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HEALTH POLICY MAKING: THE DUTCH EXPERIENCE

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Abstract—The European Strategy for Health for All by the Year 2000 urged member states to develop a national health policy. In the developmental process of HFA2000 the notion of 'healthy public policy' was conceived in the framework of the WHO Health Promotion Programme. Such 'healthy public policy'—simply referred to as 'health policy' in this article—would take health consequences in all governmental and societal realms into account. Health policy development in The Netherlands was laid down in a 1986 memorandum, 'Nota 2000'. The developmental process of the document is reviewed, and chances for factual implementation analysed. The article concludes with a list of actions to be pursued if health policy is to be successful.

Key words—health policy, health promotion, The Netherlands, policy studies

Since the Public Health Memorandum of 1966 the Dutch government has adopted a prevention rhetoric. Policy documents which have been published the past 25 years increasingly stress the importance of prevention.

Initially a change in individual behaviour was considered to be of major significance. Nevertheless, Nota 2000 was published in 1986, the document in which the prevention idea culminated [1]. It describes prevention from a more integrated and comprehensive view of all prevention modes (health education, environmental protection, population screening, etc.), preventable causes of ill health and eventually health promotion in the widest sense. Prevention was described as a broad concept, no longer restricted to the modification of individual behaviour.

With this document the Dutch government followed the international developments in Health Promotion and the 'new public health'. Nota 2000 was widely respected as an example of vigorous policy making.

The following pages will describe the conceptual developments of health promotion and the implications which have been attached to it by the Dutch government. Then an investigation which studied the feasibility of the proposed measures as part of these implications is described. Finally an assessment will be made about the future of Dutch health policy.

RATIONALE: DEMEDICALIZATION OF HEALTH

Emancipatory and democratic movements of the sixties have resulted in an increasing acknowledgement of the dependency which exists between patients, consumers and the medical–industrial complex.

Consequently the number of patient organizations, interest groups and self-help groups rose sharply and in academic circles stronger pleas for a new approach of health problems arose [2].

Among those who translated these developments into policy development were Laframboise [3], Blum [4] and Lalonde [5]. They found that health policy must not only be directed toward the quality and the volume of health care facilities but specifically also at other factors which affect health, for example individual lifestyle, hereditary and biological constitution and the social and physical environment. Empirical research has shown that indeed these other factors have a strong effect on public health and it is not just the health care system that is of major importance [6–10].

WHO became also aware of these developments as a consequence of the primary health care approach [11]. This approach had been considered primarily as a way to promote health in less developed countries, but soon the concept was translated to fit the industrialized countries in the WHO Health For All by the Year 2000 programme [1, 12, 13].

It appeared that especially in Europe the added value of an expanding health care system was limited. The health status of Europeans appeared to be determined by housing, employment, education, pollution, social networks, etc. [14].

The European member states of WHO developed 38 health targets which ought to be pursued as a part of the Health for All strategy. The member states committed themselves to develop a national policy document which reflected the ideas of Health for All and the 38 targets*. The HFA document and

*It should be noted, though, that the Regional Committee of the European office of WHO recently (1991) adopted a set of completely revised and updated targets.

the accompanying targets were nevertheless not enough incentive for governments to realize and implement such national policies. This is also reflected by the status of The Netherlands' Nota 2000: it is a discussion document in which the HFA line of thought is being presented as one out of other possibilities for health promotion.

This gave WHO reason to partly leave the fundamentalist path of the Health for All rhetoric. The new path is called the demedicalization of health [15], or 'new public health' [16].

The first step was the formulation of the Ottawa Charter on Health Promotion [17]. Health promotion was defined as the process of enabling individuals and communities to increase control over the determinants of health and thereby to improve their health. This immediately implies that no specific type of intervention is preferred. The central ideas of the Charter are the following.

Firstly (*mediate*, *advocate*, *enable*), mediate between the various and often conflicting interests of the various public, private, voluntary and community sectors involved in creating the conditions for better health. Advocate innovative thinking about health promotion and create the possibilities to participate in health promotion.

Secondly *health services must be reoriented*, aimed at a more health promoting role, instead of a uniquely institutionalized cure and care approach.

Furthermore *supportive environments* must be created. This means that the social and physical environments of people enable them to make 'healthy choices' conform the WHO slogan: "make healthy choices the easier choices".

This is to be reached by *developing personal skills and strengthening community action*. Also the building of healthy public policy (policy which makes health a legitimate part of all sectoral policies) is a major prerequisite for health promotion. This is reaffirmed by the Adelaide Recommendations [18]. With help of three concepts the health promotion and healthy public policy ideas can be summarized:

(1) intersectoral cooperation [19, 20];
(2) integrated intervention mixes [13];
(3) participation of the community [21].

These three principles find their concrete consequence in the Healthy Cities Project, presently one of the most successful and booming WHO health promotion programmes [22]. This article remains nevertheless concerned with national health policy.

'Healthy Public Policy' is a crucial component of the health promotion approach. Rhetorically, in the Adelaide Recommendations, healthy public policy is being characterized as having an explicit concern for health in all sectors of public policy making. Pederson *et al.* [23] reviewed the notion, and found that it has been conceived as "policy of the people and their elected representatives characterized by an explicit concern for health", "health-making policies", "multi-sectorial policies to achieve equity in health", and "public policy supportive of health". These descriptions, however, are all constitutive by nature. They do not define 'policy', nor 'health'.

In the study described below, we decided to use the term 'health policy', meaning all policies pertaining to health. Combining several definitions of both concepts, the definition for 'health policy' (which in our view thus becomes equivalent with 'healthy public policy') is:

> A long-term, continuously used, standing decision by which more specific proposals aimed at, or related to, the realization of optimal conditions under which individuals or groups can realize aspirations and satisfy needs, and change or cope with the environment are judged for acceptability in terms of means to be employed, ends to be pursued, and time frame in which these proposals will have to be fit.

THEORETICAL UNDERPINNINGS: BUILDING POLICY

As a member of WHO the Dutch government has also committed itself to build up its healthy policy. The first step in this direction has been the publication of Nota 2000. Building policy is, however, not something that just happens. Even a commitment of a national government to an international forum is not necessarily enough reason for policy to be built.

Policy building can only be successful if there exists a set of more or less grounded assumptions (the so-called *policy theory*) and if there exists or seems to exist enough public support for the policy.

The agenda building theory which Cobb and Elder have tried to establish [24] distinguishes a number of factors which make a controversial societal issue to be turned into a policy issue.

Firstly they distinguish between the systemic (or societal) agenda and the institutional agenda.

For a policy to be developed there must be sufficient public and interest group pressure to get the issue on the systemic agenda. After this, through various mechanisms and sufficient pressure, the issue will find a place on the institutional agenda. The more public support for an issue the better the chances are for an issue to enter the systemic agenda and in turn to be put on the institutional agenda. The public, however, is made up of several interest groups which each have own goals, mission and objectives. Cobb and Elder distinguish between four groups:

Identification groups: those groups which are oriented towards or focus attention upon, the group of primary stakeholders identifying their interests generally with those of that group or having a persistent sympathy with its generic interests. Ties between these groups tend to be relatively stable and lasting.

Attention groups: persons in those groups identify with only certain issues. For example pressure groups; they are readily mobilizable as soon as their issue is at stake.

Attentive public: that part of society which is generally interested and well informed.

General public: this is merely a statistical artefact. It is not a homogeneous group and cannot be easily mobilized at once for an issue as a group. The persons in this population are less well informed, less active and less concerned with issues.

The definition of perception of the issue is also of major importance. If the issue wants to attract the attention of the general public it must be highly symbolic [25] and have general attraction.

Cobb and Elder have defined four other characteristics of an issue which determine the success of the identification group in trying to extend the scope of the controversy, and thus get the attention of other groups.

This issue manipulation is an important mechanism in agenda building theory. Enlarging the audience responsive to the issue is necessary to put the issue on the systemic agenda. Issue manipulation will be more successful if:

(1) the issue is defined equivocally;
(2) the social relevance is perceived as high;
(3) the issue relates to the long term;
(4) the issue is not technical or technocratic; and
(5) has few historical precedents.

Use of symbols and imagery with emotional connotations is another important technique in issue expansion. Mass media play an important role in the expanding of the problem. The more symbols used appropriately and appealing to the public (this means use of symbols with emotional connotations) in issue expansion, the sooner it will be possible to mobilize the successive groups to insist on building policy. The mass media have agenda building power rather than agenda setting capacities.

The theory of Cobb and Elder has been highly criticized, mainly because of the emphasis on the role of society in building policy. Reacting, three different ways for agenda building were proposed by the original authors [26]:

(1) the outside initiative model;
(2) the inside initiative model;
(3) the mobilization model.

The *outside initiative* model covers the original theory. Sufficient public pressure under appropriate conditions would lead to policy considerations by politicians and bureaucrats. The *inside initiative* model puts forward that policy makers can place issues on the institutional agenda more or less independently.

The *mobilization* model gives a model which seems to fit the discussions around Nota 2000. Policy makers seek support for issues they are interested in. They need public support for the issue to be expanded from inside the government to groups who have not been aware of the issue conflict yet.

By cunning strategic movements mobilization of the systemic agenda is being pursued, resulting in popular support and public pressure which might induce further sharpening of the concreteness of the policy. In other words: bureaucrats put an issue on the systemic agenda hoping that public pressure around it will be built up in order to convince politicians of the necessity for policy. Policy-makers are thus expected to have many abilities: they have to avoid to be labelled manipulatory paternalists. This is crucial to their ability in acting strategically. Besides, they must be well informed about education and communication strategies and have the means to support and lead the mobilization process. They must have easy access to the mass media and have an adequate estimate of the appropriate interest groups to be approached.

RESEARCH: AGENDA BUILDING TOWARD HEALTH POLICY?

An investigation has been conducted to inquire to what extent health policy following the health promotion principles was put on the Dutch agendas. This is important for the people who are advocating such health policy. Indications can be found how to intensify efforts in agenda-building. In the following the results of this project will be presented.

1. The agenda building route

The inquiry started with the question which of the three proposed models of agenda-building applied to the publication of Nota 2000. The most important documents produced by the actors were analysed and it could be concluded that the mobilization model appeared to be the appropriate model.

Five versions of the document were found. The results were compared with the experiences of the main actors, namely the Director-General for Health in the ministry, and three bureaucratic actors who then held final responsibility for the production of Nota 2000.

The first development which would lead to the publication of Nota 2000 was the integration in the late 1970s within the Ministry of Health & Environment of two major policy-making units: long-term planning (dealing with strategic long-term matters pertaining to health) and the staff bureau of policy development (occupied with legislation on infrastructure of health care delivery, political aspects of health policy and research programming).

The new Director of the newly created Staff Bureau Policy Development (STABO) had a strong affinity with long-term planning for health on the basis of the works of Blum and he and his staff had close contacts with WHO/EURO staff developing the HFA strategy. Along with the developments and operationalization of the latter inside the Department of Health there was a growing awareness that it should be possible to develop long-term future oriented health policies. The Director-General and the Minister of

Health were won over by the idea to develop strategic long-term health policies. Long-term health priorities should therefore be set apart (in bureaucratic as well as political terms) from cost control and structuring of health facilities.

In the presentation of the health budget and the policy intentions to Parliament early 1983 the Minister of Health promised Parliament to develop a policy framework: "priorities of health policy in relation to public health until the year 2000". The sixty lines of text devoted to the document seemed to be a near-perfect translation of an abstract of the European regional strategy for Health for All [27].

However, developing a document was easier said than done. Within STABO little priority was given to the document. It was felt that it should be the translation of scientific analyses produced by the newly installed Steering Group Future Scenarios for Health (STG) into political priorities.

Development of the whole range of future scenarios stalled and among STABO staff it was felt that counterforces inside the department were beginning to grow. These counterforces were reflected in the publication of a report "Public health policies in times of limited means" by other units in the Ministry [28].

It became clear that the health policy document could not be presented to Parliament in 1984. In subsequent drafts the size of the document grew disproportionally. A good example is an expatiation of 40 pages on international health relations in one of the drafts, reduced to only one page in the final Nota 2000. In the summer of 1985, however, the strategic decision was made to present the document in the spring of 1986. This was merely a political choice because in May 1986 elections would be held and the session of the Cabinet would terminate. Uncertainty existed among staff as to what the next session would bring with regard to future oriented health policy. Activities with regard to Nota 2000 were intensified. STABO started to consult a limited number of outside experts. A lot of problems were recognized by them, mainly concerning the scope of the issue (i.e. a broad health policy).

The status of the document was lowered to that of discussion document after a Directorate Council Meeting* (this meeting was the result of one of the key notions in Nota 2000 called facet policy or intersectoral policy). The document appeared to be a threat to the other departments.

Instead of just dumping the document in the health field the responsible bureaucratic actors decided to organize a series of seminars, discussion meetings and publications to go with it [29–31].

Undoubtedly these actions were aimed at generating legitimacy to increase the status to policy document again. This can be seen as proof of the fact that the mobilization model has been used for agenda building, as the document was neither presented as 'governmental wisdom' (i.e. the 'inside initiative' model), nor the result of public pressure (the conventional 'outside initiative' model).

*The Directorate Council is the interministerial group where top-level bureaucrats discuss and finetune future policies.

2. Issue expansion: methods

The issue of Nota 2000 had to be expanded from a small group of committed people (identification group) to other groups in society. Researching if and how this expansion took place was not an easy task. The position of the several interest groups in the process had to be clarified, as well as the way the interest groups perceived and expressed the ideas of Nota 2000.

To identify the interest groups, 54 actors in The Netherlands' health scene were distinguished. This list was checked by 3 expert referees (not related to any of the groups) and there were no objections or additions to the composition of the list. Further, each of the actors was asked to identify the other players. This did not alter the list either.

To divide up the interest groups over the five theoretical concentric groups a division was made after a semi-structured interview [32–34]. The interviewed person was a representative of the organization so he or she didn't act in personal capacity. This position was stressed during the introduction to the interview.

Sequentially, the interview addressed:

(1) characteristics of the organization (size, funding, mission);
(2) knowledge with respect to the content and existence of Nota 2000;
(3) contributions in any way to Nota 2000 before or after publication (eventual similarities between Nota 2000 and own goals);
(4) the perception of which groups should have been involved or are involved in Nota 2000;
(5) the feasibility of health policy (including obstacles and stimulating factors);
(6) the role of each organization in making health policy c.q. realizing it;
(7) perception of groups which obstruct feasibility of Nota 2000;
(8) the role of the organizations in formulation, adoption or implementation of prevention policy and facet policy;
(9) the role of organizations in tackling a specific health problem (i.e. accidents involving children 0–5 years in and around the home).

Explicit questions on issue expansion criteria were not included, as these might have been directive and thus create a social-desirability bias.

The role of the media has been dealt with separately. A search was carried out with a computerized media retrieval system and a parliamentary computerized information retrieval system.

Further, all respondents were asked for any relevant formal and informal organizational documents that would illustrate their position with respect to Nota 2000 and health policy. After the first round the information was processed and a report was written and sent back to the original research population (including the 14 organizations which did not participate in the first round). The reason for this was twofold: firstly to validate the interim results and secondly to increase total response. One non-governmental organization did not participate because they said they didn't have any health goals.*

As a result of the second round response increased from 46 to 53. Eighty-two documents were produced by the participating organizations and 95 coverages by the media were retraced, including one radio broadcasting.

3. *Results*

The most important question with respect to Nota 2000 is whether building health policy is a controversial issue on either the systemic or the institutional agenda. The above already pointed out that this is not the case. Nota 2000 has been used as a discussion document through a mobilization model.

The next logical questions are whether, as a result of this mobilization process, something has changed in the composition of both agendas, how this process has progressed and what we have learned from it for the future.

It appeared to be difficult to make some pronouncements about issue expansion on the basis of the construed groups. Certain groups seem to agree with the ideas about health policy as a result of Nota 2000. This especially applies to VDB (Association of Municipal Health Services), Nationale Kruisvereniging (National Association for Community Care) and to a certain degree to VNZ (Association of State Health Insurance Funds).

Remarkable was the fact that groups which were expected to be able to adopt a strong attitude towards prevention policy didn't adopt such a strong attitude towards Nota 2000. Although consumer and patients' organizations were favourable to the Nota 2000 policy, priorities like patients' rights, adequate health care and high-tech diagnosis were thought of as being more important. Also other groups which could have interest in prevention policy (NVAGG†, NVGVO‡, LCGVO§, NcGv¶) did not enthusiastically support Nota 2000. The reason for this can be found in the overall vagueness of the document: no clear policy direction was pointed out and no means for possible implementation of policy were given.

Remarkable also was that groups which were expected to be opposed to health policy only were mildly sceptical about it. Medical-professional organizations as well as institutional care umbrella organizations favoured in broad outlines Nota 2000, but were sceptical about the elaboration of it and so they were not concerned that it would endanger their interests.

Summarizing all this leads to the conclusion that only a small group of interested people to a small extent has been mobilized effectively. This is remarkable when we compare the original data to the theoretical concepts. In the first round the majority of the respondents (on average 27 out of 39) considered health policy to be not unequivocal, socially relevant, of a non-technical nature, of temporal relevance and without any precedents. Moreover, a lot of attention has been paid to the Nota 2000 by the media, although not many metaphors have been used ('Nota 2000 wicked dream' was the most prominent metaphor). This is said to be an important instrument for issue expansion. In general the popular media were very objective and moderately optimistic towards the document. In professional journals the problems arising when implementing the policy were being discussed.

Although a majority of the respondents agreed in theory with Nota 2000 they did not think the policy was unconditionally feasible. Table 1 shows the main problems which were identified, related to feasibility of health policy. Most of these problems are not limited to Nota 2000 but address governmental health care infrastructure policies in general.

The structure of health care facilities is thought of as a special barrier for building health policy. We already have indicated that this structure is actually only of a limited importance in building health policy. The problem appears to be the following. Just after the publication of Nota 2000, the Dekker document was published in 1987. This report, called 'Bereidheid tot verandering' ('Willingness to Change') [36], dealt

Table 1. Perceived problems among interest groups in further development of health policy, and actions undertaken to remove these barriers

	N	of which action:
Structure health care system	7	6
Structure governmental bureaucracy	12	5
Conflicting interests	9	4
Financial prerequisites	18	11
General vagueness	10	2
Implementation vagueness	4	3
Lack of political will	16	3
Social incompatibilities	12	5
Other*	7	1
Total	91	52

*As phrased by interviewees: *stupidity of other actors, internal barriers, ideological problems, insufficient capacity*, etc.

*In subsequent research we have found that 'health' is a difficult concept to use in the formulation of a health policy, among individuals, organizations as well as politicians. This finding is reaffirmed in other studies worldwide, Fortin *et al.* [35].

†National Association of Ambulatory Mental Health Care Institutes.

‡National Union of Health Educators.

§National Support Centre for Health Education and Health Promotion.

¶National Mental Health Research Organization.

with a new structure and budgeting of health care facilities. The free market notion should be applied to the delivery, financing and consumption of health care facilities. Respondents in our research population did not understand that one government can first produce an innovative document like Nota 2000 and subsequently overshadow this document with another that deals with the old structure and finance discussion.

'Dekker' was seen as an immediate threat to the interests of the respondents and the attention shifted from Nota 2000 to the Dekker report. As a result Nota 2000 disappeared from the systemic agenda.

With this background in mind it is not strange that respondents were not very willing to employ any action in promoting Nota 2000. This is blamed by them on failing political will, vagueness of the document and trends in society which were not compatible with health policy.

Summarizing:

(1) Nota 2000 was produced by the Ministry of Health and Welfare. This was not a smooth process. From sheer necessity the status of the document was lowered from White Paper to discussion document.
(2) Rightly, the responsible government officials tried another way to get the document respectively on the systemic and the institutional agendas. They used the mobilization model. With carefully chosen stimuli, expansion of the issue was being aimed at.
(3) Firstly they failed due to the character of the issue. It was too vague and it didn't threaten or enhance concrete interests of the groups involved. Lack of political interest for this 'new public health' increased this attitude.
(4) A tactical as well as strategic mistake was made: the Dekker report was not connected to the discussion around Nota 2000 and even the least bit of interest disappeared.
(5) Those who were prepared to commit themselves to Nota 2000 were left alone in the cold, and subsequent activities (like the Core Document which was supposed to establish the implementation framework for Nota 2000 and health policy) from the government were doomed to too small an amount of attention from the interest groups.
(6) Regarding the theoretical scope of the project described some issues may be pointed out. It was found that the theory of agenda-building pays insufficient attention to hierarchies of power among interest groups, and thus does not address organizational behaviour which is the result of *perceived* power relations. The so-called 'iron ring' around the Dutch health care system (where any change seems doomed because no-one feels at liberty to shift positions, just *because* of perceived power relations) could therefore not be taken into account in our theoretical framework. Further, it was remarkable that most respondents perceived the issue of health policy as controversial as the theory would predict, but that this did not have any consequence regarding the status of the issue on systemic as well as institutional agendas. The explanation was found in the concept of 'equivocality'. Apparently issues can be perceived as being *too* vague, and thus not invite any action. There appears to be some sort of 'equivocality-optimum'. Below this optimum point interest groups will not feel that an issue is really at stake, above it the societal discourse will become too vague, diffuse and complex to expect any public pressure to be created. Above, we have already noted that the use of the concept of health may very well obstruct an effective discussion. Quality of life, well-being, or community development might be notions which do create an optimum equivocality for effective agenda-building [35].

DISCUSSION AND CONCLUSIONS

Considering the above it seems the Dutch have missed their chance for building true health policy.

The Core Document, which intended to synthesize Nota 2000 and discussions that had sprung from it, the Dekker recommendations and the general thrusts of governmental policy making, have all been blocked by the publication of a document called "Werken aan Zorgvernieuwing" (Work on Care Renewal) [37], which again emphasizes the structure and finance of health care facilities.

So even though it seems that nothing has changed, parliament recently asked for a continuation of Nota 2000. Other rays of hope can be distinguished. The 1990 Collective Prevention Act as well as the recent Social Revitalization Policy package refer to the Healthy Cities Project as a strong example of innovative action in health policy. As we have already explained this project demonstrates the implementation of health promotion principles and healthy policy at the local level. VNG (Association of Dutch Municipalities) supports this project with concrete activities indicating the notion of healthy policy has not vanished yet, particularly at the local level [38–40]. Dekker and Saan presume to have found an answer to the question how health policy should be further developed [41]. They find that in the traditional Dutch pluralistic society there is no role for central government as an absolute and idiosyncratic policy-maker any more.

Over the past couple of years, subsequent Cabinets have defined the role of national authorities in terms of 'the retreating government', a welfare state in which the national government determines all, is no

longer considered feasible, and under the banner of 'retreating government' a wide range of responsibilities have been given to what is called 'the social partnership'. The Netherlands should become, in this new ideology, a 'caring society' in which institutionalized interest groups should take up roles of policy-making, funding and negotiation.

Fully in line with this new ideology Dekker and Saan propose that the national government can only play two roles in the development of health policy: the supplier of information and comparisons, and the role of guide and coach. Interest groups are supposed to derive legitimacy from these roles in order to develop innovative approaches in health. They will, according to Dekker and Saan, recognize that the social advantages of pursuing health policy will outweigh their own organizational interests. Even stronger, the authors find that giving up part of organizational power bases of these interest groups would be advantageous to them. The results of our inquiry described above do not support this position.

The national government is, as we found in the inquiry, accused by 'the social partnership' of a paralysing indolence. During the discussions around Nota 2000 most interest groups found the general concept of health policy attractive, but urged government to establish a concrete instrumental framework with which respective contributions of organizations could be structured. Government failed in doing this, as we described.

The same behaviour can now be found in the Social Revitalization Programme mentioned above [42]. First the national authorities outline what the general concept is about. Municipalities, primary partners in the Programme, receive the idea with enthusiasm. But when it comes to implementation the rigid ministerial regulatory position, top-heavy bureaucracies and the inabilities for effective interdepartmental cooperation stall any progress toward innovative programmes. In sum: the social partnership is extremely receptive to innovation, but the instrumental preconditions to be set by national government are absent.

The same mechanism is found in the formulation and implementation of health policy. It is not sufficient for a government to supply information and be a guide. Mainly, a government should establish clarity in its policy-making procedures.

Therefore, we have formulated the following recommendations for effective health policy formulation and implementation:

—Government must give material and intangible incentives and rewards to those interest groups who want to commit themselves to health policy under predetermined conditions;
—Communication between government and social partnership, as well as among ministries will have to be improved considerably. Within this communication process it will be essential to work on implementation instruments in a programmatic and pragmatic way;
—Policy must only be proposed when policy-makers have an image of the instruments they can employ to carry out implementation;
—General policy has to be consistent. Conflicting policy programmes have to be avoided. It is not sufficient to achieve clarity *within* the bureaucratic apparatus; our investigation showed the *perception* of policy consistency among interest groups is problematic;
—Traditionally, The Netherlands is a country of negotiation. The wealth of advisory bodies and quasi-autonomous non-governmental organizations does not participate adequately in the process of achieving agreement on issues. This should nevertheless be pursued;
—The image of 'informal circuits' in policy-making should be avoided at all costs;
—Last, but not at all least, government should in its consultation and implementation processes account for the needs, demands and interests of various groups, particularly with regard to their relative power hierarchy. Investing energy and resources in actions to win over the most powerful opposition groups might not be fruitful. Rather, clarity should be achieved with regard to the interests and power base of potential allies, and subsequently the policy platform should be formulated in such a way that these groups will coalesce around the issue at stake. In that respect, the proposed structuring of various publics in concentric circles may be of assistance (for an effective instrument to picture interests and power bases of groups cf. the seminal work by Laumann and Knoke [43]).

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