DO THEY CARE?

A comparative case study on local health policy in Dutch municipalities

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Abstract

The research question central in this thesis is "*How can the differences, on the active pursuance of their responsibilities on local preventive health policy, between Dutch local governments be explained?"* Based on the literature a relation is expected between how actively a local government pursues its responsibilities on local health policy and the political orientation of the local government, the severity of the health problems and the availability of network partners. By means of a comparative study of eight non-randomly selected municipalities the following hypotheses will be tested in this thesis: 1. "left-wing local governments will more actively pursue their responsibilities on local health policy than right-wing local governments", 2. "in municipalities with a high problem severity local governments more actively pursue their responsibilities on local health policy than in municipalities with a low problem severity" and 3. "in municipalities with a high level of network partners, local governments more actively pursue their responsibilities on local health policy than in municipalities with a low level of network partners". Based on the results of the comparative case study the political orientation and the problem severity might explain the differences in active pursuance. No relation was found between the availability of network partners and the active pursuance of the responsibilities.

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Introduction

Do they care? This question concerns the (preventive) health care policy in the Netherlands on the local level. Since the collective public health prevention Act of 1989 local governments have the statutory obligation to actively pursue policy in the area of public health. In 2002 the first national health policy document (NHPD) was drawn up by the ministry of Health, Welfare and Sport (ministry of HWS). In this four-yearly document the minister formulates priorities or spearheads of the public health policy for four years. In the same year local governments were statutory obliged to draw up a local version of the national health policy document, based on the national one (VNG, 2005).

A national study in 2017, requested by the ministry of HWS, listed the content and execution of local preventive health policy by local governments. They concluded that two-thirds of the Dutch local governments have a local policy document and that the others do have some preventive health policy. So most local governments take their responsibilities on preventive health policy seriously, but there are differences in the execution of the policies (Cebeon, 2017).

The Cebeon study focussed on the presence of local preventive health policies and the partners that are involved in the execution of that policy. They did not elaborate on the differences in execution, or the choices and considerations behind the preventive health policies, as this fell outside the scope of the investigation. Nor did they analyse preventive health activities of the local government that are not stipulated in the formal policy documents (Cebeon, 2017). Yet, these differences, choices and considerations are the compelling aspects of local preventive health policy, that ask for further investigation in this field.

What are the actual differences between local governments on the active pursuance of preventive health policy? And can these differences be explained by the choices and deliberations the local governments made and why they did so? The decision-making on preventive health policy can be affected by the political orientation of the local government, since left-wing parties value healthcare more than right-wing parties (Van Dalen & Swank, 1996). Differences between local governments on the active pursuance of preventive health policy can perchance also be explained by the severity of the problems they face. Larger or more severe problems have a higher chance of getting on the political or policy agenda (Hoeijmakers, De Leeuw, Kenis, & De Vries, 2007). And since policy is increasingly a result of interaction between actors, one can assume that the availability of network partners also influences the active pursuance of preventive health policy by local governments (Hoeijmakers et al., 2007; Varvasovszky & Brugha, 2000).

Research question

In the Netherlands the long-term health policy of the national government is formulated in the national health document. The local governments have to draw up a local (preventive) health policy document within two years after the national one. Besides the local health policy document, the way local governments actively pursue their responsibilities concerning preventive health policy varies. In order to find out what the differences are and how these differences can be explained the following research question will be answered in this thesis.

How can the differences, on the active pursuance of their responsibilities on local preventive health policy, between Dutch local governments be explained?

In order to provide an answer to this question the following sub questions have been formulated. The variables will be discussed in more detail in the theory section.

1. How can the Dutch local governments be characterised on political orientation, problem severity and the availability of network partners?
2. To what extent are the responsibilities on local preventive health policy actively pursued by the Dutch local governments?
3. To which extent do political orientation, problem severity and the availability of network partners explain the degree to which local governments actively pursue their responsibilities on local preventive health policy?

Theory/concepts

In order to provide an answer to the research question it is necessary to elaborate on the concepts and theories that will be used. For the first two descriptive sub questions the relevant concepts will be discussed. For the third explanatory question the concepts as well as the theories will be discussed.

The concepts of the first research question that need to be elucidated are 'the responsibilities of Dutch local governments and 'actively pursued'. The 'responsibilities of the Dutch local governments' in this thesis alludes to the responsibilities and tasks concerning local preventive health policies. These tasks are a statutory responsibility for local governments. Considering the timespan of this thesis the number of the responsibilities that are investigated are limited to the tasks and responsibilities on the subjects obesity, smoking and alcohol. This is in line with the spearheads of the national health policy document and the national prevention agreement (Ministry of Health Welfare and Sport, 2015, 2018). With 'actively pursued' in this research is referred to the extent to which local governments have preventive policies on obesity, smoking and alcohol. The active pursuance of responsibilities is conceptualised by the following variables on two dimensions. The first dimension concerns formal policy that has been decided on, such as the local health policy document or the participation in national health projects. The second dimension refers to what is happening in the political arena and focuses on the handling of local preventive health policy by the local council in terms of decision-making and checking the board of Mayor and Aldermen (board of M&A).
The concepts of the second research question that will be clarified are 'political orientation, 'problem severity' and 'availability of network partners'. Political orientation is defined as the political orientation of the local government. The focus will be mainly on the executive power of a local government considering the distribution of responsibilities (Bortolotti & Pinotti, 2003). The problem severity will be conceptualised as the registered number cases (people) in a municipality that is facing problems with obesity, smoking or alcohol, as a percentage of the total population of a municipality. A problem in this sense is defined as a discrepancy between an existing situation and the norm or standard (Korsten, 2016). The availability of network partners will be defined by the presence of organisations in a municipality that can contribute to (preventive) local healthcare, such as health insurance companies, hospitals, universities and health care organisations.

The theories of the third research question will be discussed in order to provide insight in the relation between the concepts of the first two questions. Political orientation can affect the extent to which local governments have preventive policies on obesity, smoking and alcohol. In terms of government expenditures, left-wing parties and coalitions value expenditures on social security and health care more than right-wing parties and coalitions (Van Dalen & Swank, 1996). The theory of issue ownership supports this as well. This theory states that voters associate certain subjects or policy

fields to specific political parties, such as health care with left-wing parties. These parties then use their reputation to profile on the issues that voters think they are competent at (Breeman, Scholten, & Timmermans, 2015). Based on the above, a correlation between the political orientation and the extent to which local governments actively pursue their responsibilities is assumed. Severity of the problems can be a possible explanation for the active pursuance of responsibilities by local governments. According to Cromwell, Peacock and Mitton (2015) decisions concerning health care are often made based on the need of the population for this care. When a problem occurs more often or is more severe, it has a higher chance of getting on the political or policy agenda. Another factor that can explain the active pursuance of responsibilities on local preventive health policy by local governments is the availability of network partners. Today's policy arrangements are increasingly a result of complex constellations of actors and interdependencies between stakeholders (Hoeijmakers et al., 2007). Stakeholders in this thesis are defined as actors who are affected by the issue under consideration, have an interest in the issue or can actively or passively influence the process of decision making and implementation (Varvasovszky & Brugha, 2000). As policy is described as a result of the interaction between actors, it can be assumed that the availability of these actors or network partners affects the degree to which local governments actively pursue their responsibilities on local preventive health policy.

Based on the abovementioned theories the following three hypotheses are formulated:

1. *Left-wing local governments will more actively pursue their responsibilities on local health policy than right-wing local governments.*
2. *In municipalities with a high problem severity local governments more actively pursue their responsibilities on local health policy than in municipalities with a low problem severity.*
3. *In municipalities with a high level of network partners, local governments more actively pursue their responsibilities on local health policy than in municipalities with a low level of network partners.*

Research design

In order to provide an answer to the research question a comparative case study will be carried out using a cross-sectional research design. With this design it is possible to describe a situation at a certain moment in time. The values of the independent and the dependent variables can be described for that moment in time. The design allows for the description of association between the independent and the dependent variables. One of the limitations of this research design generally is that, considering there is no temporal variation, it is harder to establish the correct time order. The effect of this on the research is only limited, because time order for the variables can still be established. For instance, when a certain policy is implemented by the local government, it can be established that the political orientation of the local government preceded the implementation of the policy. Another restriction of the cross-sectional research design is the inability to rule out alternative explanations. Since this restriction is hard to counter, it will be stated as a limitation to the internal validity of the research. An answer to the research question will be provided by taking the following steps. First the dependent variable will be measured for the selected cases. After that the independent variables will be measured. Then it will be analysed how the independent variables can explain the dependent variable.

Case selection and sampling

In this research the population consists of all Dutch local governments. In order to investigate how the independent variables can explain the dependent variable, the selected cases have a high-low variation on the independent variables 'political orientation', 'problem severity' and 'availability of

network partners'. When there are three variables with a high-low variation a total of eight cases (2 x 2 x 2 = 8) has to be non-randomly selected in order to have variation on every variable. Considering the time constraint of this thesis it is nearly impossible to study eight cases thoroughly. Therefore it was decided, after deliberation with, and approval of, the supervisor of this thesis that every student of this research circle studies four cases. Every student can use his own cases, complemented with four cases of the other students. The cases have been selected by coordination between the students who has variation on what variable. Table 1 shows how the variations on the variables have been divided. Every square marked with a * is the selected sample for this thesis.

		Availability of network partners			
		High		*Low*	
		Problem severity		Problem severity	
		High	*Low*	*High*	*Low*
Political orientation	*Left-wing*	Niek*	Niek*	Bennie	Bennie*
			Hugo	Hugo*	
	Right-wing	Niek*	Niek*	Bennie	Bennie*
			Hugo	Hugo*	

Table 1: division of the variables between the students

The cases sample for this thesis all had to be high on available network partners, but with high-low variation on problem severity and political orientation. Tilburg was selected because it has a high availability of network partners, a high problem severity on smoking and drinking and the local government has a left political orientation. Utrecht is selected because it has a high availability of network partners, a low problem severity on overweight and the local government has a left political orientation. Rotterdam was selected because it has a high availability of network partners, a high problem severity on smoking and the local government has a right political orientation. Almere was selected because it has a high availability of network partners, a low problem severity on drinking and the local government has a right political orientation. The case sample for this thesis, including the municipalities of the other students, is presented in table 2.

		Availability of network partners			
		High		*Low*	
		Problem severity		Problem severity	
		High	*Low*	*High*	*Low*
Political orientation	*Left-wing*	Tilburg	Utrecht		Bronckhorst
				Doesburg	
	Right-wing	Rotterdam	Almere		Oost Gelre
				Barneveld	

Table 2: sampled cases for this thesis

Operationalisation, data collection methods and data analysis

The data in this study has been collected by document analysis. The 'active pursuance of responsibilities on local preventive health policy by local governments' is expressed in the active pursuance score and is operationalised by looking at the following indicators:

A. *The presence of local health policy documents:* is there a local health policy document drawn up within two years after the presentation of the national health policy document?
B. *The specificness of the health policy documents:* how specific are the goal, actions and means formulated in the local health policy documents?
C. *The presence of an implementation programme:* is there a plan for the implementation of the local health policy, either as a separate programme or integrated in other programmes?

D. *Presence of council/board documents:* whether and how often local health policy is considered by the local council or board of M&A, by means of motions, resolutions or questions.
E. *Local health policy in annual accounts:* to what extent can local health policy be recognized in in the annual accounts?

Data on this variable has been collected by analysing a wide range of documents of the local government, such as programme budgets, annual accounts, policy documents, minutes of council meetings and notes of working groups. These documents contained qualitative as well as quantitative data. The 'political orientation' will be operationalised by looking at the composition of the council and board of M&A. The political parties will be categorised based on their political orientation according to parlement.com. The data for this variable consists mainly of local government documents concerning the compositions of the council and board of M&A. The 'problem severity' has been operationalised by expressing it in the number of people with a certain problem. The mainly quantitative data was collected from several monitoring agencies, like the National Statistics Bureau. The 'availability of network partners' is operationalised by investigating the number of local health care related organisations, such as hospitals, insurance companies, care institutes and universities, that are available in or near the municipality.

The data in this research is analysed by studying the similarities and differences between the cases. This mainly qualitative analysis was used to draw conclusions about how political orientation, problem severity and availability of network partners can explain the differences in the degree to which local governments actively pursue their responsibilities on local preventive health policy.

Scientific and social relevance

The relevance of this thesis can be found in the question why there are differences between local governments on the active pursuance of their responsibilities on preventive local health policy. Many studies have been conducted on the effect of political orientation, problem severity or policy networks. But little has been written about the effect these factors have on the activity of local governments in pursuing local preventive health policy. It is also socially relevant to understand why local governments made certain choices and considerations. It might create learning possibilities for other local governments that are struggling with the issue.

Analysis of the cases

In this section the analysis of the cases Almere, Rotterdam, Tilburg and Utrecht will be conducted. The analysis of every case will be conducted following the same format for all cases, starting with the description of the case in terms of general characteristics, which provides an answer to the first research sub-question. Subsequently a description concerning the independent variables political orientation, severity of the problems and the availability of network partners is provided, which provides an answer to the second research sub-question. The second part of the case analysis elaborates on the activities of the municipality in terms of local health policy. Or, in other words, how actively does the municipality pursue its responsibilities on local preventive health policy. To describe, and to be able to compare the cases, the active pursuance of the local health responsibilities will be measured by analysing the following indicators.

F. *The presence of local health policy documents:* is there a local health policy document drawn up within two years after the presentation of the national health policy document?
G. *The specificness of the health policy documents:* how specific are the goal, actions and means formulated in the local health policy documents?

H. *The presence of an implementation programme:* is there a plan for the implementation of the local health policy, either as a separate programme or integrated in other programmes?
I. *Presence of council/board documents:* whether and how often local health policy is considered by the local council or board of M&A, by means of motions, resolutions or questions.
J. *Local health policy in annual accounts:* to what extent can local health policy be recognized in in the annual accounts?

For each of the indicators listed above a score from 1 to 5 will be awarded, with 1 being the lowest and 5 the highest score. At the end of each case the overall mean score will be provided, which represents the score for the level of active pursuance of local health policy responsibilities by the local government.

Almere

In this section the municipality of Almere will be described. First a characterisation of the municipality is provided in terms of political orientation, severity of the health problems and the availability of network partners, followed by an elaboration on the local health policy.

Characterisation

General characteristics

The municipality of Almere is the largest city in the Province of Flevoland and is situated near Amsterdam. In 2016 Almere had about 200.000 inhabitants, of which 18,6 percent was under the age of fifteen, 69,5 percent was between the age of fifteen and sicty-five years old and 11,7 percent was over the age of sixty-five. Almere has a very diverse population with 42,7 percent of the inhabitants being migrants, of which 32 percent with a non-Western migration background (Gemeente Almere, 2020a).

Political orientation

After the municipal elections of 2014 the local government of Almere was formed by a five party coalition, consisting of the national parties D66, CDA, PvdA, VVD and the independent local party Leefbaar Almere. When looking at the political orientation of the parties, the coalition can be considered a centre-right one. The PvdA can be characterized as left-wing party and D66 as centre-left, while CDA and VVD are on the right side of the political spectrum (Parlement.com, 2020). Leefbaar Almere cannot really be characterised as left- or right-wing. The party mainly focusses on local issues from a political standpoint that cannot easily be translated to national political cleavages (Boogers & Voerman, 2010). This coalition can be considered as centre-right in its political orientation.

Problem severity

The problem severity in a municipality will be determined by the indictors smoking, drinking and weight. These indicators have been marked as spearheads, that are essential in the improvement of the public health, in the national health policy document since 2011 (Ministry of Health Welfare and Sport, 2011). The problem severity of Almere in 2016, expressed in percentage of the total population that is experiencing this problem, is displayed in figure 1.

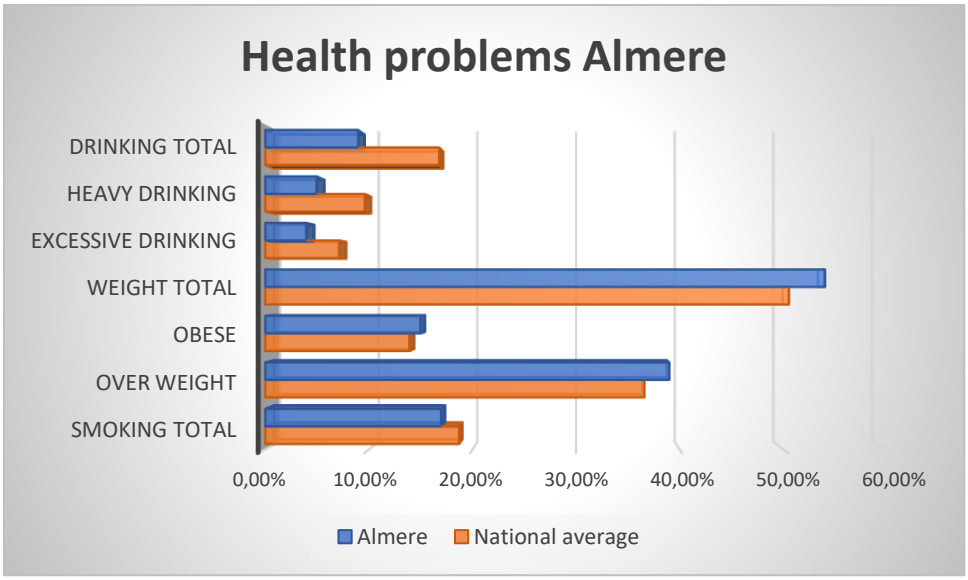

Figure 1: percentage of the population with health problems in Almere in 2016

To get a better impression of the problem severity of Almere, compared to the national average, the deviation from the national average is displayed in figure 2. For example, 5 percent of the population of Almere is a heavy drinker, which is 48,13 percent less than the national average of 9,64 percent.

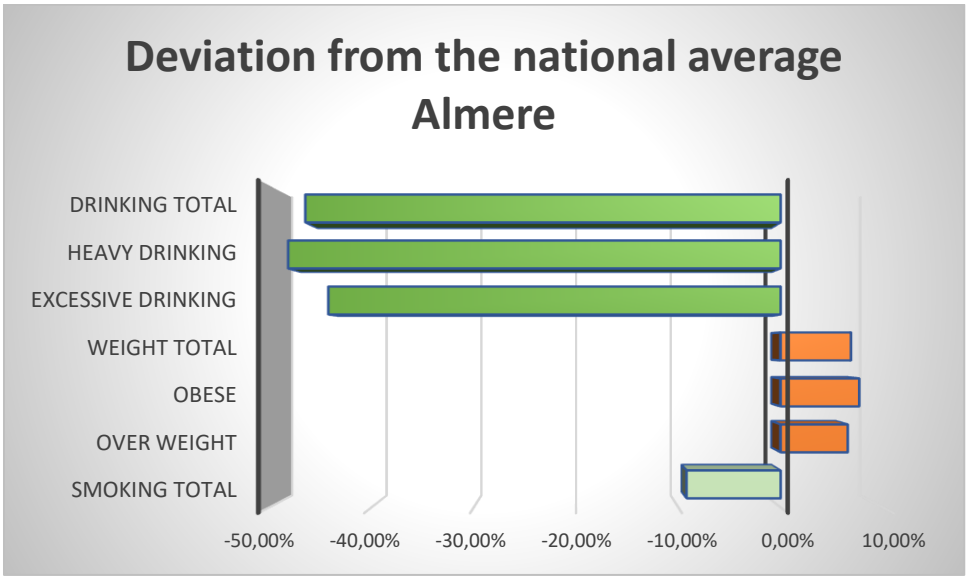

Figure 2: deviation health problems Almere from national average

On the indicator “smoking” Almere scores 17 percent, which is approximately 9 percent less than the national average of 18,7 percent. The severity of smoking is under average. On the indicator “weight total” Almere scores above average with 54 percent, compared the national average of 50,5 percent this is 6,9 percent more. Almere scores low on the indicator “drinking total”. With 9 percent this is 46,5 percent less than the national average of 16,8 percent (Volksgezondheidenzorg.info, 2020a, 2020b, 2020c).

Network partners

Local network partners can play a large role in the local health provision, in both the development and the execution of local health policy. Almere has a wide range of potential network partners, such as Univé insurances, the Aeres College, Care Group Almere, Hospital “Flevoziekenhuis”, Humanitas

foundation and informal carers organisation VMCA (Gemeente Almere, 2017). Therefore Almere scores high for potential network partners.

Local health policy

In this section a description of the local health policy will be provided, starting with a description of the policy documents and the specificness of them, followed by an elaboration on the Implementation programmes, considerations by the local council/board of M&A and the presence of local health policy in the annual accounts. The section will be concluded with the discussion of the overall score.

A. The presence of local health policy documents

The first local health policy document of Almere dates from 2001. This policy document was drawn up by a steering committee together with local care partners. The goal was to make plans to pay attention to the health of the citizens and address bottlenecks in health care institutions (Gemeente Almere, 2001). There was only little attention for prevention in the 2001 document. This policy document was in 2007 succeeded by a new local health policy document for the period 2007-2011. The aim of the local health policy in this document was still rather curative instead of preventive. Only the prevention of overweight was addressed in the policy (Gemeente Almere, 2007). Despite the period of the previous LHPD ending in 2011, no earlier than in 2013 the next LHPD was decided on by the board of Mayor and Aldermen of Almere. In this new LHPD the local government had formulated policy for the period 2013-2016. The policy in this LHPD was, compared to the previous LHPD's, aimed more at prevention of health problems instead of curing them. Also the connection with the national health policy document is clear (Gemeente Almere, 2013). The latest LHPD of Almere was drawn up two years after the national health policy document of 2016 and contained the local health policy for the period 2018-2021. This LHPD will be used in the analysis, since it is drawn up by the coalition that is formed after the 2014 elections.

Score: 4

Since 2001 health policy documents have been present within two of the national health policy document. In the years 2012 and 2017 there is no active health policy document, therefore a score of 4 out of 5 points has been awarded

B. Specificness of local health policy documents

The LHPD starts with the vision of Almere on health. This vision that is formulated in the LHPD of 2018 is aimed at prevention and early indication in order to prevent major problems. Subsequently a review of the previous LHPD is provided together with the current state of health in Almere. Based on the above the two major spearheads in the LHPD are the promotion of a healthy lifestyle and the improvement of the mental and physical resilience (Gemeente Almere, 2017). The local government of Almere fleshed out the spearheads by assigning three main challenges. The first challenge is securing and smartly connecting health as a subject in other policy fields en in collaborations with partners. The second challenge is the promotion of a healthy weight for youngsters and the elderly. Improving the mental and physical resilience is the third challenge that is formulated (Gemeente Almere, 2017). In the LHPD several spearheads are mentioned. For every spearhead is stated what the challenge is, what the approach will be by means of interventions and what the desired result is. Only, the document is not very specific about the implementation of the policy and the actual actions that are recommended. The advisory body of the social domain in Almere also concluded that the policy was not converted into executive plans and that some formulations were to informal (Adviesraad Sociaal Domein, 2017).

Score: 3

The vision of Almere and the review of the previous LHPD provide direction. In the LHPD the spearheads, challenges, interventions and goals are described clearly, but the formulations are rather informal. Also, the policy was not clearly translated into action plans, therefore a score of 3 out of 5 points has been awarded.

C. Implementation programmes

In order to take up the challenges, a number of interventions are discussed in the LHPD. The interventions concerned with the health indicators smoking, drinking and overweight will be discussed. For the first challenge, securing and smartly connecting health as a subject in other policy fields and in collaborations with partners, the following interventions have been formulated. Intervention one is aimed at creating a coherent cycle between health and other policy domains. Discuss long term health policy as an integrated subject and make arrangements with partners is the aim of intervention two. The third intervention is in line with the second, governmental integration on the subject "health" (Gemeente Almere, 2017). For the second challenge, the promotion of a healthy weight for youngsters and the elderly, the following interventions have been formulated. The first "intervention" is the continuation of the "Gezonde Jeugd in Almere" programme. A part of this programme is "Aanpak Gezond Gewicht Almere", which is based on the 5 JOGG-pillars (Stuurgroep Gezonde Jeugd in Almere, 2017). JOGG is a national programme Almere also participates in. This "Jongeren Op Gezond Gewicht" programme is pursuing a world where children can grow up in a healthy environment with a healthy lifestyle (JOGG, 2020b). Neighbourhood outreach teams and primary health care play a crucial role in prevention by observing problems and referring people to the right type of care, is what it stated in intervention two. Intervention three is aimed at surrounding the people with healthy examples, such as healthy food in the sports canteen, so it is easier to make the healthy choice. The fourth intervention is about investigating whether the healthy weight approach for children can also be applied to adults, since especially elderly people are increasingly suffering from weight problems (Gemeente Almere, 2017). The third challenge, improving the mental and physical resilience, has no interventions mentioned in the LHPD that are connected with the health indicators of this thesis.

Score: 2

For the implementation or execution of the local health policy concerned with overweight Almere has the programme "Gezonde Jeugd in Almere". How the execution of the rest of the policies in the LHPD should take place is not really specified. Only the implementation programme for the indicator overweight is present. The execution plans for the other parts of the policy look more like expressed intentions, therefore a score of 2 out of 5 is awarded.

D. Presence of council/board documents

In the term of office of the local council hardly any written questions have been asked on matters concerning local health policy. There were no written questions at all asked about the indicators smoking, drinking and overweight (Gemeente Almere, 2020d). Motions and resolutions about various aspects of local health policy have been brought forward by political parties, the local council or the board. Many of these concern the deployment of resources, continuation of projects and the approval of budgets (Gemeente Almere, 2020c).

Score: 3

Since no questions were asked about local health policy concerning smoking, drinking and overweight and only the standard motions and resolutions were considered a score of 3 out of 5 points has been awarded.

E. Local health policy in the annual accounts

In order to execute or implement the policy plans of the LHPD budgets have to be available. In the LHPD is stated that only a small budget is available for the execution of the spearheads. This budget consists of a government contribution and municipal means. The government contribution is part of the project "Gezond in de stad" and adds up to a total of €71.000 for the period 2018-2021. The municipal means will be used for the programme "Gezonde jeugd Almere". The budget for this project is set at €239.000 for 2018 and is not a structural budget (Gemeente Almere, 2017). For the execution of the regular local health care policy, such as youth health care or addiction care, the regular budgets will be available. Local health policies can hardly be recognised in the annual accounts of Almere. General policy programmes are mentioned, but it is unclear how much money in these programmes is or will be spent on the execution of the LHPD. In the annual budget for 2019 is stated that an additional €100.000 will be made available for the policy programme "Gezond in Almere" (Gemeente Almere, 2018). The annual report 2019 of Almere shows that in 2019, as a results of the worsening health problems in the municipality, a new programme is developed and executed. This programme has four main pillars: healthy weight, healthy school, smoke free generation and mental health. This programme continues to build on some existing programmes of 2018 (Gemeente Almere, 2020b).

Score: 3

Since only general programmes can be recognised in the annual accounts, and not the budgets or expenditures on the execution of the LPHD, a score of 3 out of 5 points has been awarded.

F. Overall score

The overall mean score for Almere is 3 out of 5. Almere periodically presents a LHPD that describes the policy for the next couple of years, but also reviews the period of the previous LHPD. The specificness of the document could be improved by converting policy into action plans. Also the implementation programme could be clearer and more elaborate, which would have resulted in a higher score for Almere. A mediocre score is awarded on the indicator concerning the presence of the policy in the annual accounts, since little of the plans of the LHPD can be recognised. For the considerations by the local council/board is also a mediocre score awarded, because only few motions and resolutions were considered.

Rotterdam

In this section the municipality of Rotterdam will be described. First a characterisation of the municipality is provided in terms of political orientation, severity of the health problems and the availability of network partners, followed by an elaboration on the local health policy.

Characterisation

General characteristics

The municipality of Rotterdam is the largest city in the Province of Zuid-Holland and the second largest city in the Netherlands. The Port of Rotterdam is the largest harbour in Europe and is economically important for Rotterdam as well as for the Netherlands. In 2016 Rotterdam had approximately 630.000 inhabitants, of which 19 percent was under the age of nineteen, 65 percent was between the age of eighteen and sixty-five years old and 15 percent was above sixty-five years old. Rotterdam has a very diverse population 50 percent of the inhabitants being migrants, of which 38 percent with a non-Western migration background (Onderzoek010, 2020).

Political orientation

After the municipal elections of 2014 the local government of Rotterdam was formed by a three party coalition, consisting of the national parties D66 and CDA and the independent local party Leefbaar Rotterdam. When looking at the political orientation of the parties, the coalition can be considered as right-wing. D66 is centre-left, while CDA is on the right side of the political spectrum (Parlement.com, 2020). Leefbaar Rotterdam can be characterised as a right-wing party, considering their viewpoint on immigration. But besides this topic the party mainly focusses on local issues from a standpoint of dissatisfaction with politics. This political orientation cannot easily be translated to the left-right dichotomy of the national level (Boogers & Voerman, 2010). This coalition can be considered right-wing in its political orientation.

Problem severity

The problem severity in a municipality will determined by the indictors smoking, drinking and overweight. The problem severity of Rotterdam in 2016 is displayed in figure 3.

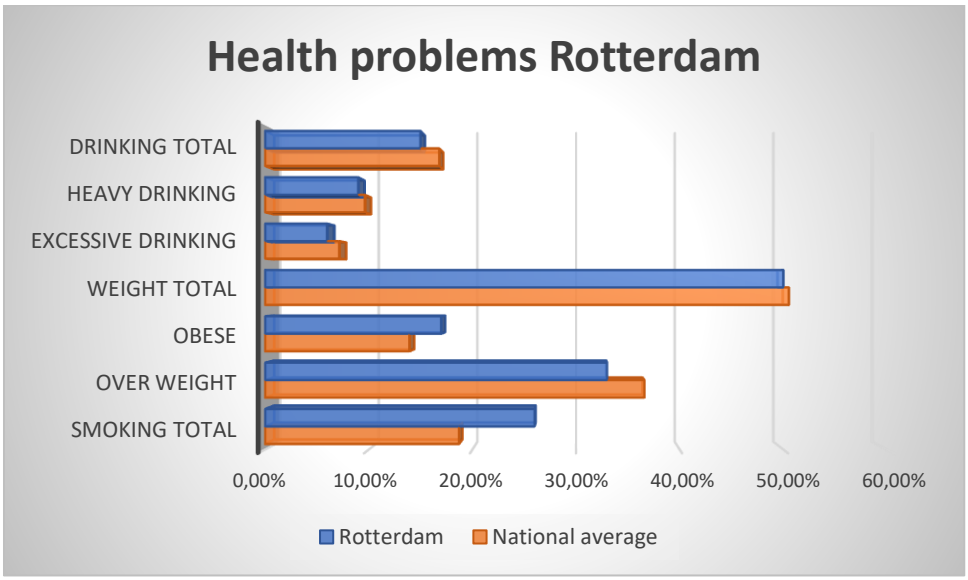

Figure 3: percentage of the population with health problems in Rotterdam in 2016

The deviations from the national average are displayed in figure 4 in order to get a better of understanding of the severity of the problems.

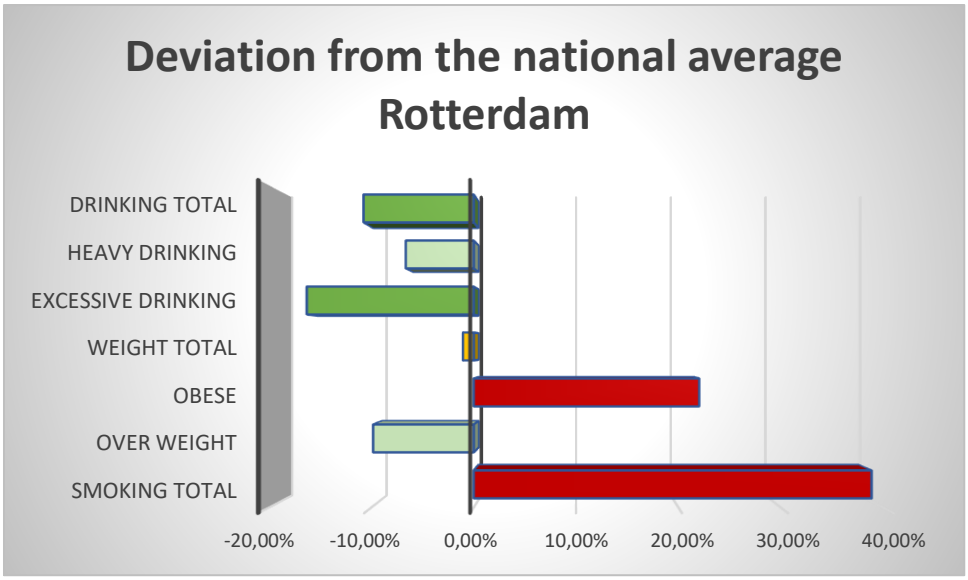

Figure 4: deviation health problems Rotterdam from national average

The percentage of people smoking in Rotterdam is high with 26 percent of the people smoking, compared to an average of when compared to the average of the Netherlands it is almost 39 percent higher. The indicator "weight total", which is a the sum of people with overweight and people with obesity, scores 50 percent. This is slightly under the national average of 50,5 percent for weight total, but when the two components, overweight and obesity, are taken separately the situation is quite different. The percentage for overweight is with 33 percent approximately 9,8 percent lower than the national average of 36,6 percent, but the on obesity Rotterdam scores 17 percent, which is 22 percent higher than the national average of 13,9 percent. Drinking shows more univocal on the separate components. Drinking total scores low with 15 percent, which is 10,8 percent lower than the national average of 16,8 percent. Excessive drinking scores 16,3 percent lower than the national average, with 6 percent compared to 7,2 percent. Heavy drinking scores under average with 9 percent. This is 6,6 percent lower than the national average of 9,6 percent (Volksgezondheidenzorg.info, 2020a, 2020b, 2020c).

Network partners

For the construction and implementation of local health policy a network of local partners is important. Rotterdam has a wide variety of potential network partners to cooperate with. Several health insurers, such as Zilveren Kruis, VGZ/IZA Cura, are present in Rotterdam (Gemeente Rotterdam, 2016a; IZA Cura, 2016). More network partners can be found in the Erasmus University, Hogeschool Rotterdam and the Erasmus hospital, but also in diverse care and welfare organisations and general practitioners (Gemeente Rotterdam, 2016a). Rotterdam scores high on potential network partners for local health policy.

Local health policy

In this section a description of the local health policy will be provided, starting with a description of the policy documents and the specificness of them, followed by an elaboration on the Implementation programmes, considerations by the local council/board of M&A, finishing with the presence of local health policy in the annual accounts.

A. The presence of local health policy documents

The first local health policy document of Rotterdam dates from 2007. In this LHPD their already was a strong focus on health prevention and lifestyle (Gemeente Rotterdam, 2007). In the following LHPD,

running for the period 2011 - 2014, Rotterdam continued and intensified the focus on lifestyle improvement and health prevention concerning sexual health, overweight, smoking and drugs and alcohol (Gemeente Rotterdam, 2011). In this thesis the LHPD "Rotterdam Vitale Stad" for the period 2016 - 2020 will be analysed. In this policy document lifestyle and prevention are being put in a broader perspective. In the document is stated that people nowadays know that regular exercise, eating healthy, not smoking and moderate drinking are better for our health, but there is a gap between knowing this and doing this. The policy in "Rotterdam Vitale Stad" is partially based on the spearheads of the national health policy document and is aimed at enticing the people of Rotterdam to display healthy behaviour and make healthy choices (Gemeente Rotterdam, 2016a). Concerning the indicators smoking, overweight and drinking Rotterdam has set goals in the LHPD that include less smokers, a reduction of alcohol consumption and more people on a healthy weight, compared to the last measurements. Also, by 2020 more people are exercising in accordance with the Dutch norm for healthy exercise and the share of people with diabetes in 2020 is at least the same as in the 2012 measurement (Gemeente Rotterdam, 2016a).

Score: 5
In the last two periods the health policy documents have been present by Rotterdam within a year after the presentation of the national health policy document. In the years 2015 there is no active health policy document, but the policy from the LHPD 2011-2014 is extended. A score of 5 out of 5 points has been awarded since LHPD's have been present the last two periods and have been presented within two years after the national one.

B. Specificness of the local health policy documents

In order to achieve the abovementioned goals Rotterdam has formulated a coherent approach that will be realised through four action courses: health within reach, prevention prominently in care, welfare and youth policy, safe and sound in the city, and E-public health and innovation. Each of these action courses has its own set of objectives. For instance, the objectives for the health within reach action course are (Gemeente Rotterdam, 2016a):

- more people in Rotterdam make healthy lifestyle choices and possess adequate skills for a healthy and active life
- the public space in Rotterdam tempts to go play, do sports, exercise an meet people

For every objective is described what the meaning is and where Rotterdam will pay attention to in the period of the LHPD and what partners will be involved. The progress on each of the objectives will be monitored and the monitor that will be used is discussed in the LHPD. Local health policy is formulated for smoking, overweight and drinking, but the focus in the LHPD is more on smoking and overweight than on alcohol. In the LHPD is described how the execution of local health policy is incorporated in or connected with other policy fields and programmes of the municipality of Rotterdam (Gemeente Rotterdam, 2016a). A retrospective of the previous LHPD, running for the period 2011-2014, is also provided. The current LHPD is in many ways a continuation of the previous one.

Score: 5
The LHPD scores 5 out of 5, because it has a distinct structure where from a general vision is worked up to detailed policy through an action course and objectives. For the policy concerning smoking, weight and drinking is described what partners will be involved and how it will relate to other policy programmes. The LHPD also describes how the progress of the policy on the set objectives will be monitored through diverse monitors.

C. *Implementation programmes*

For the implementation of the local health policy that is formulated in "Rotterdam Vitale Stad" the municipality of Rotterdam has a separate implementation programme called "Uitvoeringsprogramma Rotterdam Vitale Stad 2016-2020". Further details and elaboration of the goals from the LHPD can be found in this implementation programme, together with an outline of the specific actions Rotterdam is going to carry out in order to reach the goals (Gemeente Rotterdam, 2016c). In order to reach the goal "less smokers" the local government of Rotterdam is, for instance, going to continue the partnership with "Alliantie Nederland Rookvrij". Through the action programme "Stevige Start" Rotterdam tries to ensure that babies live in a smoke-free environment and that pregnant women do not smoke (Gemeente Rotterdam, 2016b). The policy to realise the intended reduction of alcohol consumption is mainly focussed on young persons through the programme "Blijf Helder!". This programme is based on three pillars for local alcohol policy: set the boundaries through regulation, transmit the boundaries through education and guard over the boundaries through enforcement (Gemeente Rotterdam, 2015). It has to be noted that the actions in the programme focus more on the prevention of drug than on alcohol problems. To get more people on a healthy weight a combination of the implementation programmes "Gezond Gewicht", "Lekker Fit!" and "Sport beweegt Rotterdam" will be deployed (Gemeente Rotterdam, 2016c). Besides these local programmes Rotterdam participates in the national JOGG project since 2011 (JOGG, 2020a).

Score: 5

Rotterdam has framed an implementation programme to execute the local health policy. In this extensive programme is formulated what actions, partners and other programmes are necessary to achieve the goals of the LHPD. Since this implementation programme is covering the execution of the LHPD completely, a score of 5 out of 5 is awarded.

D. *Presence of council/board documents*

In the term of office of the local council/board eleven questions were asked about subjects concerning local health policy in some way, of which two were related to one of the indicators smoking, overweight or drinking. In June 2014 a council member of the CDA asked questions about the sale of pre-mixed alcoholic drinks by Big Bazar, based on a newspaper article where parents expressed their worries that under age children might purchase the drinks, because the lack of age-checking by store (CDA Rotterdam, 2014). In May 2015 a council member of the PvdA asked questions about problems concerning unhealthy dietary patterns and overweight in disadvantaged neighbourhoods in Rotterdam, based on the publication of a study on overweight (PvdA Rotterdam, 2015). In the same period one motion has been filed by the Partij voor de Dieren and NIDA, with the request for the board to urge schools to promote healthy food (Partij voor de Dieren Rotterdam & NIDA Rotterdam, 2015). Further considerations on local health policy by the local council and board in this term of office concerned the deliberation and passing of the diverse projects and programmes, such as Stevige Start, Blijf Helder and Gezond Gewicht, but also the LHPD Vitale Stad, the implementation programme Vitale Stad and the mid-term review of the implementation programme are on the council agenda frequently.

Score: 4

Local health policy is considered important by the local council, since a variety of questions, motions and programmes have been considered. Therefore a score of 4 out of 5 is awarded.

E. *Local health policy in the annual accounts*

To finance the implementation of the local health policy Rotterdam is using the GIDS-means, a decentralisation payment from the national government, of two million euros in annually. These

means are divided as follows between the four action courses: €850.000 for health within reach, €850.000 for prevention prominently in care, welfare and youth policy, €150.000 for safe and sound in the city and €150.000 for E-public health and innovation (Gemeente Rotterdam, 2016a). For the implementation of the "Blijf helder" programme a budget of €1.394.000 is available annually (Gemeente Rotterdam, 2015). It cannot be derived from programme nor from the annual accounts how much of this budget is being used for the prevention of alcohol problems.

Score: 4
The budgets for the implementation of the local health policy in Rotterdam are discussed in the implementation programmes. In the annual accounts it cannot be figured out which part of the total budget is spent on the implementation of local health policy on smoking, overweight and drinking. Therefore a score of 4 out of 5 is awarded.

F. Overall score

The overall awarded mean score for Rotterdam is 4,6 out of 5. This relatively high score is the result of the maximum score of 5 on the indicators presence of local health policy documents, specificness of the local health policy documents and on the implementation programmes. On the indicators presence of local council/board documents and local health policy in annual accounts Rotterdam was also awarded high scores of 4 out of 5.

Tilburg

In this section the municipality of Tilburg will be described. First a characterisation of the municipality is provided in terms of political orientation, severity of the health problems and the availability of network partners, followed by an elaboration on the local health policy.

Characterisation

General characteristics

The municipality of Tilburg is 7th largest city in the Netherlands with a population of 213.000 inhabitants in 2016 (Overheid in Brabant, 2016). Age of the population was distributed as follows, 14,5 percent is under the age of fifteen, 68,5 percent was between the age of fifteen and sixty-five and 16,9 percent is above sixty-five years old (Gemeente Tilburg, 2020b). In 2016 in Tilburg 74,5 percent of the population had a Dutch background and 25,5 percent a migration background, of which 10,4 percent non-Western (CBS, 2020).

Political orientation

After the municipal elections of 2014 the local government of Tilburg was formed by a four party coalition, consisting of the national parties D66, SP, CDA and Groenlinks. When looking at the political orientation of the parties, the coalition can be considered as left-wing. CDA can be considered right-wing, D66 is centre-left, while SP and Groenlinks are on the left side of the political spectrum (Parlement.com, 2020). This coalition can be considered left-wing in its political orientation.

Problem severity

The problem severity in a municipality will determined by the indictors smoking, drinking and overweight. The problem severity of Tilburg in 2016 is displayed in figure 5.

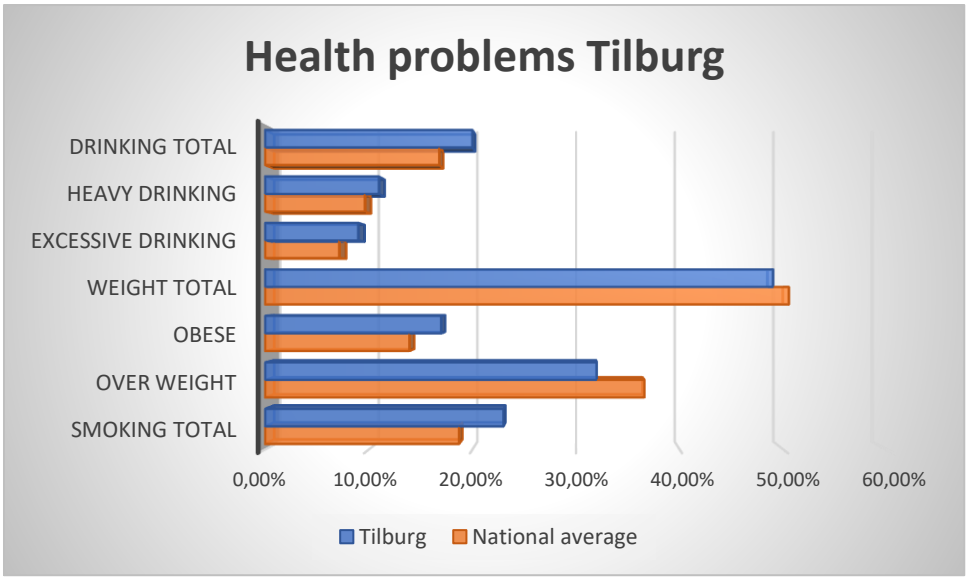

Figure 5: percentage of the population with health problems in Tilburg in 2016

The deviations from the national average are displayed in figure 6 in order to get a better of understanding of the severity of the problems.

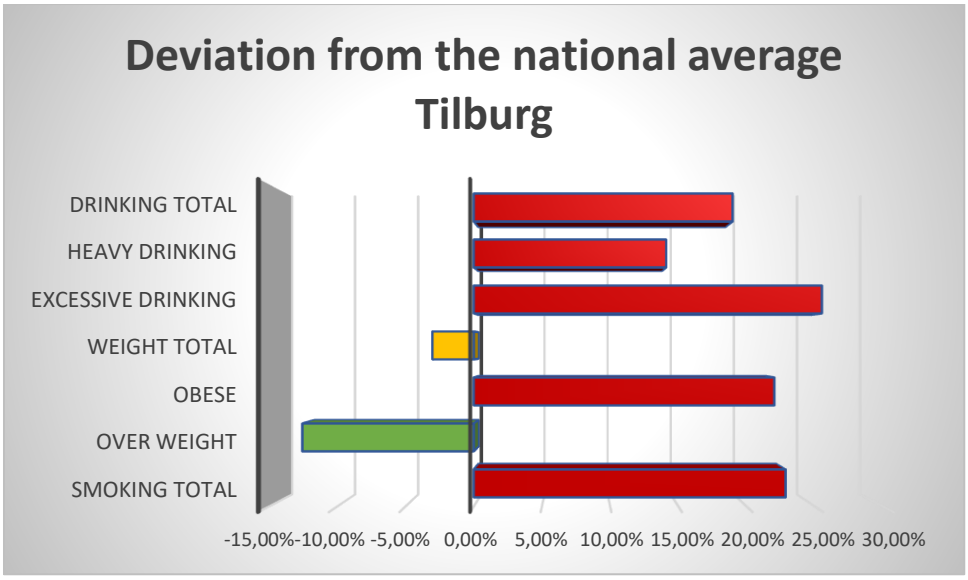

Figure 6: deviation health problems Tilburg from national average

The problem severity in Tilburg for the three indicators in total can be marked as high. A score of 23 percent on smoking is about 22,9 percent higher than the national average of 18,7 percent. The problem severity for weight total is with 49 percent slightly over 3 percent lower than the national average of 50,5 percent, but is not distributed equally between overweight and obese at all. With 32 percent overweight Tilburg scores 12,6 percent lower than the national average of 36,6 percent. But the score of 17 percent for obesity shows completely the opposite, as this is 22 percent higher than the national average of 13,9 percent. Therefore, despite total weight be average, the problem severity of this indicator will be marked as high. The score for drinking is univocally high, with both excessive drinking and heavy drinking being higher than the national average. A score of 9 percent on excessive drinking is 25,5 percent higher than the national average of 7,17 percent and heavy

drinking scores with 11 percent about 14,1 percent higher than the national average of 9,6 percent (Volksgezondheidenzorg.info, 2020a, 2020b, 2020c).

Network partners

For the construction and implementation of local health policy a network of local partners is important. Tilburg has a whole range of potential network partners to cooperate with. CZ and VGZ are two health insurers present in Tilburg and in the field of education and research there is Tilburg University, Fontys College and Avans College (Tilburg studentenstad, 2020). More network partners can be found in the Elisabeth hospital and the Tweesteden hospital, but also in diverse care and welfare organisations and general practitioners (Gemeente Tilburg, 2015). Tilburg scores high on potential network partners for local health policy.

Local health policy

In this section a description of the local health policy will be provided, starting with a description of the policy documents and the specificness of them, followed by an elaboration on the Implementation programmes, considerations by the local council/board of M&A, finishing with the presence of local health policy in the annual accounts.

A. The presence of local health policy documents

The first local health policy that Tilburg has drawn up dates from 2001. The following local health policy, for the period 2003-2007, was the first one that was obligatory for local governments. The policy in this LHPD was mainly focussed on monitoring and curing of health problems (Gemeente Tilburg, 2003). In the LHPD for the period 2008-2011 the focus is shifting to prevention and the promotion of a healthy lifestyle (Gemeente Tilburg, 2008). Until this moment local health policy has always been drawn up as a separate document in Tilburg. For the LHPD 2012-2015 it is decided to incorporate it in the policy framework Social Support. In this document policy is still aimed at prevention of problems and lifestyle improvement, but more attention goes to promoting the vulnerable citizens to be able to do things independently (Gemeente Tilburg, 2012). In October 2013, during the period of the approved LHPD, Tilburg and eight other municipalities in the region Midden-Brabant, together with the Regional Health Authority, expressed the intention to coordinate on local health policy. To enforce this intention and as a pilot, the first regional health policy was drawn up by the nine municipalities with support from the Regional Health Authority (Regio Midden-Brabant, 2013). This regional pilot ran parallel to the local health policy 2012-2015. The health policy document for the period 2016-2019 was the first health policy document that was coordinated and agreed upon regionally. The motivation for the regional approach is to improve health gains and clout, but also to enforce the connections with other policy fields. He document is identical for all municipalities in the region, besides the local chapter “Lokaal gezondheidsbeleid: Gezonde Stad”, which is specified for Tilburg (Regio Midden-Brabant, 2016). The document was presented within two years of the presentation of the national health policy document.

Score: 5

In all periods the health policy documents have been presented within a year after the presentation of the national health policy document. In the years 2014 and 2015 the pilot for a regional policy document ran parallel the local one. A score of 5 out of 5 points has been awarded since LHPD’s have been present the last two periods and have been presented within two years after the national one.

B. Specificness of the local health policy documents

The regional health policy document is formulated in accordance with the vision that starts from the idea of people’s own strength and appeals to the participation of the citizens. In accordance with this vision a set of regional is formulated in the policy. The regional ambitions are that young people

under the age of eighteen do not drink alcohol and children have a healthy weight. These regional ambitions are divided in regional and local objectives. The regional ambitions “young people under the age of eighteen do not drink alcohol” are: better follow-up care after alcohol intoxication, make young people aware of the consequences of harmful alcohol use and schools, sport clubs and parents structurally work on alcohol prevention. The regional objectives for the ambition “children have a healthy weight” are: improve the cooperation between the JOGG-municipalities, better referring options for overweight children, schools work structurally work on healthy weight and parents raise their children in a healthy way (Regio Midden-Brabant, 2016). The local ambitions for “young people under the age of eighteen do not drink alcohol” are: a reduction of the alcohol consumption and the harmful effects of alcohol consumption for under age people, and a reduction of drunkenness during nights out in the public domain. Tilburg also formulated an extra local ambition based on the problem severity of the local situation: reduction of health deprivation. The objectives for this ambition are a healthy green environment and the use of a lifestyle coach (Regio Midden-Brabant, 2016).

Score: 3
The policy document has a distinct structure where from a general vision is worked up to regional ambitions that are divided in regional and local objectives. Also, a good overview of the health situation of Tilburg is provided as well as the overlapping fields between the health policy and other policy fields. The objectives are described rather informal and could have been more specific, therefore a score of 3 out of 5 is awarded.

C. Implementation programmes

For the realisation of the abovementioned policy, ambitions and objectives Tilburg uses several implementation programmes. For health improvement and interventions at schools the “Gezonde School” approach is used. This approach is based on four pillars: indication and referral, education, school environment, policy and enforcement (Regio Midden-Brabant, 2016). The lifestyle factors of children can be improved by enforcing the upbringing by the parents. The Triple P-method is used for this purpose. To get children on a healthy weight the national JOGG-programme is used. The programme “Gezonde Stad” will be used for the implementation of local policy and achieving the local objectives. This programme consists of three sub-programmes: Gezonde Start, Gezonde Jeugd and Gezonde Wijk. Sub-programme Gezonde Jeugd will be combined with the JOGG-programme to get the young people on a healthy weight and with the prevention and enforcement plan alcohol to prevent young people under the age of eighteen from drinking (Gemeente Tilburg, 2014a).

Score: 2
Tilburg uses a variety of implementation programmes, or parts of them, and approaches, but many of these programmes are not very specific about the actual action that will be taken. The programmes that are worked out in more detail are Gezonde Stad and the national programme JOGG. A score of 2 out of 5 is awarded to this indicator.

D. Presence of council/board documents

In the period 2014-2018 numerous documents have been considered by the local council and the board of Mayor and Aldermen. Just after the installation of the new council and board they had to consider the basic assumptions for the spending of the GIDS allowance from the national government for the period up to 2018. In March 2015 the starting memo for the regional health policy was agreed upon by the board. In November of that year the board proposed the regional health policy document to the council. A council member of the VVD filed a motion that the objectives in the regional policy document had to be formulated more specifically, in order to make

them better suitable for directions (VVD Tilburg, 2015). In December 2019 the board agreed upon the spending plan for the GIDS-allowance for 2018 and 2019. In the period no questions were asked by council members on matters concerning local or regional health policy (Gemeente Tilburg, 2020a).

Score: 3
The propositions and decisions on the health policy documents are present, as well as the propositions and decisions on programmes and spending plans. But in the period of four years only one motion was filed and no questions were asked about local or regional health policy. This leads to the impression that this subject is not on top of the mind of the council. A score of 3 out of 5 is awarded.

E. Local health policy in the annual accounts

The budgets that are available for the implementation of the regional and local health policy are specified in the financial paragraph of the policy document. The health policy is implemented via the programme Gezonde Stad, with an annual budget of almost €205.000 for the sub programme Gezonde start, €832.000 for Gezonde Jeugd and almost €158.000 for Gezonde Wijk (Gemeente Tilburg, 2015). For the implementation of the prevention and enforcement plan alcohol an annual budget of approximately €300.000 is available (Gemeente Tilburg, 2014a). These budgets are also recognisable in the annual budgets of Tilburg. For instance, the above mentioned policy programmes are all present in the budget for 2015 (Gemeente Tilburg, 2014b).

Score: 4
A score of 4 out of 5 is awarded for the presence of local/regional health policy in annual accounts, since the policy programmes, including the available budgets, are stated in the annual budget.

F. Overall score

The overall awarded mean score for Tilburg is 3,4 out of 5. This score is constructed by the maximum score of 5 on the presence of local health policy documents and a score of 4 out of 5 on the presence of local health policy in the annual budgets. Specificness of the local health policy documents and presence of local council/board documents both scored 3 out of 5. A score of 2 out of 5 was awarded to the presence of implementation programmes, since these programmes were not really specific.

Utrecht

In this section the municipality of Utrecht will be described. First a characterisation of the municipality is provided in terms of political orientation, severity of the health problems and the availability of network partners, followed by an elaboration on the local health policy.

Characterisation

General characteristics

The municipality of Utrecht is the capital of the Province of Utrecht and is the fourth largest city in the Netherlands with a population of 339.000 inhabitants in 2016. Of this population 17,4 percent was under the age of fifteen, 72,4 percent was between fifteen and sixty-five years old and 10,1 percent was older than sixty-five. The population of Tilburg consisted of 67 percent inhabitants with a Dutch background, 11 percent inhabitants with a Western migration background and 22 percent inhabitants with a non-Western migration background (CBS, 2020; Utrecht Monitor, 2020).

Political orientation

After the municipal elections of 2014 the local government of Utrecht was formed by a four party coalition, consisting of the left-wing SP and Groenlinks, the centre-left D66 and the right-wing VVD (Parlement.com, 2020). This coalition can be considered left-wing in its political orientation.

Problem severity

The problem severity in a municipality will determined by the indictors smoking, drinking and overweight. The problem severity of Tilburg in 2016 is displayed in figure 7.

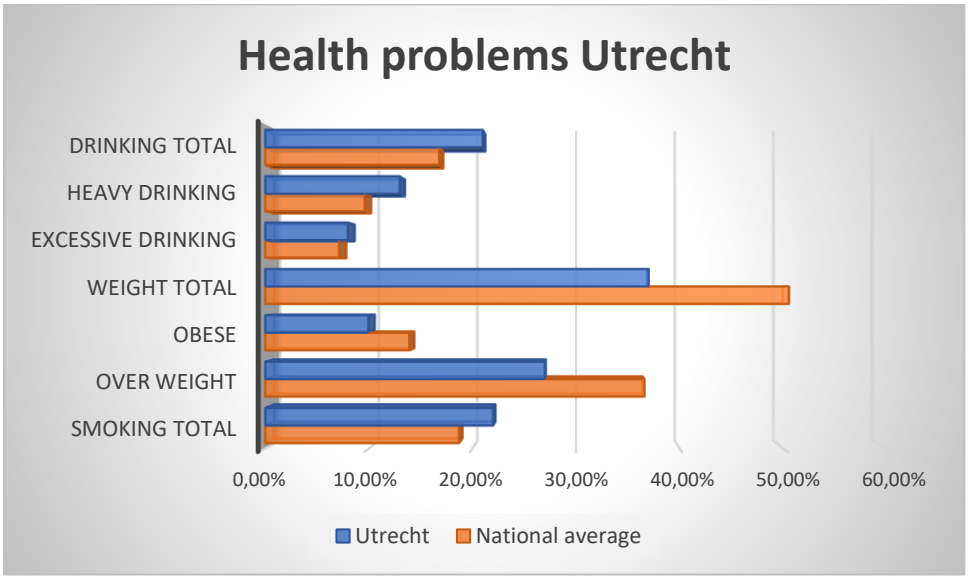

Figure 7: percentage of the population with health problems in Utrecht in 2016

The deviations from the national average are displayed in figure 8 in order to get a better of understanding of the severity of the problems.

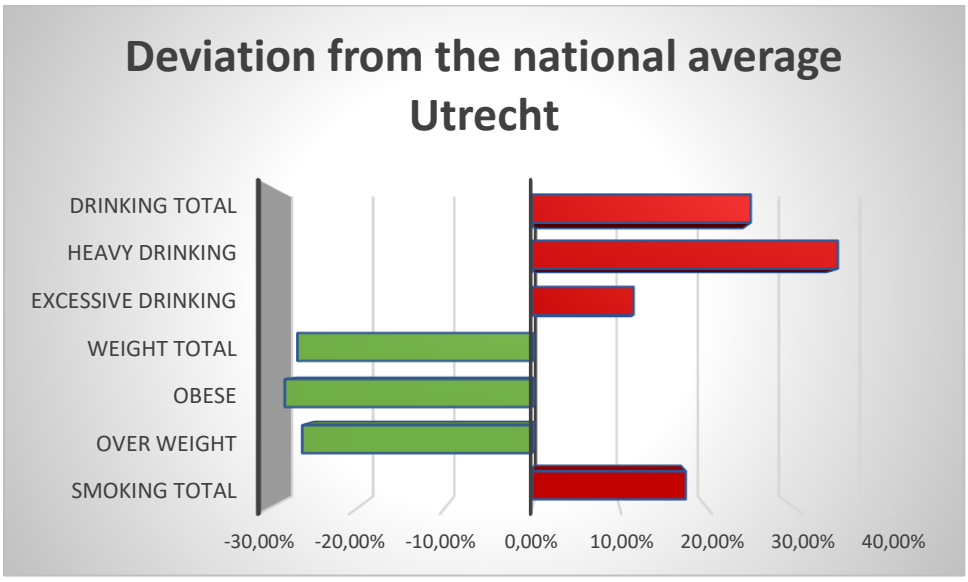

Figure 8: deviation health problems Utrecht from national average

The problem severity in Utrecht can be marked as high for the drinking and smoking and as low for weight. Smoking scores 22 percent, which is about 17,5 percent higher than the national average of 18,7 percent. With a score of 37 percent on weight Utrecht scores 26,8 percent lower than the

national average of 50,5 percent. With 27 percent overweight Utrecht scores 26,2 percent lower than the national average of 36,6 percent. On obesity the score of 10 percent is about 28,2 percent lower than the national average of 13,9 percent. The score for drinking is with 21 percent almost 25 percent higher than the national average of 16,8 percent, with both excessive drinking and heavy drinking being higher than the national average. A score of 8 percent on excessive drinking is 11,6 percent higher than the national average of 7,17 percent and heavy drinking scores with 13 percent almost 35 percent higher than the national average of 9,6 percent (Volksgezondheidenzorg.info, 2020a, 2020b, 2020c).

Network partners

For the construction and implementation of local health policy a network of local partners is important. Utrecht has a whole range of potential network partners to cooperate with, such as health insurer AGIS and in the field of education and research there is Utrecht University and Utrecht College. More network partners can be found in the three hospitals in Utrecht; UMC Utrecht, St. Antoniusziekenhuis and Diakonessenhuis, but also in diverse care and welfare organisations and general practitioners. (Gemeente Utrecht, 2015a; Gemeente Utrecht & Agis Zorgverzekeringen, 2008; Hogeschool Utrecht, 2020). Utrecht scores high on potential network partners for local health policy.

Local health policy

In this section a description of the local health policy will be provided, starting with a description of the policy documents and the specificness of them, followed by an elaboration on the Implementation programmes, considerations by the local council/board of M&A, finishing with the presence of local health policy in the annual accounts.

A. The presence of local health policy documents

The municipality of Utrecht has presented a consecutive series of local health policy documents starting in 2011. In the LHPD of 2011-2014 the ambition was for the people of Utrecht to feel healthy, be healthy and stay healthy. According to the LHPD for the period 2015-2018 “Bouwen aan een gezonde toekomst. Een uitnodiging aan de stad” it should be seen as an invitation to the city to contribute to a more healthy life and more healthy living in a sustainable and healthy city (Gemeente Utrecht, 2015a). The LHPD is presented within the period of two after the national health policy document is presented. The three substantive main issues in the LHPD are Gezonde Stad, Gezonde Wijk and Gezonde Start. For each of these main lines the same basic principles apply: a positive approach on health, aim for prevention, reduce health deprivation and a dignified existence for everybody.

Score: 5

In all periods the health policy documents have been presented within a year after the presentation of the national health policy document, therefore a score of 5 out of 5 is awarded.

B. Specificness of the local health policy documents

The health policy document of Utrecht can be divided into the three main lines, of which “Gezonde Stad” is the first one. The idea behind this main line is that Utrecht is a city in which people reside, work and live in good health an where everybody is worth participating (Gemeente Utrecht, 2015a). In order to achieve this, local health policy is organised along the themes spatial development, public development, sustainable local food, renewing lifestyle and healthy behaviour, economic development and human dignity. The aim is to fulfil this themes by connecting partners and initiatives. Which partners and what initiatives is yet to be seen and is not specified in the LHPD. With the main line Gezonde Wijk, health deprivation should be reduced by focussing on specific

neighbourhoods where these problems are more severe. These problem should be reduced by the deployment of neighbourhood teams that stimulate people to make the healthy choice. Main line Gezonde Start focusses on the health of young children by teaching the parents lifestyle and health skills (Gemeente Utrecht, 2015a).

Score: 2
The policy in the LHPD is formulated rather informal and unspecified. A lot of plans are mentioned, but many of them are yet to be specified. Therefore a score of 2 out of 5 is awarded.

C. Implementation programmes

For the implementation of the local health policy, the municipality of Utrecht uses mainly two programmes. To improve the lifestyle and health skills of children and young people, the JOGG-programme is being used to get children on a healthy weight. The Prevention and Enforcement plan Alcohol is being used to educate young people about the regulations concerning buying and drinking alcohol, but also about the consequences of alcohol consumption at a young age. Enforcement is the last resort in this plan (Gemeente Utrecht, 2015b). The rest of the policy of the LHPD will be implemented integrally with other policy fields and programmes. How this exactly will take place is not elaborated on in the policy document.

Score: 2
Since only two separate implementation programmes can be identified and the integral implementation of other polies is not specified, a score of 2 out of 5 is awarded.

D. Presence of council/board documents

In the term of office of this local council/board two motions have been filed concerning the local health policy. Both motions requested to look for further synergy between the policy programmes for sports and health, since this combination has baneful effects (SP Utrecht, VVD Utrecht, & Groenlinks Utrecht, 2016; VVD Utrecht, 2016). Further, the LHPD and the "Prevention and Enforcement plan Alcohol" and the annual budgets have passed the local council/board. Questions concerning the local health policy could not be found for the term of office for this council/board.

Score: 3
The filing of the motions and the absence of question provides a somewhat mixed picture of the activity of the local council on this matter. All the regular documents, such as budgets and policy plans, have passed the council/bord regularly. All together a score of 3 out of 5 is awarded.

E. Local health policy in the annual accounts

The annual budget of Utrecht provides a very detailed statement about not only the available budgets, but also about the policy and the implementation. In the annual budget three effect objectives are discussed, together with the performance indicators and the available budget. The first objective is to keep Utrecht a healthy and socially active city where the health of every inhabitant is guarded and protected, by means of limiting health risks caused by spatial development, noise pollution and unsafe situations. Lifestyle interventions will be used to prevent escalations and addictions under young persons. The available annual budget for this objective for the period 2015-2018 is €17.500.000 (Gemeente Utrecht, 2014). The second objective is to reduce the health differences by improving the health of the people of Utrecht. In order to achieve this a coherent approach will be applied to area's with the biggest health deprivation. These tracks are Gezond meedoen, Gezonde leefstijl, Gezonde omgeving and Toegankelijke zorg. The available annual budget for the implementation of this approach is €2.019.000 (Gemeente Utrecht, 2014). The third objective is to reduce the number of vulnerable people in Utrecht and prevent the vulnerable

becoming extra vulnerable. To achieve this the current policy, where a combination of combination of prevention, care and recovery is applied based on the participation and strength of the people. Annually a budget of €8.300.000 is available to implement this policy (Gemeente Utrecht, 2014).

Score: 5
The annual budget of Utrecht provides detailed information about policy, plans and the budget that are available for the implementation of these plans. Therefore the maximum score of 5 out 5 is awarded.

F. Overall score

The overall awarded mean score for Utrecht is 3,4 out of 5. This score is constructed by the maximum score of 5 on the presence of local health policy documents and the presence of local health policy in the annual budgets. Specificness of the local health policy documents and presence of implementation programmes both scored relatively low with 2 out of 5. The presence of local council/board documents scored 3 out of 5.

Comparative case analysis

In this section the results of the cases analysed in this thesis and of the cases analysed by the fellow students will be compared. The cases of the fellow students are Barneveld, Bronckhorst, Doesburg and Oost Gelre. With the comparison the hypotheses that have been formulated will be tested.

Hypothesis 1: Left-wing local governments will more actively pursue their responsibilities on local health policy than right-wing local governments.

The results of the case analysis concerning political orientation and the active pursuance score are provided in figure 9. The cases are ordered based on the active pursuance score.

Municipality	Political orientation	Active persuance score
Oost Gelre	Centre	2,8
Almere	Centre-right	3,0
Barneveld	Right	3,2
Tilburg	Left	3,4
Bronckhorst	Left	3,4
Utrecht	Left	3,4
Doesburg	Centre-left	3,8
Rotterdam	Right	4,6

Figure 9 Political orientation and the active pursuance score

What stands out is that four of the five cases with the highest active pursuance score have a left political orientation and the three cases with the lowest active pursuance score have a right or centre-right political orientation. The only exception seems to be Rotterdam, with the highest active pursuance score and a right political orientation. The findings on the relation between political orientation and the active pursuance score supports the hypothesis.

Hypothesis 2: In municipalities with a high problem severity local governments more actively pursue their responsibilities on local health policy than in municipalities with a low problem severity.

The results of the case analysis concerning problem severity and the active pursuance score are provided in figure 10. The cases are ordered based on the active pursuance score.

Municipality	Smoking	Overweight	Drinking	Active persuance score
Oost Gelre	Under average	Average	High	2,8
Almere	Under average	Above average	Low	3,0
Barneveld	Low	Under average	Low	3,2
Tilburg	High	Average	High	3,4
Bronckhorst	Low	Above average	High	3,4
Utrecht	High	Low	High	3,4
Doesburg	High	High	Low	3,8
Rotterdam	High	Average	Low	4,6

Figure 10: Problem severity and the active pursuance score
** Indicator that was the selection criteria for this case*

Looking at the results of the cases with the three highest active pursuance score, Tilburg, Bronckhorst, Utrecht, Doesburg and Rotterdam, compared to the problem severity on the smoking, overweight and drinking, it shows that 8 of the 15 values have a high problem severity, 1 out of 15 values has an above average problem severity, 2 of the 15 have an average problem severity and 4 of the 15 have a low problem severity. Of the top three cases 60% of the values indicates above average or high problem severity and 40% an average or lower problem severity. Of the bottom three cases only 33% of the values indicate above average or high problem severity and 67% an average or lower problem severity. These findings on the relation between problem severity and the active pursuance score seems to support the hypothesis.

Hypothesis 3: In municipalities with a high level of network partners, local governments more actively pursue their responsibilities on local health policy than in municipalities with a low level of network partners.

The results of the case analysis concerning available network partners and the active pursuance score are provided in figure 11. The cases are ordered based on the active pursuance score.

Municipality	Availability of network partners	Active persuance score
Oost Gelre	LOW	2,8
Almere	HIGH	3,0
Barneveld	LOW	3,2
Tilburg	HIGH	3,4
Bronckhorst	LOW	3,4
Utrecht	HIGH	3,4
Doesburg	LOW	3,8
Rotterdam	HIGH	4,6

Figure 11: Availability of network partners and the active pursuance score

Looking at the results of the relation between availability of network partners and the active pursuance score is stands out that the values for availability of network partners is distributed equally over cases with a high and a low active pursuance score. Based on the scatter of the availability of network partners compared to the active pursuance score the hypothesis is not supported, so it appears there is no relation between these two variables.

Conclusions

The main question in this thesis was how the differences, in the active pursuance of responsibilities on local health policy between Dutch local governments, could be explained. Theories from the literature provided some clues about variables that could explain these differences. Political orientation of the local government, the severity of the problems and the availability of network partners were selected as factors that could explain how actively a local government pursues the responsibilities on local health policy. The comparative case study that is used to answer the main question provided some clear results. Based on these results a relation between political orientation and the active pursuance score seems present, since 80% of the cases with a high active pursuance score have a more left political orientation. There also appears to be a relation between the severity of the problems and the active pursuance score. Of the cases with the top three active pursuance score 60% of the values scores above average or high on problem severity, compared to 33% of the values in the bottom three cases. A relation between the availability of network partners and the active pursuance score seems to be absent, as these values are scattered evenly. So, the conclusion can be drawn that the differences, on the active pursuance of their responsibilities on local preventive health policy, between Dutch local governments can be explained by the political orientation of the local government and by the severity of the health problems in the municipality.

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