5
Policies for Health
The Effectiveness of their Development, Adoption, and Implementation

EVELYNE DE LEEUW

Framing the Effectiveness of Policy for Health

There is a strong belief, and in many cases a strong evidence-base, that policy impacts on our collective shaping of individual, population and global parameters of life, in terms of operations of humanity, and of the natural world of which we are such an intricate and fragile part. Unfortunately, the same could be said of the absence of policy: a failure of governments to address, for instance, global climate change may have severe health, eco-systemic and social impacts.

In looking at the effects of policy on health we therefore have to specify what we are seeking to examine, and how we will assess impact. As policies have such a profound and sweeping impact, our assessment of the effectiveness of policies for health should therefore reach beyond efforts in health sectors. Yet, at other conceptual levels we will have to limit our analysis.

A first proxy is that we will be including deliberate policy action, with the added condition that deliberate inaction, in spite of its sometimes overwhelming impact on health, is not within the remit of this chapter. Secondly, we will have to look at policy that has been implemented. This statement merits some reflection on the conceptual nature of "policy". There are two extremes on a conceptual continuum: at the one end, there are those who believe a policy to be a rule or principle that guides decision-making. In many cases, such rules or principles might remain implicit. At the other extreme, policy has been defined as the explicit (and thus documented) formal decision by an executive agency to solve a certain problem through the deployment of specific resources, and the establishment of specific sets of goals and objectives to be met within a specific time frame. Legislation (with associated sanctions and incentives) could be regarded as ultimate policy statements. In this chapter we wish to look at deliberate decisions to solve (health) problems, and thus exclude "policy" that could be characterized as implicit general rules of principles for further decision-making. It is for this reason that we are interested not just in the decisions per se, but precisely in active implementation.

A third element that we will have to include is therefore a review of the implementation tools. Policy as an ambition needs to be translated into an operational

Box 5.1. HIV/AIDS prevention and the optimal intervention mix

Many studies have identified bars and discotheques as venues for high risk behaviour leading to infections with STDs, including HIV/AIDS. In many instances, health promotion agencies have endeavored to *communicate* these risks to the clientele, and advise options to limit them. One of these options would be to practice safe sex. This would involve the use of reliable condoms.

Access to such condoms could be *facilitated* by the installation of vending machines (or, as is common practice in some gay entertainment venues, free hand-outs).

Some local governments, after considering the impact of the communication-facilitation mix, have decided to *regulate* the compulsory presence and operation of these vending machines.

form if it is to be executed. These operational forms are known in the practice and academia of health promotion as "interventions". In the political sciences they are known as "policy instruments". Described by some as carrots, sticks and sermons, a more functional classification would distinguish between communicative, regulatory, and facilitative interventions/instruments. It is generally recognized that some optimal magical mix between the three would yield the highest policy effects. Thus, in this review we will also attempt to identify the types of health interventions/policy instruments that have been developed to implement policy.

It may be worthwhile to reiterate the fact that, in our view, "policy" is not simply equivalent to "intervention". Policies are higher order arrangements that, in our view, frame, order and define sets of interventions.

In terms of these arrangements, three policy types can be distinguished. Redistributive policies are policies that impose costs or provide incentives to encourage the adoption of certain types of individual and systems behaviors. These costs or incentives generally come in the form of taxations or subsidies. Regulatory policies impose restrictions or inducements on defined individual and systems behaviors. They specify sanctions, for instance fines. "Allocational" policies finally fund activities and strategies with the intent to produce longer-term health benefits for the population. The more specific the policy relates to behavioural outcomes, the easier it is to evaluate its effects. Redistributive and regulatory policies are thus easier to evaluate than allocational ones.

A policy can only be effective if its constituent parts are. Policies would be more effective if these constituent parts are developed, planned and implemented, preferably synergistically, from a solid evidence-, community and theoretical base. This is the core of the argument that follows, and we will return to this in the conclusion.

What is Health Policy?

Since Nancy Milio's landmark publication, *Promoting Health Through Public Policy* (1986), and the inclusion of its critical conceptualization of Healthy Public Policy in the Ottawa Charter and subsequent global conference statements on the role of policy in health promotion, policy development has become a legitimate concern of the health promotion community.

There is, however, considerable conceptual confusion around the various combinations of "health", "policy" and "public". If we are to review the evidence of effectiveness of policies on health, we need to develop an appropriate typology.

Policies can be developed by virtually any organized group in society with a substantial constituency. Public and private agencies have the legitimacy to formulate decisions to solve existing, emerging, or potential problems. *Health policy* is thus a generic term for any policy, public, private, or elsewhere (NGOs, QUANGOs – quasiautonomous non-governmental organizations), explicitly addressing health and/or quality of life issues.

Relating specifically to the level and type of governance, one can distinguish between public and corporate policies. Within the public policy domain, there should be an effort to develop *Healthy Public Policy*. Healthy public policy might these days be labeled a "whole of government approach to health", "joined-up government" or "Health in All Policies": some policy issues merit the attention of a range of government sectors. The Health Promotion Glossary (Nutbeam, 1998) states that *healthy public policy is characterized by an explicit concern for health and equity in all areas of policy, and by an accountability for health impact*.

Some of these issues frequently mentioned in the literature include "early-life interventions" (maternal and child health sector, education, social work, economic interventions, gender-specific policies, etc.) and indigenous quality of life issues (policy domains such as justice, social work, provision of essential health and social services, and possibly specific policy domains such as agriculture and fisheries, cultural affairs and education, etc.). Milio's recent glossary of policy terminology in the health field (2001) is further helpful in understanding the dynamics involved.

How does Policy Impact on Health?

Lasswell (1936) has defined policy succinctly as deciding who gets what, where and how. Apart from further philosophical academic reflections on the nature of (public) policy this definition demonstrates how policy impacts on health: with an increased understanding of the importance of social determinants of health it is obvious that policy regulates choices in every domain pertaining to such social determinants, be it housing, social assistance, environmental protection, employment and economic issues, agriculture or science and technology policy.

It is Milio's assertion that it would be governments' moral obligation to develop and sustain policies that are healthful or at least not detrimental to health. Ideally, the development and sustenance of such policies would be a

Box 5.2. Policy types – examples of innovation

public policy for health – a local government stimulating safe cycling by designing and building bicycle routes for work and leisure purposes.

corporate policy for health – a business regulating and facilitating the availability of healthy food choices in its canteen.

health policy – a partnership between government, business and NGO (Cancer Council) communicating, regulating and facilitating accessibility and affordability of sun protection measures – the Australian SunSmart programme.

healthy public policy – a government programme regulating, communicating and facilitating the primary production, processing and delivery of healthy food and nutrition across ministries of agriculture, economic affairs, taxation, health and social affairs – the Norwegian farm-food-nutrition policy.

public health policy – a government programme for mandatory vaccination packages.

health care policy – a government programme facilitating the establishment of 'transmural nursing', taking care of continuity of care between hospital and primary care settings.

purposeful endeavour at all levels of government. In some countries (such as Sweden and Finland) this focused development has a high policy priority. In others (such as The Netherlands and Australia) the national government requires local authorities to develop healthy public policy. This happens with varying degrees of success (Hoeijmakers, 2005).

When is Policy Effective?

This leads us to consider the question when policy is effective. Naively, one might assume that the mere adoption of a policy by its constituency is an indication of its effectiveness: it would establish the intent to solve an identified problem, and would thus suggest that appropriate interventions are in place to be implemented.

Although the formal adoption of policy is often a major accomplishment involving years of negotiation with stakeholders and the generation of knowledge suggesting appropriate policy directions (cf., for instance, the WHO Framework Convention for Tobacco Control, 2006) it does not solve the problem per se. On the contrary, there are policies that have no intent of solving a problem; they are merely generated for their symbolic value. For instance, in March, 2005, the European Union embarked, according to its own press releases, on an ambitious programme to combat smoking in its 25 member states. With a budget of 72,000,000 euros over a three-year period the campaign aims to reduce smoking among young adults through television campaigns, road shows, and advertorials (HELP, 2006).

There is very little evidence that this type of intervention effectively reduces smoking prevalence. Yet, it is apparently important to the EU (and thus its member states) to develop such a policy – it purports to show that the Union takes the smoking epidemic seriously. This would be in line with a decision to phase out agricultural subsidy programs for tobacco growing in 2001. Such subsidies continue to total nearly 1,000,000,000 euros annually. This policy seems to be symbolic rather than anything else: the subsidies continue, and a fraction of the amount is symbolically spent on tobacco control.

In our view, a policy can only be regarded effective if the problem it has defined has been reduced significantly, and if that reduction can be attributed unequivocally to changes that the policy has brought about. Policies that focus on relatively simple, discrete issues, would thus have a higher potential to be defined effective than policies that address complex issues involving intricate chains of proximal and distal determinants of health, such as for instance policies to reduce health inequities. A further complication for determining the effectiveness of such policy types are secular social trends and biases. For instance, governments that adopt policies to reduce inequities in health are likely to be the same governments that developed policies on social and environmental justice, equitable work conditions, et cetera.

A Meta-Review of Healthy Public Policies and Health Policies

Any policy, thus, has a potential impact on health. Milio (1986) has already adequately reviewed the extent to which this is the case. We would be interested, in this chapter, to review what health effects purpose-built policies have. To find out, we have reviewed a review.

The government of the United Kingdom has, over the last decade, endeavored to develop a wider health agenda (taking into account insights on social determinants of health) drawing on "hard" evidence of effectiveness. Focusing on the main scourges of public health, a White Paper proposed policy action on cancer, coronary heart disease and stroke, accidents, and mental health. A review of the effectiveness of the proposed policies and associated interventions was carried out by the National Health Service Centre for Reviews and Dissemination (Contributors, 2000). Materials were provided and analyzed by the Cochrane and Campbell Collaborations.

For the majority of the proposed policies evidence of effectiveness could be demonstrated, for the health sector predominantly on policies impacting on disease, and for non-health sectors on proximal and distal determinants of health. Surprisingly, though, there is a substantial number of policy options that does not seem to be effective. Also, some policy options impact neither on disease nor determinants, but seem to have synergy with other policy alternatives. A final 36 policy options could not be classified: they appeared to have some hypothesized, but no demonstrated effect.

It must further be observed that virtually all "policies" reviewed in fact are interventions; the health sector interventions impacting on disease parameters are all clinical interventions. Very few of the "policies" are such in the sense that policy and political science, politicians or decision-makers would define them.

This conceptual opacity limits not only our analysis of evidence of effectiveness, but is more importantly problematic in the discourse that would lead to the establishment of true policies for health: if (health) practitioners continue to believe that "policy" can be equalled with "intervention", then their effective input into the policy development process is limited.

In considering policy options, politicians and other decision-makers operate on the basis of sets of assumptions and implicit values. They generally generate, often implicit, policy ontologies, sometimes called "causal field models" (Milewa & de Leeuw, 1996). These map causal (cause-effect), final (intervention-outcome) and normative considerations, e.g. "Poverty causes ill health", "Income support reduces poverty", and "In our country we do not subsidize individuals". Whether these considerations are valid, just or equitable is no issue in policy development, unless governed by normative frameworks.

One type of causal relations often found in policy considerations can be called the hypothetical effect, or "hypo-effect". For instance: covering a perimeter around high-rise apartment buildings with heavy padding would minimise casualties in case of fire. Obviously there may be truth in such effectiveness arguments, but they do not take into account whether a real problem is tackled, and whether the intervention meets efficiency criteria.

Finally, in choosing between intervention options considerations of effectiveness or efficiency (greatest gain at least cost) are not dominant. Before anything else, the "least coercion rule" is applied (Van der Doelen, 1998): always choose the intervention first which is least intrusive/coercive into peoples' lives. This rule explains why governments generally prefer the communicative intervention (even when not supported by evidence of effectiveness) over other types.

Our analysis is moreover clouded by a phenomenon already identified by the Swedish government in the 1980s (Figure 5.1). It is very rare that there is a unique relation between one determinant and one disease (group): for instance, the physical work environment impacts on five out of six disease categories, whereas respiratory diseases are affected by seven out of ten determinant categories. This means that policy on diet and nutrition would affect much more than, say, nutrient deficiency syndromes alone. Referring to Table 5.1, there were policy types and associated interventions that had evidence of effectiveness related to one type of health issue, whereas the same package did not impact on another type of health issue, although it was theorized that it should. More often than not this difference could be attributed to an absence of effectiveness studies rather than the pure absence of evidence of effectiveness.

The UK review has one final drawback which has been highlighted most astutely by a US Institute of Medicine (IOM) review of the contributions of the social and behavioural sciences to the promotion of health (Smedley & Syme, 2000). This work identified that a multitude of intervention types at different levels of interaction (individual, group, community, system) for any segment of the population (gender, age, ethnicity, ability status, etc.) would yield synergistic effects far beyond the development and implementation of singular and isolated

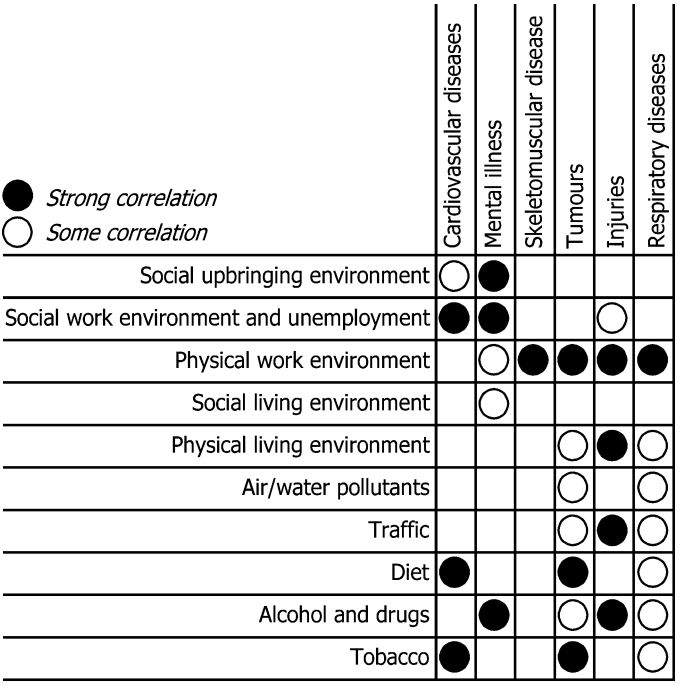

FIGURE 5.1. Correlates between determinants and health states (HS90, 1984).

interventions, be they communicative, facilitative, or regulatory. At this stage in our argument this should come as no surprise, as such a finding is consistent with the complexity of the field. It is worth noting one of many recommendations the IOM report makes:

TABLE 5.1. Analysis of proposed policies' evidence of effectiveness (Contributors, 2000)

Impact of policy divided into evidenced impact direct on disease; on proximal/distal determinants of specific etiology; or as a synergy or prerequisite factor for other effective policy, and further into whether the policy could legitimately be considered as a planning and implementation remit of the health sector, or of other sectors. 36 policies are *hypo-effective* (cf. below).

	Evidence of effectiveness	No evidence of effectiveness	Evidence of synergy or support
Health			
On disease parameters	25	20	5
On determinants parameters	15	3	2
Non-Health			
On disease parameters	16	27	3
On determinants parameters	49	11	18

Recommendation 17: Cost-effectiveness analyses are necessary to assess the public health utility of interventions. Assessments are needed of the incremental effects of each component of multilevel, comprehensive interventions, and of the incremental effect of interventions over time. Such analyses should consider the broad influence and costs of interventions to target individuals, their families, and the broader social systems in which they operate.

The underlying critical notion to this recommendation is obviously that, as such analyses become available, they should be informing development and decision-making towards exactly those policies that would include multilevel, comprehensive interventions.

The "policy game" is however not the rational process that would take available clear-cut evidence into account. Some authors even argue that many policy decisions are paradoxical to what would be "best choice" (Stone, 1997). We have found that:

(a) the more targeted and specific the problem is (Table 5.1); and
(b) the more utility-driven the associated generation of evidence has been (de Leeuw & Skovgaard, 2005; Weiss, 1979), an appropriate and effective policy might be developed. However, such policies would be far less effective than those suggested by the IOM report.

There are few exceptions to this general finding, such as Norway's farm-food nutrition policy (Milio, 1981), the Australian SunSmart efforts (Montague, Borland & Sinclair, 2001), and the Swedish overall health policy (Hogstedt et al., 2004), all of which are comprehensive healthy public policy packages dealing with highly complex issues. As such, these are three examples of effective healthy public policies at the national level, albeit with very different perspectives, lead stakeholders, and to some extent different political ideologies. The success of these policies can be attributed to three factors:

- the strong resource-base on which the policy could draw;
- the long-range policy negotiation tradition, or the persistent policy push exerted by a committed agency, that enabled involvement of a broad domain of stakeholders; and
- strong political commitment to the preferred outcomes of the policy package.

There is also documented evidence of the factors that play a role in failures to develop national healthy public policy (de Leeuw, 1989b):

- competing policy agendas (where agendas with profound economic aspects will win);
- the drivers of policy (Kingdon (2003) calls them "policy entrepreneurs", but Skok (1995) found that others theorists have described similar roles under different names: "social entrepreneur," "issue initiator", "policy broker", "strategist", "fixer", "broker" or "caretaker") are found to be associated with one unique agency rather than the full policy domain;
- critical actors maintain a position of "benevolent inaction" which is misinterpreted as support for the suggested policy.

At the local level, the international Healthy Cities movement claims policy successes, though (de Leeuw, 2001; de Leeuw & Skovgaard, 2005; Awofeso, 2003). The integration of different policy domains (health and Local Agenda 21 initiatives, for example), the involvement of a range of "new" actors (NGOs, industry), the active engagement of communities, and a persistent focus on health inequities and social determinants are accomplishments that are rarely mirrored in other health policies. But again, there are very few demonstrations of the health impacts of (healthy public) policies developed in Healthy City contexts. An exception is a study from Curitiba that found that such policies are significantly more effective in the prevention of dental trauma (Moysés et al., 2006). Again, some "magical" mix of interventions is more effective and more synergistic than a series of disconnected singular interventions. An explicit comprehensive policy theory (that is, the set of assumptions underlying the policy ontology) would be helpful in structuring these different interventions into a policy package. In an evaluation of ten Healthy Cities in the European Union de Leeuw, Abbema & Commers (1998) found that there is strong commitment among city administrations to develop such broad policies, but Goumans & Springett (1997) do not necessarily view the "Healthy City" label as the crucial factor for such a position.

Multiple Case Studies: Examples from Canada*

In this section, we draw upon the experience of evaluating many of Canada's major public health initiatives over the past 20 years. In so doing, we fully recognize the limitations of such an approach – that lessons learned from the Canadian experience may not apply similarly elsewhere.

Compressed Time Frames

In Canada, a majority government has a maximum life-span of 5 years before standing for re-election. In the case of minority government, the period may be much shorter. As such, many of the major public health strategies have been introduced with a five year time frame. This leads to a succession of health strategies – some of which are renewed after the initial period – others, not. Among others, these have included the following:

- Canada's Health Promotion Strategy;
- Canada's Tobacco Strategy (Various versions);
- The Canadian Strategy to Reduce Impaired Driving;
- The Canadian Alcohol and Other Drugs Strategy;
- The Canadian Heart Health Strategy;

* This section provided by Reg Warren, Reg Warren Consulting Inc., Ottawa, Canada.

- The Canadian Breast Cancer Initiative;
- The Canadian Strategy on HIV/AIDS;
- The Canadian Diabetes Strategy.

Generally the first year of the Strategy involves the national government in preparing the infrastructure to implement the Strategy. By year two, key activities are being developed and community groups and intermediaries are being funded to deliver programs to the population. By year three, implementation has begun. In year four, full implementation is in progress; by the end of year four, most activity is devoted to project finalization (evaluation; renewal of funding proposals; looking for other employment; sources of funding).

Ultimately, in order to ensure continued funding, the Strategy is required to demonstrate reductions in morbidity and mortality accruing from this large investment of public funds (the objective of each of these strategies is to accomplish this – otherwise it likely would not receive funding).

Of course, in most cases this is impossible to demonstrate, and simply will not occur, given 1–2 years of full implementation. In fact, in many instances reported morbidity and mortality actually increase during the funding period – given increased public and institutional awareness; and improved detection and reporting systems.

The Impossibility/Implausibility of Control Groups

Simply stated, it is impossible (as well as politically, ethically and morally unfeasible) to exclude societal groups from the benefit of a health promoting public policy. Thus, threats to internal and external validity are virtually impossible to rule out – no matter the research design used, and requires the investigator to rely upon triangulation of multiple (frequently competing) sources of evidence. This is especially problematic, given that most major public health strategies tend to be information-driven. There is simply no way in the information age to exclude even non-participating sub-jurisdictions or the citizenry itself from the benefits of access to information. In fact, in a great many evaluations, populations effected by the policy have shown improvements – but so too have others – leading to highly equivocal conclusions regarding effectiveness.

Diffusion of Implementation

In large industrialized countries, like Canada, it is rare that national governments deliver public health programs directly to the citizenry. Generally, an "empowerment-of-intermediaries" approach tends to be adopted, with national governments supporting those civil societies, NGOs, other levels of government and other groups who are better positioned to deliver programs to the citizenry.

While this is an excellent delivery model, the difficulty – from an evaluation point of view – is that these intermediaries (particularly, other levels of government)

tend to be extremely reluctant to have their activities evaluated by the federal government. And, this is entirely understandable given that they have their own constituencies and accountabilities – which may not always completely accord with those of the federal government.

Unfortunately, this renders the attribution issue functionally impossible to address – since the evaluation frequently ends with examining the role of the federal government in the empowerment of intermediaries.

Multiple Actors

There are a great many groups in Canada, including various levels of government involved in promoting public health. In fact, an examination of a recent federal public health strategy noted that the amount of money invested represented less that a 5% increase in the amounts of funding already devoted to the issue.

Policy = Politique = Politik

Whereas in English there is a clear semiotic distinction between "policy" and "politics", the French word for policy translates into politics. The same is true in German. And this is perhaps is the greatest barrier to the evaluation of national policies for health.

In Canada, most of the evaluations of major public health policy initiatives are funded and controlled by the federal bureaucrats in charge of those programs – compromising the independence of the evaluation exercise. And, indeed as far as we are aware, the plans tend to suggest increased controls on this information in the future.

Any results that could potentially be perceived as "negative" have the potential to compromise the Minister (policy) or the Department (implementation).

As such, insofar as we are aware, the vast majority of evaluations of national public health policies carried out over the past 20 years have neither been published, nor made available to the public or to partners/stakeholders – other than through rarely used "Access-to-Information" requests. This not only deprives the broader community from learning the lessons of major policy initiatives, but also to a lesser degree, calls into questions the credibility of the information that is made available though the many dissemination mechanisms available.

The Success of Healthy Public Policy

Whether or not the public sector is able to develop and implement healthy public policy depends on a range of factors. Some of these factors relate to the very substance of the policy, others on the context in which policy is developed (de Leeuw, 1989a, b). We have assessed these factors as follows:

TABLE 5.2. Overview of design complexities and parameters, including feasibility and effectiveness considerations (and their measurement aspects) of policy types

Indicator Policy type	Synergy with other policy types	Population health impact assessment	Feasibility to implement at national and local levels	Complexity of policy design
Specific policy elements and isolated communicative, facilitative or communicative policy interventions	low	specific and relatively easy to assess	Nat: easy Loc: easy	relatively simple
Health Care Policy	low	specific, and believed to be assessed easily through, e.g., RCTs	Nat: moderate Loc: easy	relatively simple but much depends on ❶ degree of professional autonomy of stakeholders; and ❷ public/private financing mix
Public Health Policy	medium	Proper assessment should be multi-level, long-term, and multi-method: hard to assess	Nat: hard Loc: contextual (depends on national parameters and local culture)	complex, as it depends on the alignment of a range of public sector stakeholders
Healthy Public Policy	high	Potentially very high, but difficult to frame as few such policies are being developed purposefully	Nat: very hard Loc: contextual (depends on national parameters and local culture)	very complex,as it includes the range of stakeholders from Public Health Policy plus NGOs, community representation, etc.
Health Policy	very high	Potentially very high, but final attributions between cause and effect are hard to establish	Nat: extremely hard Loc: contextual (depends on national parameters, local culture, and corporate commitment)	extremely complex to establish one coherent health policy package as the range of stakeholders is at its extreme

Theory to the Rescue

In the above we have seen that a considerable number of policy options can be considered effective in the promotion of health. We have also seen, though, that a larger number of policy options claims unsubstantiated effectiveness. More, and new types of, research is required to demonstrate the effects of such policies. We have also seen that a range of intervention types is effective, whereas others are not, and that a mix of interventions addressing a variety of determinants of health will be more effective than the simple sum of isolated interventions. More studies are required to shed light on the developmental logic and evaluation of such intervention mixes. It is worth noting that most of the communicative and facilitative intervention types are subject to effectiveness inquiries and Cochrane and Campbell Collaboration reviews, and that the findings of such reviews in an ideal world should inform policy making. There is a lack of effectiveness studies on regulatory interventions for health. Most of these interventions, plus a substantial number of other intervention types and most policy packages, can be typified as hypo-effective. Finally, we have seen that the development of policy is not a rational process that draws on scientific insight alone.

To explain the realities of policy-making, and in order to interpret the findings of Table 5.2, it is helpful to apply current theoretical insights into the "policy game". Rather than viewing policy development as a relatively simple democratic process, these insights maintain that policy development takes place in highly complex and fluctuating policy domains (Kingdon, 1995). The range of stakeholders and interests involved in these domains depends on the framing of the policy issue (Stone, 1997). This framing is constantly adapted by both stakeholders as well as policy and social entrepreneurs, thus incessantly moving ownership of the policy issue between stakeholders (Gusfield, 1981). The final outcome of this networking process has so far been hard to predict. However, dynamic network modeling provides new insights into the purposeful manipulation of the domain and its components (Hoeijmakers, 2005).

There is another theoretical realm that closely relates to our question: the art and science of policy implementation. Not all policies seem to be implemented effectively. This failure might generally not be attributed to the policy itself, but rather to characteristics of the policy *environment:* one might have, for instance, formulated a policy in the area of counselling, but if no properly trained personnel would be available, or resources to develop counselling capacity, the policy is bound to fail. Regrettably, sometimes policy are designed to be ineffective. Weiss (1979) identifies six ways in which "knowledge" (or "evidence") is utilized for political purposes, one of which is to stall effective action. Combining these insights with, for instance, Mazmanian & Sabatier's (1989) policy implementation theory, it is clear that there is no "ideal world" where all available evidence can be translated into effective policy frameworks.

In the perspective of Mazmanian & Sabatier there are factors conducive to effective implementation of policy that fall within the remit of the implementing agency, factors in the socio-economic environment, and issues directly related to the nature of the problem the policy intends to resolve. This approach has been

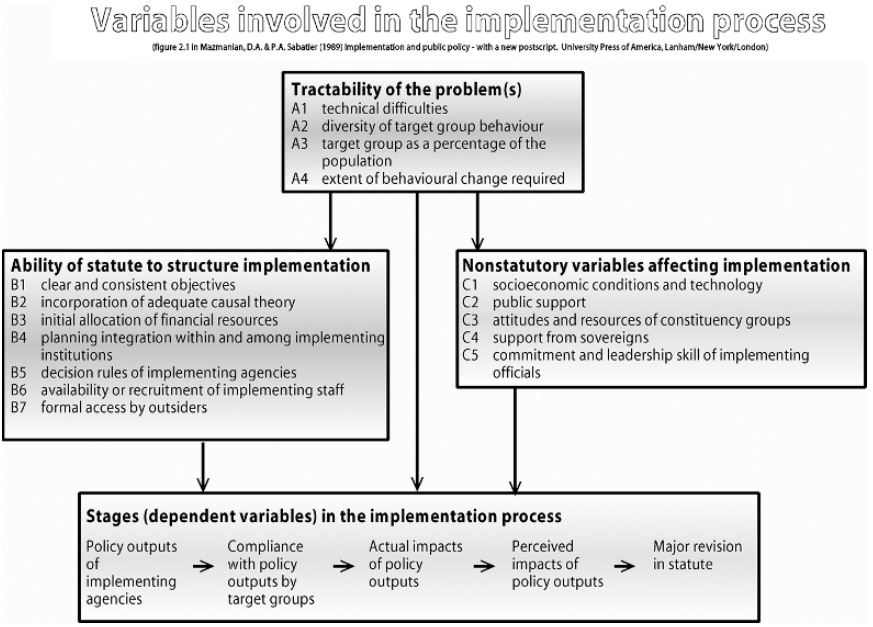

FIGURE 5.2. Variables involved in the implementation process (Source: Figure 2.1 in Mazmanian, D.A. & P.A. Sabatier (1989) Implementation and public policy – with a new postscript. University Press of America, Lanham/New York/London).

criticized as too top-down, focusing only at actions that can be taken by policy and decision makers (e.g., Hill & Hupe, 2002) whereas a more whole-of-systems approach would engage communities, their representatives, and practitioners in making implementation work (e.g. Lipsky's (1980) street-level bureaucracy as a critical force in effecting policy change). Much can be gained by the health promotion community in developing a more profound understanding of such implementation issues, as signalled for instance by Bartholomew et al. (2006).

Making Policies for Health more Effective

There are lessons to be learnt from the findings and propositions formulated above. If health policy issues are extremely clear-cut, mono-causal and impacting on very specific segments of the population (which should preferably be part of mainstream political consideration) effective policy programs can easily be developed, even more so at the local than at higher levels of government. However, most if not all public health problems do not fit this description. They are multi-dimensional (spatially, temporally, and cognitively) and generally "messy" or "wicked" problems (Mitroff & Mason, 1980). The populations that matter in health promotion (policy) are generally on the periphery of the decision-making radar scope and getting their

health issues on the policy agenda is not easy. However, theoretical reflections on the policy process provide insights how this might very well happen.

One approach recognizes the importance of engaging "non-traditional" actors in the policy debate. Beyond the often mere symbolic acknowledgment of community interests, this engagement would include sectors such as social work, education and agencies involved in (fiscal and physical) infrastructures. These would, often surprisingly to the health promotion community, offer problem analyses similar to the health realm, but can present other problem-solving patterns and policy entry points than commonly used in health promotion.

In sum, some of the core qualities of the Ottawa Charter (enable, mediate, advocate) equip the health promotion community more than anything else to effectively engage in the policy-making enterprise and contribute further to its effectiveness.

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