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**Health governance by collaboration: a case study on an area-based programme to tackle health inequalities in the Dutch city of the Hague**

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**Background:** Area-based programmes are seen as a promising strategy for tackling health inequalities. In these programmes, local authorities and other local actors collaborate to employ health promoting interventions and policies. Little is known about the underlying processes of collaborative governance. To unravel this black box, we explored how the authority of The Hague, The Netherlands, developed a programme tackling health inequalities drawing on a collaborative mode of governance. **Methods:** Case study drawing on qualitative semi-structured interviews and document review. Data were inductively analysed against the concept of collaborative governance. **Results:** The authority’s ambition was to co-produce a programme on tackling health inequalities with local actors. Three stages could have distinguished in the governing process: (i) formulating policy objectives, (ii) translating policy objectives into health interventions and (iii) executing health interventions. In the stage of formulating policy objectives, the collaboration led to a reframing of the initial objectives. Furthermore, the translation of the policy objectives into health interventions was rather pragmatic and loosely based on health needs and/or evidence. As a result, the concrete actions that ensued from the programme did not necessarily reflect the initial objectives. **Conclusion:** In a local system of health governance by collaboration, factors other than the stated policy objectives played a role, eventually undermining the effectiveness of the programme in reducing health inequalities. To be effective, the processes of collaborative governance underlying area-based programmes require the attention of the local authority, including the building and governing of networks, a competent public health workforce and supportive infrastructures.

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**Introduction**

Socio-economic inequalities in health are present in all European countries. People in lower socio-economic groups on average have a lower life expectancy, a worse perceived health status and higher morbidity rates.¹ Area-based programmes, i.e. a programme consisting of health-promoting interventions and policies aimed at deprived neighbourhoods, are one strategy to tackling health inequalities. Assumingly, they are effective in targeting the interventions to the local context, by involving local actors and residents in identifying local problems and delivering solutions.²,³ Furthermore, they perfectly fit within the growing attention for the concept of social conditions being the main determinants of population health. Area-based programmes are mainly focused at health determinants in other sectors than health, including social security, urban planning and transport.²

In this context, collaboration with many partners—including citizens, community groups, professionals, public and private providers and business partners—is imperative. As such, area-based programmes fit within a model of collaborative governance, which can be defined as a governing arrangement where one or more public agencies directly engage non-state stakeholders in a collective decision-making process that is formal, consensus oriented and deliberative and that aims to make or implement public policy or manage public programs or assets.⁴
Area-based programmes are often singled out as a promising strategy of tackling health inequalities. However, previous evaluation studies, such as the evaluation of the New Deal of Communities initiative, do not consistently support a health effect of these programmes. These negative results might reflect a failure of the processes of implementing effective intervention and policies within these programmes. To obtain more insight in a possible 'failure of implementation', a detailed insight into the collaborative processes underlying these programmes is warranted. This might lead to a better understanding of the mechanisms that might explain flawed implementation processes. Involving a broad array of organizations in the governance of policies tackling health inequalities might for example increase the likelihood of diluting the intended effects of the policy while engaging in local stakeholders. This might involve the risk of a disconnection between the initial policy intentions and the ultimate impact as reflected in the employed activities and their outcomes, which essentially questions how the policies were governed. Little is known, however, about these collaboration processes, and about the conditions under which these processes successfully lead to health improvements.

Against this background, the aim of this article is to open the black box of the development of an area-based programme. In our analysis, we will focus on the collaborative mode of governance employed in an area-based programme to tackle health inequalities in The Hague, The Netherlands. The following research questions were addressed:

1. How did the local authority in The Hague collaborate with a broad range of stakeholders to develop and implement an area-based programme in deprived neighbourhoods aimed at tackling health inequalities in The Hague? How did the local authority ensure that the implementation of the programme for tackling health inequalities in a context were they collaborate with a broad range of stakeholders?

2. How did the local authority maintain the connection between their initial policy intentions and employed activities to tackle health inequalities in a context were they collaborate with a broad range of stakeholders?

**Tackling health inequalities in The Hague**

The city of The Hague with ~475,000 residents is known as one of the most segregated Dutch cities. The average standardized household incomes vary between 70% of the Dutch mean in deprived areas to 220% in affluent ones. Furthermore, although 13% of the total population lives at or below the legal minimum, this percentage is 43% in the city’s deprived neighbourhoods. Additionally, the mortality rate in deprived areas is 11% higher than elsewhere in the city, with residents in these areas living an average 12 years shorter in good health. The inequalities in health at the time of the study were amongst the highest reported in the Netherlands.

From 2002 onwards, local policymakers succeeded in getting health inequalities on the political agenda for the first time. The attention was prompted by data from the municipal health monitor, which contained epidemiological information on the health of the city population, including significant socio-economic inequalities in various health (and health-related) outcomes between neighbourhoods. The issue then became part of the negotiations on a policy agreement to form a new Municipal Executive, resulting in the funding of a 4-year action programme (2002–06). The policy was deliberately labelled as a ‘programme’ to highlight its innovative nature. At that time, local policymakers acknowledged that collaborative modes of governance are required to make local policy making more effective.

The new collaborative mode of governing led to collaborations with a broad range of local public and private providers delivering public health, primary care and welfare services; amongst them were providers such as general practitioners, midwives, pharmacists, dentists, physiotherapists, home care nurses, health promotion specialists, youth care physicians, public health officers and social workers. Initially, attempts were also made to engage in citizens. But the early experiences learned that citizens’ panels did not function as envisioned. They were hardly attended, and the citizens who did were not representative for their community. For that reason, citizens were actively engaged in specific health promotion projects such as an exercise referral scheme, but not in the overall programme development (i.e. the policy-making process).

The programme was collaboratively governed by two programme coordinators, controlled by one programme leader and supervised by a steering committee consisting of municipal administrators who formally decided on subsidizing activities. For the programme in the period of 2002–06, there was a budget of 1.9 million euro made available.

**Methods**

A prospective single case study was carried out in the period 2002–06 using face-to-face semi-structured interviews and document review.

**Sampling and recruitment**

**Semi-structured interviews**

To obtain a detailed insight into the collaborative processes underlying the development of the area-based programme, we held semi-structured interviews with key players in these processes, at different points in time. Participants were purposefully sampled for their position, organization and role in the programme. Key municipal administrators including the programme leader, programme coordinators, aldermen and several members of the steering committee were asked to participate in the study. Key representatives of the local health system were conveniently selected by asking the programme leader and coordinators for their main contacts. Potential participants included directors, project leaders, health promotion specialists and general practitioners, who were approached by telephone and/or email. All those approached agreed to participate or appointed a colleague if they were unable to participate themselves. Informed consent was automatically retrieved when making the appointments for the interviews. Supplementary file S1 shows the sample of 22 participants.

**Document review**

In addition to the interviews, also written documents formed the basis for the analyses of collaboration processes. Documents were continuously collected during the study. Participants drew our attention and/or provided us with hard copies of documents. Furthermore, documents were downloaded from websites of relevant stakeholders (e.g. www.denhaag.nl, www.welzogezond.nl, www.lijn1haaglanden.nl, www.stiom.nl). Selected documents included public information, official policy reports, fact sheets, working documents, research and discussion papers, minutes of meetings, slides of presentations given during conferences and professional literature. T.P. and M.S. selected the documents when they considered them relevant to the research question (see Supplementary file S2).

**Procedure**

Two researchers (T.P. and M.S.) interviewed the participants face-to-face in an environment of their choice, usually their office. For practical reasons, five interviews were conducted by both researchers and the rest by one, either T.P. or M.S. Interviews provided the participants both with an opportunity to give an account of their experiences and to share what they considered important concerning the implementation of the programme for tackling health inequalities. The purpose of the interview was to obtain a precise description of the processes underlying the collaborative governance.
of the programme, and to obtain insight in the difficulties perceived by the actors. A topic list was developed on the basis of the two research questions and used to guide the interviews. It contained some open questions, thus leaving room for participants to expand and clarify their answers. The interviews took ~1 h each, were recorded and later transcribed verbatim. The researcher’s observation and reaction notes were recorded after each interview.

**Data analyses**

We inductively analysed the interview data and documents against the concept of collaborative governance defined as a governing arrangement where one or more public agencies directly engage non-state stakeholders in a collective decision-making process that is formal, consensus oriented and deliberative and that aims to make or implement public policy or manage public programs or assets. Thereby, the focus of the local authority was on collaborative health governance (i.e. governing the local health system) rather than on governance for health (i.e. governing the joint actions of health and non-health sectors, of public and private sectors and of citizens for a common interest). Taking collaborative health governance as the starting point, we focused on analysing how the local authority of The Hague maintained the connection between their initial policy intentions and employed activities to tackle health inequalities. Thereby, we made a distinction between three stages in the governing process: (i) formulating policy objectives, (ii) translating policy objectives into interventions and (iii) executing health interventions. From this combined perspective, we analysed within each stage how the local authority collaboratively governed the program by interacting, activating and bringing together relevant professionals and institutions, and what rationales and interests were leading.

Interview and documentary data were used to triangulate each other. The analyses were performed by T.P., and M.S. read all transcripts, discussed and confirmed the findings in cooperation with T.P. For additional validation, the findings were presented to the research team and other colleagues working at the Department of Public Health of the Academic Medical Centre (AMC) of Amsterdam.

**Results**

**Formulating policy objectives**

The primary objective of the health inequalities programme as stated in the political assignment was to improve the health of residents living in deprived neighbourhoods of The Hague (Supplementary file S2, b). This objective was reframed into more practical terms for the further development of the program, whereby three rationales were critical.

First, epidemiologists from the municipal health service extracted the five most prevalent health problems in the city from several municipal monitors. Notwithstanding slight differences amongst neighbourhoods, the top five included cardiovascular disease (associated with diabetes type 2), lung cancer, accidents at home, psychosocial problems and developmental problems amongst children (Supplementary file S2, b). Targeting these health problems in the deprived neighbourhoods would potentially lead towards the highest health gains, thus most contributing towards smaller health inequalities.

Second, at the start of the program in 2002, professionals such as physiotherapists, midwives, general practitioners, community workers, health promotion specialists, social workers and mental healthcare workers were consulted, and put forward four themes: information on and access to health care, healthy diet and physical exercise, pedagogical support and the strengthening of primary care (Supplementary file S2, b). As such, the professional focus was more on preconditions supporting the functioning of the local healthcare system rather than addressing the top five health problems per se.

Third, municipal administrators basically took over the four themes given by the professionals. They specified them by adding criteria for guiding the decision-making process on which health interventions should be supported and implemented (see table 1). When reflecting on the reframing, various administrators indicated that epidemiological realities played a minor role in the process and were subordinate in the desire to engage in the local actors.

The four professional themes were adapted without much debate. One of the administrators in our study attributed this lack of debate to unfeasibility amongst administrators to keep the collaborative process going and purposefully use it to reframe the programme objectives. The administrators would lack the expertise and knowledge. This notion was supported by most members of the steering committee who said they missed conceptual debate on reframing the programme objectives as well. Discussions within the committee predominately concerned the shaping of bureaucratic procedures and processes, i.e. how to adequately run the program in accordance with bureaucratic and administrative rules. Further specifying the four themes as put forward by the professionals was insufficiently done to obtain clear and concrete objectives (Box 1).

Last, participants notified that the reframing did not result in explicit targets or outcomes set in terms of health inequalities reduction. Most municipal administrators were reluctant in doing this, as they considered it impossible to achieve measurable reductions within the 2002–06 time frame.

As a result of the above, the municipal rationale was being led by specifying the four themes put forward by the professionals. The reframed programme objectives, as reflected in the criteria guiding the decision-making processes (table 1), were more on the process (e.g. creating support for the programme amongst healthcare professionals, and designing appropriate subsidy procedures) than on the outcome (i.e. what health targets should be explicitly set in terms of health disparity reduction and how will they be accomplished).

**Translating policy objectives into interventions**

Following the municipal procedure, the set of criteria (table 1) should have guided the translation of objectives into health interventions. In practice, however, the criteria were loosely applied. This is reflected in the projects that were funded (tables 2 and 3). The link between the criteria and funded projects is equivocal, which was also recognized by the participants. Their main criticism was the inability to check whether the granted interventions had the potential to tackle health inequalities.

When reflecting on granted projects, participants said that at least three rationales, other than the ‘managing by objectives’ rationale, underpinned the translation process (Box 1). First, municipal administrators, supported by local professionals, decided to fund already existing interventions to keep them upright and/or to give them more time to get structurally embedded in the local health system.

Second, subsidized projects should lead towards quick and visible wins. This was considered important for maintaining political and community support. Arguably, this is one of the reasons for subsidizing, for example, the broadcasting of two local television programmes focusing on health issues (table 3). Apart from promoting health, both television programmes highlighted granted health interventions, and thus seemed to serve electoral purposes as well.

Third, municipal administrators said the programme budget had to be spent quickly to prevent budget cuts from being made in the coming year. The administrative logic of municipal procedures is that saved money will not automatically add up to the budget for the following year. This clarifies the differences in the granted pillar projects and the short-term projects in 2003 (tables 2 and 3).
Box 1 Health governance by collaboration: a case study on an area-based programme to tackle health inequalities in the Dutch city of the Hague

Epidemiological realities played a minor role
‘I thought it was interesting that in the beginning there was a top five of health problems based on epidemiological data including diseases like heart problems, smoking, etc. These were the biggest problems in the neighbourhoods. But during the interactions with the professionals and residents, there were other themes highlighted. So, what are you going to do as a local authority? You want to mobilize the local health system, and therefore the themes are important. However, the epidemiological data suggest other themes.’
(Member steering committee, nr. 6)

Steering committee focused on administrative procedures
‘There is a lack of dialogue within the steering committee on the content. The program leader is searching for this dialogue, but outside the steering committee.’ (Member steering committee, number 12)

No explicit targets in health inequality reduction
‘If we succeed in keeping this theme on the policy agenda and invest at least 5 more years in tackling health inequalities, then we can set targets in terms of percentages for reductions in health. I do not see that happening within those 5 years.’ (Member steering committee, number 12)

Equivocal link between the criteria and funded projects
‘There are overviews of granted projects, which give me concrete insight in the interventions employed. However, I am more interested in assessing whether these interventions are needed. Are these the interventions related to our objectives which we want to meet?’
(Member steering committee, number 6)

Keeping existing interventions
‘I said that the budget was insufficient and asked whether the local authority had ideas for funding. […] Then, they came up with funding from the programme on tackling health inequalities. The funding was not that much. Besides, I support the objective of reducing health inequalities. Thus, it fits in with my project.’ (Project leader, no. 22)

Highlighting granted interventions for electoral purposes
‘The desire of the alderman for health is to implement many visible activities.’ (Member steering committee, number 12)

Availability of local networking infrastructure
‘I was really on my own and puzzled by the question of how to build the programme. So, you started orienting and calling organizations in the local health system. The organizations that deserved most to receive a phone call were the Municipal Health Service (GGD), STIOM and later on the BOOG foundation.’ [The Municipal Health Service is officially integrated within the local authority Department of Education, Culture and Welfare and delivers public health services (i.e. health promotion, infectious disease control and epidemiology) in the city.] (Programme leader, number 1)

Questioning the capacity of the local network organization
‘It cannot be that one small institute like STIOM is running the programme for the whole city with just a few people.’ (Programme coordinator, number 3)

Questioning the credibility of the local network organization
‘Care providers either like or dislike STIOM. Aversion is nurtured by the impression that there seems to be a strong imperative of the local authority behind STIOM. […] It seems to be an ideological drive on how the local health system in deprived neighbourhoods should look. This will not work.’ (Key figure, number 20)

Consequently, the projects that were granted did not necessarily reflect the primary policy objective of the programme on tackling health inequalities. The translation process seemed to be led by multiple rationales (i.e., granting interventions that pop up in the local health system), only loosely dealing with health needs, and not based on evidence as to how to effectively tackle health inequalities.

Executing health interventions
To execute health interventions, the local authority engaged in local stakeholders, in particular the Municipal Health Service (GGD) [The Public Health Service is officially integrated within the local authority Department of Education, Culture and Welfare and delivers public health services (i.e. health promotion, infectious disease control and epidemiology) in the city.] and the Dutch organization for the promotion of health and welfare services—Stichting ter Ondersteuning van de Gezondheidszorg en Maatschappelijke Dienstverlening in Den Haag (hereafter STIOM) [STIOM is a project and development organization founded in 1994 with the objective to support primary care in The Hague by community-based working, health networking as well as starting innovative projects (www.stiom.nl)]. STIOM runs platform meetings on a monthly basis attended by local healthcare professionals working in the deprived neighbourhoods.). Both organizations provided infrastructures for collaborative governance. Therefore, it was both probable and pragmatic to contact both organizations from the start, and closely collaborate with them. Some municipal administrators even pinpointed the availability of STIOM as being one of the enabling factors of implementing the programme.

Nonetheless, several participants also criticized this close collaboration, as they thought it would exclude alternative options (Box 1). First, both organizations gradually functioned as intermediaries towards other care providers in the local health system, thereby placing the local authority at a distance from the execution of the programme. Both organizations thus had discretionary power and could influence the governing process while safeguarding their own interests. This is illustrated by the fact that both organizations executed most of the granted projects consuming most of the programme budget (tables 2 and 3).

Second, using the infrastructure of STIOM meant that networks did not have to be constructed anew for the programme, but it also restricted the scope of the programme to the existing network. Care providers not attending platform meetings were not actively engaged. Municipal administrators indicated this and questioned whether STIOM had the capacity to mobilize the local health system on its own.

However, the non-mobilization of providers via the STIOM network was not only a matter of capacity, but also of credibility. Participants representing these care providers, perceived STIOM as a
policy instrument of the local authority who were implicitly imposing their health policies via STIOM. They consequently withdrew their commitment to the programme. So, the local authority mobilized two intermediary organizations, which was practical. However, it became clear that it also restricted the scope of the programme and kept the local authority at arm’s length from the health professionals working in the neighbourhoods.

Discussion

The objective of this case study in The Hague was to explore the processes that underlie health governance in an area-based programme aimed at tackling health inequalities. We explored how the local authority attempted to maintain the connection between their initial policy intentions and employed activities to tackle health inequalities in the context of collaborative governance. The findings reveal that, in the execution of the
programme, the city’s local authority succeeded in collaborating with local actors, mainly through two intermediate organizations. But, the intended policy objectives became gradually disconnected from the employed activities. Throughout the collaborative governing process, various other rationales overruled the ‘management by objectives’ rationale (i.e. evidence-based public health). This was manifest in the reframing of the programme objectives, focusing more on the process than on the aimed outcome, in the rather pragmatic translation of policy objectives in activities that were only loosely based on health needs and/or evidence with regard to the effectiveness of interventions, and in the restricted scope of the programme with the local authority at a distance from the health professionals working in the neighbourhoods.

Validity

The findings of this case study were based on interviews conducted with a wide range of relevant participants, and on an analysis of a broad range of documents. This thorough approach allowed for interpretations that we could not have developed without the ‘in depth’ data collection. This applies in particular to the changes in the different rationales underlying the process of the translation of policy objectives into interventions, and how this led to a specific set of interventions within the programme.

Nonetheless, probably small pieces of information were not accessible for us as researchers, as they were not written down, or the participants did not mention these. In addition, the interviews were unevenly distributed among the key persons. We addressed these sources of bias by triangulation. Because the documents and interviews showed a consistent pattern, the lack of some information would not have biased our main conclusions.

Another limitation relates to the lack of measurements on the health impact of the programme. At the start of this evaluation study, we expected the impact to be too limited to warrant an effect evaluation in the chosen time period. As a result, we do not know whether the interventions that have been implemented actually improved the health status of the inhabitants of the deprived neighbourhoods, which is of course the ultimate test of the appropriateness of the processes of health governance studied.

A case study imposes limits on whether the results can be generalized. The case of The Hague does not provide a blueprint for health governance within an area-based programme anywhere in the world. Still, we identified some elements that may be critical to the success of collaborative governance aiming to tackle health inequalities.

Lessons learned

There is a well-evidenced gap between rhetoric and action on tackling health inequalities as Marmot et al.10 point out. Many evaluated initiatives have shown that despite the widely supported agenda for health inequality reduction, progress is relatively limited and disappointing.11–14 One of the reasons for this gap, particularly at the local level, might be related to the complexity of the processes of collaborative government—a model of government that is considered necessary to develop policies and interventions to tackle health inequalities. The case study that was described in this article shed some light on these processes. What can be learned from this case study when it comes to health governance by collaboration in a local setting?

First, a starting point of the collaborative government model is that population health cannot be achieved without collaborative approaches.15 The case study in this article indicates, however, that the actors with whom government should collaborate, might be driven by other rationales, i.e. other than the original aim of tackling health inequalities. These include the aim of supporting the functioning of the local healthcare system (professionals), or electoral purposes (aldermen). As a result, the interventions and policies employed in the programme were not consistently targeted at reducing the health burden in deprived neighbourhoods as indicated by epidemiological data. In a policy context with

### Table 3 ‘Pillar’ projects funded by the programme in 2003–06 (source: Evaluation report 2003–06)

<table>
<thead>
<tr>
<th>‘Pillar’ project</th>
<th>Description</th>
<th>Provider(s)</th>
<th>Target population</th>
<th>Programme funding 2003–06</th>
</tr>
</thead>
<tbody>
<tr>
<td>Micro grant scheme</td>
<td>To fund small-scale initiatives of residents and community workers to stimulate innovation and community health action</td>
<td>Many</td>
<td>Many</td>
<td>€360 000</td>
</tr>
<tr>
<td>Exercise referral scheme</td>
<td>Patients are referred to a 20-week exercise program by a general practitioner (GP) or other health professional</td>
<td>STIOM</td>
<td>Inactive adults</td>
<td>€445 000</td>
</tr>
<tr>
<td>Healthcare consultants for ethnic minority groups</td>
<td>Consultants provide advice and information on health and healthy living to patients with an ethnic minority background during individual consults or when consulting a healthcare professional</td>
<td>Foundation primary healthcare centres The Hague</td>
<td>Ethnic minority groups with healthcare demands</td>
<td>€248 505</td>
</tr>
<tr>
<td>HOPLA</td>
<td>A campaign stimulating healthy diet and physical exercise to stabilize the prevalence of overweight amongst children in the age of 0–6</td>
<td>Municipal health service/ youth network</td>
<td>Children aged 0–6 years old and their parents</td>
<td>€48 600</td>
</tr>
<tr>
<td>Children’s symphony</td>
<td>Providing 11 classes to educate parents in stimulating their children in their health, language and physical development</td>
<td>Coordinated by foundation BOOG (social care and community building)</td>
<td>Parents and children aged 0–3 years living in deprived neighbourhoods</td>
<td>€8000</td>
</tr>
<tr>
<td>Educational television</td>
<td>Two television series on healthy diet and physical exercise broadcasted on local television</td>
<td>ETV local television</td>
<td>All citizens in The Hague</td>
<td>€115 000</td>
</tr>
<tr>
<td>The ‘home doctor’</td>
<td>Informing the public on little health problems to stimulate their self-support</td>
<td>Municipal health service</td>
<td>Adults</td>
<td>€26 000</td>
</tr>
</tbody>
</table>
multiple stakeholders, rationales and interests, it proves to be challenging to ensure that the ‘management by objectives rationale’ leads. Other coexisting rationales, whether administrative, political or economic, transform the process, often disconnecting the intended policy objectives from the employed activities. This implies that the local authority needs to be aware of the possibility that other rationales might override the rationale of ‘managing by objectives’, and need to learn how to purposefully align them with each other.

Second, this seems even more difficult when local health systems lack an existing infrastructure, e.g. an intermediary or networking organization, for actively involving and bringing together local healthcare professionals. In the case of the Hague, the local authority was able to implement specific interventions in particular through two intermediary organizations with which stable relationships had been established. This was a logical choice, given the short time frame of programme. For future programmes, this indicates that specific attention must be dedicated to developing a network of actors through which interventions can be implemented. The growing body of knowledge on how to build and govern these networks, and how they function, might be helpful in this respect.4

Third, the role of public health officials appeared to be critical. The case of the Hague indicates that much progress can be made regarding successful collaborative governance when these officials hold a ‘managing by objective’ rationale, and succeed in keeping uprightness the policy objectives of reducing health inequalities throughout the whole policy process. This calls for a public health workforce that has not only know-how on the manifestation of health inequalities and evidence-based approaches to tackle them (the what), but also the skills to collaboratively govern and manage the policy processes (the how). This is in line with the plea to focus on the governance,15 the various reflections on how to move forward to tackle health inequalities,12,16 and the renewing of public health competencies more generally.17,18 The latter debate opens a window of opportunity to describe and add those competencies needed to empower public health officials in collaboratively governing policies tackling health inequalities.

Finally, the functioning of the public health officials could not be separated from the conditions the local authorities shaped to support public health officials in their governing role. The results of the case indicate the importance of developing strategies allowing for the decentralization of control and the strengthening of bottom up responsiveness. Local authorities must put planning and control mechanisms in place that are flexible and robust at the same time. This does not only mean making sure that targets make sense for the policy context within which they are employed, but also that they are monitored, and that the results are communicated with the public.15

Conclusions

Despite a poor record of success, the process of introducing the system-wide changes at the local level that are necessary to reduce inequalities receives little attention. The aim of our study was to explore the mechanisms that underlie the collaborative governance in this area. Our results emphasize the importance of governing the connection between employed activities and the intended policy objective of tackling health inequalities in the first place. We hope that the results of this study might serve as a source of inspiration for those who want to effectively tackle health inequalities at the local level.

Supplementary Data

Supplementary data are available at EURPUB online.

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Conflicts of interest: None declared.

Key points

- Neighbourhood-based programmes are seen as a promising strategy to tackle health inequalities, requiring collaboration between local authorities and a wide variety of other actors at the local level. There is paucity in knowledge on how collaborative health governance, in particular in the local context, could successfully lead towards health inequality reduction.
- When developing neighbourhood-based programmes, there is a risk of the employed activities becoming gradually disconnected from the original objectives of the programme in terms of tackling health inequalities.
- Preventing this risk seems to require explicit attention for the processes that underlie health governance, including building and governing networks, development of competences of public health professionals and a supporting governing infrastructure.

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Rurality and avoidable hospitalization in a Spanish region with high population dispersion

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Introduction

Avoidable hospitalizations (AHs), also known as hospitalizations for Ambulatory Care Sensitive Conditions (ACSC), refer to hospital admissions for conditions amenable to Primary Health Care (PHC) level management. Timely PHC services may reduce the risk of admission for these ailments by preventing the onset of a disease, treating an acute illness or managing a chronic condition. Since the early 1990s, when the ACSC term was defined in the USA,1,2 a large number of articles have been published in various countries, which have adapted the classifications included in the ACSC concept to each field of study.3,4 These studies have shown greater rates of AH associated with racial/ethnic inequality,5 poorer socio-economic status (SES)6,7 and lower access to health care.8,9 Studies examining AHs in Spain have also confirmed the inverse relationship between AH rates and SES.10,11

Despite the importance of investigating equal access to health care in rural areas and the concern for their vulnerability, the research on AHs in relation to rurality is limited. Furthermore, in many of these studies, the rurality indicators have been included only as control variables in studies on health inequalities.12 In the USA, larger AH rates have been found in rural populations13 except among Medicare beneficiaries (national health insurance program that covers Americans aged ≥65 years and younger people with disabilities).14 Findings in countries with universal coverage, such as Canada15,16 and Australia,17 have been contradictory. To our knowledge, no studies on AHs and rurality in Spain have been done so far, though research using certain rurality indicators as adjustment variables has also yielded contradictory results.10,18,19

As one may expect, among the complexities of this field of research is that the definition of rurality itself is controversial. Traditionally, studies have used the number of inhabitants or population density to classify urban and rural areas. The Organization for Economic Co-operation and Development20 defines a population density <150 inhabitants/km² as rural, whereas in Spain, the Rural Sustainable Development Act 45/2007,21 classifies as rural domain all administrative jurisdictions from municipality of residence to reference hospital and percentage of population aged >65 years were inversely associated with risk for avoidable hospitalization [RR = 0.996 (95% CI 0.993–0.999) and RR = 0.989 (95% CI 0.982–0.996), respectively]. Conclusions: It is important to determine whether these lower avoidable hospitalization rates reflect an adequate level of accessibility and quality of primary care health services for rural populations or, in the contrary, they reveal access barriers to hospital care.