bekker & Putters, 2003). In the post-war era of welfare state expansion, the Dutch health care system became, on the one hand, a classic example of a corporatist social health insurance system with predominantly public financing and a private delivery of health care (Helderman et al., 2005). Public health, on the other hand, had largely been delegated to the local municipalities. In the Dutch decentralized unitary state, municipalities were obliged to establish and maintain Municipal Health Services to perform these tasks.

As a consequence, health policies in the Netherlands used to be dominated by the technical and financial details of the health insurance system and the curative health care and medical sector, at the cost of the broader issue of public health promotion and prevention (Mackenbach, 2003). Meanwhile, public health consisted of a mostly *unilateral, state-dictated* policy and framework for local services. Since the general belief for a long time has been that there would be no "public demand" for prevention, standardized expert tasks in public health developed at a distance from both the citizens and CSOs.

But even if public health policies could theoretically have benefited from experiences with the Dutch corporatist mode of collaborative governance, *corporatism itself has eroded* under the influence of neoliberal governance in the 1980s and 1990s and the financial-economic crisis (2007–2012) (Brandsen & Pape, 2015). For about 80 years Dutch coalition cabinets were dominated by the Christian-Democrats, effectively deploying consensual policy-making with representatives of majority and minority interests. Under the historic "Purple cabinet" (1994–2002), however, the socio-liberal government decided that

policies should become more evidence-based rather than interest-based. In the second half of the 1990s corporatist intermediary associations evolved into branch organizations, while the former corporatist Advisory Councils were converted into science-based knowledge institutes or independent regulatory agencies (Putters & Twist, 2007; Bekker et al. 2010; Helderma, Bevan & France, 2012).

### **10.2.2 Trends in the relationship between the state and the market**

While these formerly corporatist associations try to strike a new balance between being a branch service organization and an effective representative interest organization, successive governments have started experimenting with new kinds of “*collaborative governance*”, mobilizing civil society and corporate sources for public problem-solving. Going beyond more traditional subsidy programmes and social insurance schemes, government in several policy areas developed covenants, public-private partnerships and “Deals” directly with community and commercial entrepreneurs. Gradually, the role of government is changing towards facilitating an independent committee or long-term commissioner, who designs a general framework of requirements or guidelines, and monitors progress. The government positions itself as a more equal, relatively neutral, and facilitative partner. Examples are the Green Deals programme (Van Mil et al., 2013) or the Delta commissioner,<sup>2</sup> who has recently been appointed by the government to a second term of seven years (Jong & Brink, 2013).

In commercial industries there is also a growing awareness of *corporate social responsibility* (Carroll, 1991). Publicity concerning incidental or structural risks and wrongs of corporate activities with regard to environment and health in the past decade have resulted in consumer power and boycotts, and corporate management of externalities beyond business damage control. An eight-year governmental programme on Corporate Social Responsibility developed corporate support and CSO expertise (MVO Nederland, 2013). More than 2000 corporate partners now pay a membership fee to the independent CSR Netherlands foundation<sup>3</sup> developing corporate norms, and offering CSR expertise and change management services. CSR awareness is now moving beyond managing externalities towards incorporation into the operational core of business organizations. Even though at this stage this is an “early adopter” practice, it is exemplary of proactive efforts integrating “social capital policies” into economic business plans, such as sustainable labour participation, healthy production chains, or advanced consumer feedback methods, regional stakeholder dialogues and co-production chains. At the same time, *health in itself has become a marketed product and service*, focusing primarily on lifestyle

<sup>2</sup> See for more info respectively, <http://www.greendeals.nl/english> and <https://english.deltacommissaris.nl/>.

<sup>3</sup> For more info see <http://mvonederland.nl/csr-netherlands>.

coaching, food, physical and social activity services as well as medical(-ized) products in medicines, medical aids, e-health apps and web tools, and other products for self-diagnosis and self-treatment.

### **10.2.3 Trends in the role of the state and the community**

As a consequence of the highly institutionalized corporatist nature of the Dutch welfare state, with its reliance on social insurance schemes, citizens' initiatives and community involvement in social welfare provision have been rather limited in the Netherlands. But in the last decade, in response to reforms of the financially unsustainable social security system and the long-term care system, successive governments stress the *need for more self-reliance, autonomy and informal care* among citizens and community groups. In his first Annual Speech to Parliament in 2013, King William-Alexander spoke about the need to revitalize communitarian involvement and citizens' participation in the welfare state (National Government of the Netherlands, 2013). With welfare state retrenchment and reforms, the rising share in GDP of health care expenditures and other welfare support costs, and the financial crisis, government now turns its public call for more citizen and community responsibility into *legal and financial measures*. For instance, in the Youth Act the former citizen's "right to care or assistance" is now replaced with a state obligation to provide support "when necessary" with regards to the family supportive capacity (National Government of the Netherlands, 2015b). A second example is the requirement of those receiving unemployment benefits in some municipalities to perform a "compensatory act" within their individual abilities in the Participation Act (National Government of the Netherlands, 2015a). In the relatively short period of time since its legal introduction, this has introduced strategic uncertainties with regards to accountability and liability, but it has also created room for experimentation and innovation.

Following recent decentralizations in long-term and social care with specific policy goals for prevention in the Health Insurance Act (2006), the revised Social Support Act (2015), the Youth Act (2015) and the Long Term Care Act (2015), municipalities now voice a *call for prevention in the local development* of integrated and capacitating neighbourhood service teams. Public health services, however, for a number of reasons seem to participate only to a limited extent. As opposed to these decentralizations, municipal public health services in the past thirty years have merged from 65 (1985) to 25 regional services against 390 municipalities (1 January 2017) so as to match the regional emergency preparedness teams. Community-based health promotion in the past ten years, moreover, was under heavy retrenchment, which leaves very limited means and support for neighbourhood team participation (Koornstra

& Stom, 2016). As a consequence, with some exceptions, public health services are still not well integrated into the local networks for care services and social support (Andersson Elffers Felix, 2013).

#### **10.2.4 Public health challenges**

Public health problems have posed new challenges to government and public health services in the Netherlands in the past ten years. With regard to vaccination policies and cancer screenings, for instance, government and services are faced with *declining trust in expert judgement* among citizens groups in the population who articulate and mobilize collective suspicion of health risks on social media (Wallenburg & Bal, 2008; Rondy et al., 2010). On the other hand there is a growing recognition in society of the need for *collective action* on public health, for instance on tackling the root causes of behaviour-related diseases and health conditions as a shared responsibility across the state, the market, the family and (organized) CSOs (Hendriks et al., 2013; Mackenbach, 2016). In the past ten years many citizen, community and commercial initiatives have been initiated, focusing on weight loss, physical activity, lifestyle coaching, etc. Although this exemplifies public awareness of the social determinants of lifestyle-related health problems, it has also led to fragmentation, inefficiency and a lack of transparency on the societal impact of public health-related initiatives (Tweede Kamer der Staten-Generaal, 2014).

#### **10.2.5 A political opportunity**

An opportunity for collective action on health presented itself when Parliament in 2012 asked the Ministry of Health to develop a National Prevention Plan (Tweede Kamer der Staten-Generaal, 2012). The Minister and State Secretary agreed and, in consultation with a broad representation of interests, developed the National Prevention Programme “All about Health...” (Ministry of Health, Welfare and Sport et al., 2013). It consists of (a) existing legal regulations; (b) a number of government-led health programmes, such as Healthy School, Youth on a Healthy Weight (JOGG), and Healthy in the City (GezondIn); and (c) a platform of pledges called “All about Health...”. Below we will first describe the generic framework of the NPP: the platform of pledges and their emerging networks. We then describe the activities, processes and strategies, and the conditions for CSOs as emerging from the early “All about Health...” experiences.

### **10.3 “All about Health...” 2014–2016 and the role of civil society**

In response to the challenges described above, the Dutch National Prevention Programme “All about Health...” (2014–2016) was initiated in an attempt to integrate public and private health initiatives. It was thought that fostering domain-crossing activities and knowledge exchange would increase the reach and impact of health promotion initiatives. We first describe the general framework, followed by observations on the actual practices developed in the pledges locally and in relation to the national Programme Office, the Ministry of Health, and other Ministries involved.

#### **10.3.1 The “All about Health...” general framework**

The general framework consists of ambitions, instruments, infrastructure and independent monitoring informing democratic accountability and programme improvement.

#### **Long-term ambitions and settings**

The “All about Health...” initiative aims to create a social “health movement” among equal participants in society, business, communities and governments at multiple levels with long-term health goals. By 2030 it aims to reduce chronic diseases by reversing the trends in six public policy priorities (smoking, alcohol abuse, diabetes, obesity, depression and physical exercise) (Ministry of Health, Welfare and Sport, 2011) and bringing the growing health disparities to a halt. The programme is categorized into four settings – school, work, living neighbourhood and health care – and separate attention is paid to health protection (Tweede Kamer der Staten-Generaal, 2013).

#### **Partner pledges as a quasi-social contract**

Partner commitment to the programme manifests itself in a pledge: “a public statement by which an organization expresses commitment and an active contribution to the realization of the NPP-Health goals by conducting specific focused activities” ([www.allesisgezondheid.nl](http://www.allesisgezondheid.nl)). In 2013 the programme was positioned explicitly as a joint initiative of six Ministries (Health, Welfare and Sport; Education and Cultural Affairs; Internal Affairs; Infrastructure and Environment; Social Affairs and Employment; and Economic Affairs). The government takes a non-hierarchical role and partners are primarily responsible: “It will be the art of being mutually inspiring and keeping each other focused and

committed, making visible results and learning from experience without ending up in a stifling bureaucracy. This means there will be no single project organization with central decision-making and monitoring” (Tweede Kamer der Staten-Generaal, 2013, p. 16). Low entrance and limited requirements for participation are maintained so that partners, within the general health ambitions, can develop their own goals and activities even when these are sometimes perceived to be at a distance from being health-relevant, such as low literacy.

## Infrastructure

A small facilitative Programme Office is funded by the coordinating Ministry of Health, populated by part-time, non-governmental account managers in the respective domains, and situated at a distance from the government seat in The Hague. The Office consists of two MoH-appointed officers and six temporary part-time *account managers* for the four domains (health protection being part of all domains). Other arrangements include a *partner platform* of representatives aimed at sharing experience with and advising the Programme Office, a number of *celebrity ambassadors* in sports, architecture (healthy urbanism), and social entrepreneurship. There are *regular meetings* and an *annual conference* presenting the pledges and their progress. The marketing and communication strategy consists of *social media*<sup>4</sup> making publicly visible the contributions of partners and offering opportunities for networking.

## Independent monitoring and evaluation

Responsibilities for achieving the goals of the pledges are kept decentral, asking partners to be transparent about progress in an online survey once a year. Partners are asked to account for their activities among themselves in a dynamic and horizontal review: “Each partner is responsible for the activities and results in their own domain, can be questioned by other partners, and will account for their actions in public” (Tweede Kamer der Staten-Generaal, 2013, p. 16). The Dutch Organization of Health Research and Innovation (ZonMw) has set up three different and independent monitoring trajectories. There was a small-scale quantitative monitoring trajectory focusing mainly on process indicators (numbers of pledges, partners, activities, etc.); a qualitative governance-monitoring trajectory (of which this paper is a product); and an evaluation trajectory of implementation and health outcomes in nine single pledges.

<sup>4</sup> <http://www.allesisgezondheid.nl/>; <https://www.facebook.com/allesisgezondheid>; <https://twitter.com/AlGezondheid>; <https://www.linkedin.com/company/alles-is-gezondheid>; <https://www.youtube.com/user/allesisgezondheid>; <http://www.socialmarktplaats.net/>.

### 10.3.2 Research methods

Since the programme is a relatively new phenomenon and had only recently started before our study took off, we decided to conduct a formative, action-oriented process evaluation. We first of all conducted an international scoping of literature about similar programmes (the Quebec “Investir pour l’avenir” programme and the UK Public Health Responsibility Deal programme), and a quick scan of similar Dutch programmes and evaluations (the economic Green Deals programme and the Corporate Social Responsibility Foundation)<sup>5</sup>. We then engaged in qualitative monitoring, consisting of (a) national level participant observations of Programme Office meetings, “All about Health...” events, and discussion with the Ministry of Health; and (b) a multiple case study design of six pledge partner networks selected to represent as much diversity in the “All about Health...” programme as possible. We additionally set up a digital marketing analysis of the five social media channels used in “All about Health...”; and in one of the cases conducted a responsive future scenario exploration with local partners. Finally, we provided feedback into the programme by regularly sharing our preliminary findings with programme officials. The results in this chapter are derived primarily from the literature scan and the case studies, and have been cross-checked with programme officials.

### 10.3.3 Results

#### Which activities do CSO partners of the ‘All about Health...’ programme contribute?

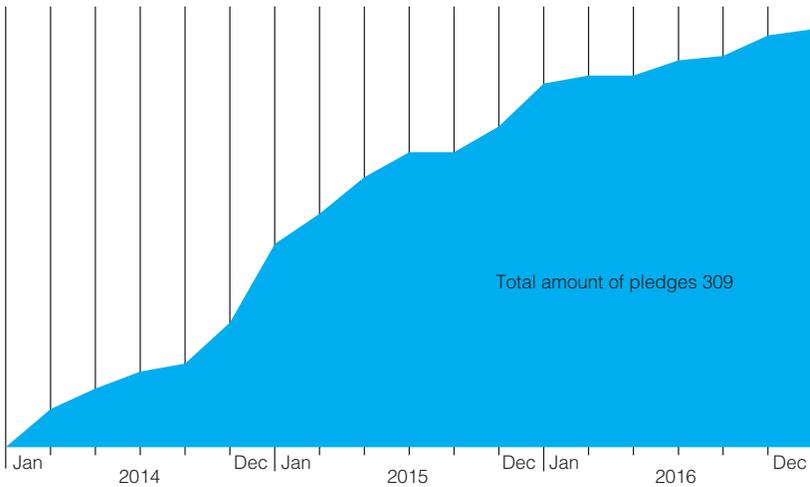
After three years the “All about Health...” programme has generated 309 pledges from 1825 partners in society<sup>6</sup> (see Fig. 10.1).

Strictly speaking, not all the “All about Health...” partners are CSOs. We roughly estimated that about half the partners are CSOs (mostly voluntary, not-for-profit organizations such as foundations, networks and alliances, and citizen initiatives, and a smaller proportion of private organizations with a public task and no profit-sharing, including care providers and insurers, educational and cultural organizations). About a third of the partners are *commercial* partners (individual entrepreneurs, small and large businesses). Finally, about 10% are *public* organizations, such as municipalities, government agencies and public health services. The juridical status of the remaining 5% is unknown to us. Some of the pledges formalize activities that have been going on for a long time, while other activities result from partner commitment in the “All about Health...” pledge.

<sup>5</sup> [www.quebecenforme.org](http://www.quebecenforme.org); <https://responsibilitydeal.dh.gov.uk/>; [www.greendeals.nl](http://www.greendeals.nl); [www.mvonederland.nl](http://www.mvonederland.nl).

<sup>6</sup> [www.allesisgezondheid.nl](http://www.allesisgezondheid.nl) (in Dutch only).

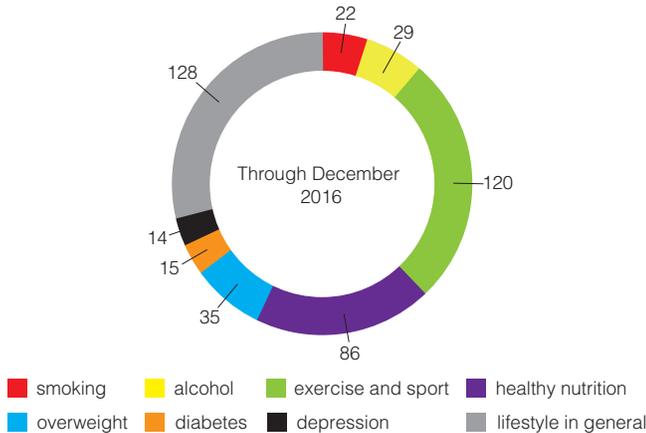
**Fig. 10.1** Total amount of pledges and development over time, 2014–2016



Source: National Institute for Public Health and the Environment, 2017.

The annual “All about Health...” Monitoring and Progress Report shows that around two-thirds of the pledges focus on promoting general lifestyle and behaviour, including sports and physical activity (see Fig. 10.2).

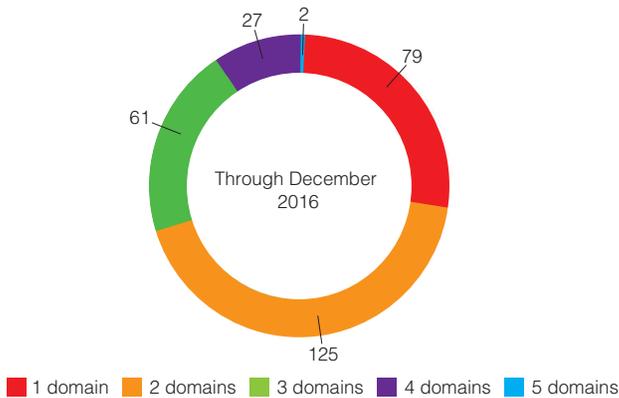
**Fig. 10.2** Amount of pledges for each of the six public health policy priorities



Source: National Institute for Public Health and the Environment, 2017.

Mental health and smoking are relatively underserved in the pledges but these are addressed in other activities outside the pledges. In 2015 partners reported that 20% of single pledges reached fewer than 100 people, 27% reached 100–1000 people, 27% reached 1000–10 000 people and another 20% more than 10 000 people. About 70% of partners actively work together with other domains, and this percentage is increasing (see Fig. 10.3).<sup>7</sup>

<sup>7</sup> <http://www.allesisgezondheid.nl/monitoring> (in Dutch only).

**Fig. 10.3** Share of pledge partners actively working together with other domains

Source: National Institute for Public Health and the Environment, 2017.

In Chapter 2 of this book the matrix of CSOs distinguished between nine types of activity and roles CSOs may be involved with. In the “All about Health...” programme, we encounter examples of all of these nine types. First of all, *organizing services and events for members and the public* is the most prominent type of activity among all pledge partners. As an example, the Care Innovation Centre West-Brabant<sup>8</sup> organizes meetings and events for the elderly and other interested groups in their “House of Tomorrow” based in a school for vocational training, showcasing care innovations, offering free advice, and educating vocational health care students on health innovations and patient/consumer demands.

The Care Innovation Centre (CIC) is also exemplary of *being a key to industrial relations with the health sector*: the CIC made it its core business to engage industrial partners from the health innovation and design industry and link them up with consumer groups such as local associations for the elderly. In order to make this connection acceptable and effective, providing advice rather than selling products turned out to be crucial. The CIC literally fills the void between innovators and potential user groups, making possible user feedback and product improvement. The organizations in between, the health care providers, are also actively engaged in the network.

Thirdly, *helping consensus building* in all pledges is centred around creating awareness of health, disease prevention and the role and interest of non-health actors and organizations in and beyond the pledge. In the case of Deltion, a large school for broad vocational training with 15 000 students and about 1200 staff, the Sports education team took the initiative to introduce a

<sup>8</sup> <http://www.cic-westbrabant.nl/> (in Dutch only).

Vitality programme for students and staff. The Board has embraced this, and now all students undergo vitality tests and a healthy lifestyle education. The staff has access to a Vitality coach and participate in regular events. The Logistics educational department (for truck drivers, car mechanics, etc.) is now experimenting with an educational module on Vitality and sustainable labour participation, thereby also going into dialogue about this topic with businesses offering student internships.

The Sports team thus has also effectively built consensus and *contributed to Deltion's organizational policy development*: the Vitality ambition is part of the organizational mission statement that is displayed on banners throughout the school. Additionally, the school *acts as a self-regulator* with a large red carpet outside the entrance to the school, displaying the statement “smoke-free zone” (Fig. 10.4).

**Fig. 10.4** Deltion self-regulatory red carpet “smoke free zone”



Source: M. Bekker.

In another pledge network, on implementing the concept of “Positive Health”<sup>9</sup> as an organizing principle of integrated primary and social care, general practitioners managed to negotiate contractual funding with care insurers for the coordination of this social (= organizational) innovation. This could be a first step towards organizational, insurance and municipal policies and contracts for integrated primary and social care.

Other activities of pledge partners include *providing evidence*: some pledges are centred around investing time and funding into research, or research is a by-product making the implementation of the pledge more transparent. For example, in a pledge from Heineken and the Sports Federation NOC-NSF about the prevention of alcohol abuse in sports canteens, Heineken organized the “Stay Clear” campaign. Heineken funded research into the impact of a peer youth visitor (aged around 18) in two subsequent “mystery visits” engaging in

<sup>9</sup> Based on six stakeholder group consultations (doctors, nurses, patients, policy-makers, scientists and health care insurers), health was suggested to be redefined as the ability to adapt and self-manage in light of social, physical and emotional life challenges, such as disease, divorce or unemployment (Huber et al., 2011).

conversations with bar-tenders, providing information, education and feedback on alcohol abuse. Heineken also made available “Stay Clear” banners for sports canteens and initiated a contest for the best “Stay Clear” canteen. Based on the results, Heineken and NOC-NSF decided to continue their commitment and strengthen their intervention so as to improve impact.

In the long-standing collaboration between Heineken and the Sports Federation NOC-NSF, the latter also acts a *watch dog*, or rather as a “*moral counsellor*” pushing the former to be more ambitious, to take longer-term actions and to develop stronger interventions in social responsibility. This commercial and CSO partnership could be a first step towards a more fundamental balancing of public health values and commercial interests. For Heineken, as a multinational corporation, this is a relatively small activity, yet without it NOC-NSF would not be able to get this intervention funded and organized.

*The Heineken “Stay Clear” banner for sports canteens: “Our club is clear: no alcohol under 18. Older than 18? Enjoy responsibly. When in doubt we will ask to show your ID. Bar tenders rule.”*



Source: T. Bosch.

Some of the pledge partners also engage in *exercising advocacy*; for instance, under the “flag” of “All about Health...” an alliance was forged around the problem of illiteracy. About 50 organizations joined the alliance to link up knowledge, resources and ambitions. The national Programme Office organized events around this theme and was also involved in regional or local pledge network activities raising awareness of illiteracy and its impact on health (and health disparities). One observed impact was an elected municipal Alderwoman taking up this topic as a priority in the municipal Health Policy memorandum.

Finally, most of the CSOs and other partners in the “All about Health...” programme offer *committed people, flexible working routines, and responsive service delivery*. At this early stage, dialogue and collaboration are centred

mostly within the single pledge partner networks. Feedback between pledges, and with the Programme Office and the national government, is still occasional rather than structural and systematic. We elaborate on this in the next section.

### **How do governments and CSOs develop dialogue and collaboration in practice?**

Partners' motivations to participate in "All about Health..." range from sharing a common challenge such as underperforming students or staff with risky lifestyles to sharing a good idea or innovative solution for integrating primary and social care, to maintaining good relationships with the Ministry of Health in order to be in a better position to avoid or co-develop regulations.

Most of the partner organizations invest many working hours. Other sources are made available through sharing knowledge and experience, and providing access to new partners and targeted groups by linking up different networks across domains. The level of commitment in such people is exceptionally high, as expressed in devoted private hours and compared to regular organizational or business activities. The coordinators are able to be "agile" and responsive to changing circumstances, as our process tracing has showed.

The pledges that were investigated in-depth all show an organic and pragmatic development of targeted activities, often in direct contact with the relevant risk or user groups. In order to keep the energy going, partners undertake action rather than build consensus and detailed project plans as these are (too) time-consuming. Partners actively reflect and learn from these experiences and adapt their strategy or approach. As a result, pledges' activities and networks address context-appropriate and thus very different topics and issues in many different ways with many different partners, and their networks develop at a different pace. Diversity in this programme is a powerful resource.

We observe that a small number of the pledges are conducted by a single partner and there is hardly any network development. A bigger proportion of the pledges display features of *explorative collaborations*. At this early stage partners build relationships and explore common ground for a general health ambition and more concrete goals that serve (or at least do not harm) the various interests. At this "goal-seeking" stage partners do not yet depend on each other and the stakes are relatively low. There are no obligations (yet) towards one another. This enables a growth of trust, intrinsic commitment and coherence. The explorative collaborations in some of the pledge networks thus advance to shared objectives, conditions and terms of engagement, such as self-monitoring and evaluation. Such "*entrepreneurial*" collaborations no longer need external incentives to keep things going and manifest a degree of "self-organization" (Kaats & Opheij, 2012; Bekker et al., 2016a).

While some partners conduct formal research, others engage with “reflexive dialogues and monitoring”. Adapting and improving goals, strategies, perceptions and working routines, making them more appropriate and responsive, generate legitimacy and create room for social innovation of organizational structures, procedures, and rules. There is a call for scaling-up of good practices but there is hardly any evidence of this actually occurring. Because of context-appropriateness, good practices are not easily transferable to other settings. Another explanation is the lack of felt ownership in other settings. For each setting, combining elements of different good practices matching local utility, acceptance and feasibility seems more appropriate.

Pledge partners feel that the added benefits of the “pledge” as a coordinating instrument include the incentive to actually undertake action; the access it provides to new partners and the opportunities for new partnerships; the public stage for their ambitions and impacts in “All about Health...” social media posts; and the legitimacy that goes with participating in a national level platform in which various Ministries are involved. The latter in particular has helped partners to mobilize commitment from influential parties such as large municipalities or care insurers. At the same time there are also partners who expect more value in return for their investments.

### **Which conditions emerge enhancing the work of CSOs in “All about Health...”?**

During the course of the first three years of “All about Health...” it became clear that a distinction drawn between the governmental programmes, municipal health policies and their implementation networks on the one hand and the “All about Health...” movement and pledges on the other hand, would clarify the different roles, responsibilities and accountabilities involved. In the policy implementation networks, the government takes a central top-down role in setting priorities and terms of implementation, such as supervision and control, but the role of government in the “All about Health...” networks is far more facilitative to CSO needs (Bekker et al., 2016a). External requirements, such as SMART-formulated objectives and quantitative monitoring, scaling-up and organizational consolidation of good practices, should be trimmed down to become realistic, appropriate and enabling conditions rather than disqualifiers that might paralyse practice.

In addition to facilitating the partners, “All about Health...” programme support (now the Programme Office) has several important functions (Bekker et al., 2016b):

- brokering cross-domain connections;
- organizing systematic on- and offline knowledge sharing and exchange;

- incentivizing new pledges and partners as well as strengthening the ambition in current pledges (while also accepting pledge closure when the pledge is fulfilled and partners no longer feel committed); and
- systematically collecting partner feedback and detecting signals about contradictory regulations or bureaucratic obstacles, as well as feeding back on follow up and actions taken.

Trust and reciprocity are crucial conditions. The pledge partners expect the government to be actively interested in their activities and achievements. They also want government to take a consistent position in this social health movement without constraining partners or judging whether their achievements are in line with government priorities or not. Most of the activities, if not all of them, contribute to the determinants of health. A low entrance for newcomers as diverse as possible remains important so as to keep the flow of innovative domain-crossing ideas going.

Democratic accountability remains important since network initiatives might, in the end, only serve their own partners' interests while the public issues and challenges of external groups remain unsolved. Transparent progress deliberation and horizontal, forward-looking accountability among equal partners secures ownership that is more conducive to adaptation and improvement (Sabel, 1993). The direct participation of citizens can help improve democratic legitimacy. Moreover, citizens are co-producers, not passive recipients of health, and so may well improve implementation and impact.

Programme monitoring and evaluation (Bryden et al., 2013) is also important as a touchstone for reflection, contextualization, comparison, and accountability. Additionally, elected politicians and representatives at the municipal, provincial and national level could be more actively invited to take part in reflexive work visits and dialogue tables with street level workers and risk or user groups. Learning about the many small steps towards impact and change might help to develop appropriate procedures and requirements for democratic accountability.

Finally, based on comparative research into similar programmes in other policy sectors and in Quebec and the UK, it generally takes at least five to ten years before such a "Whole of Society" programme produces irreversible conditions: having CSOs develop trusting and solid partnerships; developing a public attitude for domain-crossing actions; and establishing regulatory and other institutional conditions for a working routine that enables being and remaining responsive and conducive to social innovation (Dubé et al., 2014; Addy et al., 2014; Petticrew et al., 2013). Small successes count because they induce trust and continuity. Early experiences with "All about Health..." confirm that time, trust and reciprocity remain important conditions for bottom-up governance

by CSOs, fostering innovation and change, towards a higher reach and impact on health (Bekker et al., 2016b).

#### **10.4 Conclusion: from government to health governance**

In this chapter we investigated the background, trends and early stage innovations in the relationship between CSOs, the market and the state in the Netherlands. We illustrated this with the recent programme "All about Health..." which created a platform of collaborative public, private and CSO initiatives for health.

The analysis of the first three years of "All about Health..." seems to provide an early backing of the hypothesis in this book about the potential of civil society organizations contributing to public health. In Chapter 1 of this book it was expected that "Civil society organizations (CSOs) tackle a large variety of diverse health issues and represent the interest of different constituencies including citizens, patients and stakeholders. They could offer committed people, flexibility, and responsiveness in service delivery that public sector and private sector organizations alike fail to muster. They could also mediate problematic policies; bring expertise, ideas, and diverse perspectives. Finally they would be seen to be more credible. Government would have to cope with more criticism and an element of unpredictability that comes with commitment and flexibility." Further details on how CSOs operate would, however, be dependent on the context of state-society relationships and were therefore not prescribed.

In the Netherlands state-society relationships consisted for a long time of corporatist organizations representing majority and minority interests in a consensual style of public policy-making. This corporatist tradition has eroded in favour of evidence-based policy-making with new or revised institutions at the policy-making table. The dominant public issue for decades had been reforming the health care system towards a regulated competition model. Disease prevention has been decoupled from health care for a long time and locked into the public sector, with little support from societal interests and a strong role for science-based public health institutes. In the past decade, however, challenges have evolved around *declining trust in public health expert judgement* and public recognition of the need for *collective action* on health problems. Health is rapidly becoming marketed, contributing to community awareness and demand, as well as to a fragmented health field. Recent government incentives are trying to introduce new forms of collective action among the state, the market and the community for health and other welfare issues. Experiments with a facilitative rather than controlling government provide early experience of opportunities and pitfalls.

The “All about Health...” programme, aiming to create a social health movement with CSO pledges to promote health and reduce health inequalities, is an early example of a “Whole of Society” approach. This approach indicates a shift from government to governance, attempting to reconcile state, market and society, economic and health interests, and public and private organizations. In so doing it is also seeking a reconciliation of ideas, interests and institutions. Its partners consist of CSOs, commercial businesses and public institutions working together in explorative cross-domain networks with an adaptive attitude in organic and pragmatic processes of learning by doing.

We have illustrated how the “All about Health...” partners provided evidence, contributed to policy development, exercised advocacy, helped consensus building, acted as watch dogs, provided services to members and to the public, acted as self-regulators and were key in industrial relations in the health sector. They have offered committed people, flexibility, and responsiveness in service delivery. They mostly did so in close collaborative relationships across different domains developing from explorative towards entrepreneurial networks. Nevertheless, in the long run these core features of early networks in the “All about Health...” programme are vulnerable. Legitimizing new working routines across the partners and domains could be one way of consolidating the rewards, values and impacts of the “All about Health...” pledge activities.

A final condition to making civil society work for health is to have research scientists who are capable of conducting independent, yet action-oriented and contextualized evaluations based on qualitative and responsive research methods in order to reconstruct its meaning across different settings. Based, among other sources, on this research, on 4 November 2016 the Ministry of Health sent a letter to Parliament deciding on a five-year extension of “All about Health...” (Ministry of Health, Welfare and Sport, 2016). While it is still too early to present the “All about Health...” programme as a successful governance innovation, it certainly is a courageous, challenging and promising addition to the traditional systems, patterns and routines of public health policy and practice.

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