P44- Puzzling publics in 21st century public health

Shifts in public health governance:
towards pragmatic, inclusive, and capacitating arrangements?

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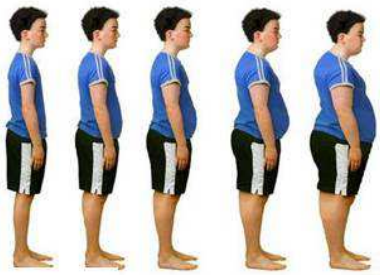

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The rise of public health into 'splendid isolation'

Ever since the beginning of the 20th century, when medical doctors entered the political arena setting the agenda for public health policies and services in order to prevent infectious diseases, the promotion and protection of population health has been a governmental responsibility. National and local public authorities decide upon the goals, means and services operation in disease prevention, health promotion and protection. Different Ministries over the years developed legal regulations settings minimum standards in food production, labour conditions, the production and use of chemical substances, traffic safety, exposure to environmental risks etc. The Ministry of Public Health formulated and delegated responsibilities for disease control and health promotion to public institutions and services with limited room for additional tailored services. Health professionals such as health educators, child and youth health doctors and nurses, and infectious diseases control doctors, for many years were the primary frontline workers carrying out these strict policies in practice.

Public health for decades remained an undisputed governmental responsibility, which was based on the idea of a 'prevention paradox': prevention tasks could not be left to market or citizen initiative, because the return on investment is postponed and benefit recipients rather than investors. Also, citizens do not actively demand prevention unless there is an immediate and urgent outbreak, nor have the means or specialised knowledge to organise it themselves. It provided opportunity for the emergence of an inward oriented sector of increasingly specialised professionals and scientists in epistemic communities that produced strong orientations on procedural requirements, routinised practices, and resistance to change. On the other hand, many innovative policy ideas developed within this realm seem to stumble on decisive moments in agendasetting, implementation, and consolidation.

In this paper, we reconstruct the rise, challenges and transformation of public health governance in the past decades. We describe the gradual change in the scientific, social and political governance conditions, in which the concept of health seems to be shifting so as to fit those conditions. We question whether these shifts actually will induce a public health governance that is more adaptive, more inclusive and more effective. Policy intentions in an early analysis of the Dutch National Prevention Program 'Everything is Health' seem to be subject in a constant struggle with monitoring requirements in the context of a control-based political accountability regime. Does the concept of Experimentalist governance offer a compelling and feasible alternative in the form of a dynamic peer review infrastructure focused on capacitating people, services and government? What will it take? And what kind of research do we need to analyse this adequately?

Pressures on the public health order

Since the 80s the order of public health responsibilities increasingly is under pressure. With the rise of the welfare state and the dominance of the biomedical pespective on health, investments in healthcare services often replaced governments' primary focus to the development and governance of the curative care system. Later on, the 'epidemiological transition' (from infectious diseases

toward the global burden of chronic diseases) caused governments to develop a long term and elderly care system. In the 80s Western governments and WHO were caught by surprise with the outbreak of new infectious diseases such as HIV causing AIDS or BSE causing Kreuzfeldt –Jacob's disease. Today also, outbreaks of Ebola and currently the MERS virus continue to challenge the infectious diseases control systems at national as well as global scales.

Additional challenges occur in the emergence of chronic diseases in which lifestyle and behaviour are important drivers or 'determinants'. Overweight and obesity in the 90s and early 2000s were contested as being the consequence of individual autonomous choices in lifestyle. Yet the scientific evidence, uncovering bits and pieces of the complex causal chain in which obesity is considered both a cause and an effect, indicates that personal lifestyle may very well activate individual risk genes or risk factors in the direct social or physical environments that are outside the individual control of citizens. Moreover, people with obesity not all become severely ill or disabled, even though these disease patterns have been identified in populations. These obesity and diseasepatterns also describe an increase in health disparities among different socioeconomic groups. These and other scientific studies and innovations induced the rise of personalised medicine with individual screening tests, total body scans and personalised medical treatments.

Scientific discoveries implicated that legal standards in health protection, and legal tasks in health promotion and disease prevention needed adjustment. But scientific evidence also made clear the complicated relationships between individual genes, lifestyles and environment, implicating that we increasingly learn about what we do not know. We increasingly know how strategic uncertainties are unavoidable and persistent. For instance: the reach of infectious diseases control was limited due to the increased global transport, migration and logistics patterns, yet, coordination is severely hampered by the lack of a supranational mandate.

Under the influence of the rise in welfare benefits, individualisation and technological progress, social behavioural norms slowly shifted from strong single group orientations to multiple individualised identities. 'Old school health education' by their paternalistic approach failed to connect effectvely to the new generation of citizens expressing their various new identities through their personal lifestyles. In disease prevention and control , vested institutions such as the national vaccination program or population cancer screening , despite past successes, are increasingly questioned because their dominantly evidence-based orientation and organisation of interventions fall short in addressing the personal values and experiences of citizens. The2009 vaccination campaign among 12-15 year-old girls agains Humane Papilloma Virus causing cervical cancer, for instance, in the Netherlands thus turned out to have much lower participation rates than expected: 49% against the expected 95%. One inportant factor here was the fact that HPV is sexually transmitted, causing a highly normative discussion between parents and young girls deciding on whether or whether not to attend the vaccination campaign. Another factor unaccounted for beforehand was the fact that these girls started heated discussions on social media and the internet that often lacked any scientific grounding but nevertheless caused many girls deciding against vaccination. The professional expertise of the national centre for Infectious Disease Control relied solely on countering these arguments with scientific evidence, disregarding the scientific uncertainties involved and explicitly turning down the worries and emotions of the targeted groups and failing to motivate them effectively to participate.

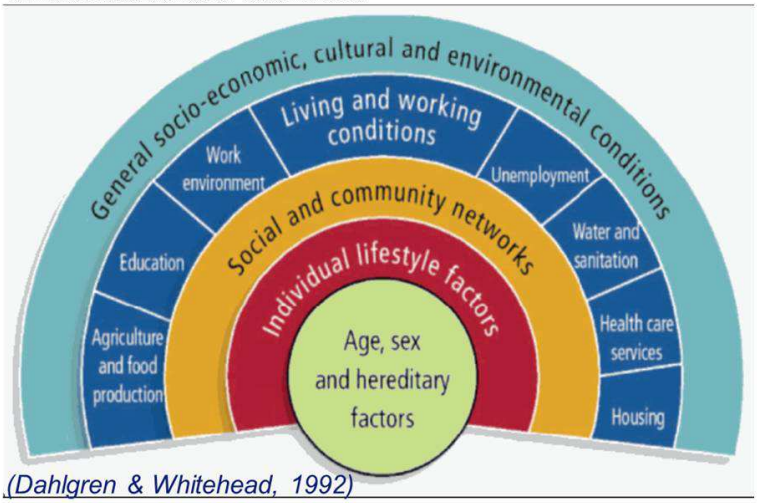
Thus put briefly, no one in or outised the health sector has the panoramic overview that helps to predict when and where new problems and challenges will arise. Under such developments the role of government and the dominance of unilateral and blueprint public health governance is questioned. The public health system has become inadequate in early detecting and effectively managing these new challenges, and there is a generally felt lack of room for innovation in the public health sector. Many successful innovations depend mostly on temporary project subsidies and there hardly is room to adapt and absorb them into the operational procedures, structures and routines. It has badly affected the sector's reputation in relation to other medical specialties in curative care.

Nevertheless, inside the public health sector some powerful, but hardly effective policy innovations were developed such as the horizontalisation of coordination in, first, intersectoral policies within government ('healthy public policy' and 'Health-in-All-Policies', 'Whole of Government'), and later, voluntary agreements, public-private partnerships, covenants and other arrangements for horizontal coordination of public health in society ('Whole of Society').

Towards a 'Whole-of-Society' approach

While the 20th Century saw accelerated human and economic development around the world, it also gave birth to new health problems (pandemics) that could not be dealt with in a (cost-) effective way within the narrow domains of healthcare and medical care. Solving these problems means to include all physical and social determinants of health as possible targets for intervention. The challenge for public health policies is to identify and coordinate the fragmented and dispersed health initiatives of a large number of different public and private stakeholders, who often have conflicting goals, values and priorities in the face of scarce economic resources and for whom the positive and negative health effects of their actions are often only externalities of their primary motives, goals and strategies (Dubé et al., 2014: 1). The need for a more comprehensive (multi- or intersectoral) approach towards health was already acknowledged in the 1978 WHO "Health for All" declaration of Alma-Ata and in the 1986 Ottawa Charter for Health Promotion. In 1977, the WHO had launched its campaign 'Health for all in the year 2000' as a means of urging governments to adopt measurable health targets (the WHO identified 38 targets) and to align their policies with these targets. A pioneering document in this respect was authored by the Canadian Minister of Public Health, Lalonde, which gave a new impulse to public health policy, not only in Canada but also in many other countries including the Netherlands (Lalonde, 1974). The 'Lalonde model' stated that the health status of the population could be conceived of as the outcome of three determinants: endogenous (hereditary or acquired disorders), exogenous (life-style and the physical and social environment), and care and prevention (which can in turn affect the endogenous and exogenous determinants).

Rainbow model of Health determinants



(Dahlgren & Whitehead, 1992)

In the Ottawa Charter, health promotion was defined as "*the process of enabling people to increase control over, and to improve, their health*." Health promotion should be the responsibility of all actors and sectors affecting health. Until around 2006, the efforts focused mainly on sectors mainly, labeled 'intersectoral policies', or 'healthy public policy'. This so-called 'Whole-of-Government' approach then transformed into a 'Whole-of-Society' approach, such as Health in All Policies (HiAP). *Health in All Policies* (HiAP) aims to be a comprehensive policy-strategy that complements prevention and health promotion programs and projects by focusing explicitly on the non-health domains (outside medical care and healthcare) in order to include all physical and social determinants of health as possible targets for intervention. The 'Health-in-All-Policies' strategy (HiAP) was introduced by the Finnish government during its EU Presidency in 2006 (Puska and Stahl, 2010), but its origins can be traced back to a couple of successful pioneering projects and programs developed in the early 1970s in Finland in which a so-called socio-environmental (or ecological) approach was developed towards determinants of population health. Already in 1972, Finland had started to experiment with prevention policies for cardiovascular diseases in a comprehensive way (the North Karelia project). Although its analytical and scientific roots were in public health sciences and epidemiology, with a clear focus on population health instead of individual level determinants, the intervention strategies that were developed in mainly had their origins in the social sciences disciplines (from marketing and psychology to communication science, social policy sciences and political science) and targeted at the nonhealth domains of agriculture and commerce (Dubé et al., 2014: 202). Another feature of the program that helped to make it successful was that from its start, the project was monitored and evaluated in a systematic way by the National Public Health Institute (KTL), which worked closely with the Finnish Ministry of Social Affairs and Health. After successful evaluations of the initial five-year period of the North Karelia pilot, the prevention program has been scaled up to the national level and towards other diseases. The evaluation system has evolved into a national monitoring system for chronic disease prevention and health promotion (Puska and Stahl, 2010: 317).

HiAP has been brought to the European agenda by the Finnish government during her EU presidency in 2006 and has been adopted by the United Nations General Assembly in 2011 (where HiAP was brought in relation to the Millennium Development Goals) and in the 2010 Adelaide Statement on Health in All Policies (WHO, Government of South Australia, 2010). Yet, despite the fact that HiAP has

become a sensitizing policy-image in a relatively small time, and that the call for a multisectoral approach towards health has a longstanding tradition, it has proven to be difficult to overcome the fragmented sectoralized bias of governance. HiAP programs or projects often result in the trade-off between a systematic and integrated approach towards health and its determinants and vertical disease oriented approaches (Kickbusch, 2010: 262). This bias towards disease oriented approaches also has to do with the disciplinary roots of HiAP in clinical epidemiology and the modern disease management approaches towards health. HiAP therefore remains primarily focused on the negative impact of other policies and activities on health (negative external effects), relying mainly on instruments such as health impact assessment (HIA) and policy briefings. What was missing in the adoption and diffusion of HiAP in other contexts was an understanding of the governance consequences and the contextual conditions at the micro and meso-level of such a more comprehensive health policy strategy, despite the fact that the success cases of HiAP (in particular the North Karelia project) were especially innovative in these enabling governance infrastructures.

The 2010 WHO 'Adelaide Statement on Health in All Policies' brought HiAP a bit further by recognizing the importance of establishing enabling governance infrastructures for comprehensive health policy approaches. With its plea for 'shared governance' or 'joined-up' governance, the WHO not only reflected on how the negative impacts on health of activities in other sectors could be assessed and mitigated, or on how these other sectors could contribute to health promotion in a positive way, but also on how health contributes to the goals of other sectors. By doing so, reciprocity was brought into the interrelatedness between health and its determinants. Good health not only is a value in itself, but it also instrumental to other values, including 'quality of life', more productive labour forces, increased capacities for learning, strengthened families and communities, supported sustainable habitats and environments. Promoting good health, and supporting health as a capacity to self-manage and adapt to changing circumstances, should be seen as a means that contributes to security, poverty reduction and social inclusion. Health promotion should be aimed at enabling people to meet these conditions in pursuance of improving overall health. By doing so, the Adelaide Statement outlined the need for what was called a new 'social contract' between all sectors to advance human development, sustainability and equity, *as well as* to improve health outcomes.[1] In other words, health not only is a primary end but also a principal means (Sen, 1999).

By referring to a new social contract, moreover, a clear link was made between the different institutionalized spheres of authority within societies: communities, markets, states and the more organized civil societal sphere. Such a social contract, on its turn, could only be created in partnerships between governments and civil society. The governance approach that has evolved out of this search for a new social contract has become known by the twins concepts 'Whole-of-Government' (WoG) and 'Whole-of-Society' (WoS). WoG is about the need to horizontalize government and to depart from traditional departementalism and vertical silos within government. WoS goes further and aims at engaging cross-sectoral public authorities and service providers as well as civil society organisations and commercial and industrial enterprises, into programs for increasing (a) awareness, (b) coordinated multi-stakeholder initiative, and (c) health impact (Dubé et al., 2014: 204). Whereas WoG remains primarily focused on the government and its internal organization and structures, the shift to WoS is based on seeing health systems as being part of the overarching social, economic and political systems, at different levels and on different scales. In the interface between

[1] Adelaide Statement on Health in All Policies, WHO, Government of South Australia, Adelaide 2010.

government and civil society, the health sector should then be responsible for creating the platforms needed for cross-sectoral dialogues, policy innovations and cross-sectoral problem solving. Special reference was made to the need for clear mandates, mediation procedures, and accountability, transparency and participatory mechanisms, as well as the need to encourage experimentation and to pool intellectual resources, by means of systematic monitoring and feedback mechanisms.

An example is the Dutch Covenant on Overweight that was agreed by the Ministry of Public Health and food and sports associations, care insurers, business and employer associations and a labour Union, in 2005. Under the influence of a liberal Minister of Public Health, the call for strict legal regulation of obesity risks was effectively reframed toward this public-private agreement aimed at promoting public awareness, developing self-regulation among the partners as representatives in their respective sectors, and in turn promote partners' reputation as socially responsible corporations. Within this agreement it is unclear how public health representatives are involved and facilitated to provide feedback and influence the outcomes of self-regulation. Examples of self regulation are the Advertisement Code on Food products limiting 'kids marketing'(2005, and adjusted in 2015), and the Agreement on Improving the composition of Food Products (2014). These examples are publicly criticised by organised public interests such as the Consumers Association, and organised scientific expertise in the Scientific Council for Government Policies (WRR): agreements are formulated in such ways that primary production chains remain intact, and facilitate detours, eg. Replacing tv ads by internet and social media strategies.

Thus, it remains to be seen whether such initiatives provide adequate responses to the new public health challenges and the increased scientific and professional pressures for policy interventions, and under which conditions these can be rendered effective?.

In the remainder of this paper we will describe a number of developments that form partial explanations of pieces of the governance puzzle towards effective, inclusive and capacitating arrangements. Firstly we go back to the concept of health, how it has evolved over the decades and how it might facilitate or hinder a new social order of responsibilities for health. Such transitions in social thinking about health may also induce institutional transitions in public health ordering, performance and accountability regimes. Experimentalist governance may facilitate an infrastructure in which the goals, means, and performance conditions are renegotiated locally and in second instance at system level. We present an early example of enabling conditions in the Dutch National Prevention Program 'Everything is Health', exploring the opportunities and threats for experimentalist governance and the 'health-as-a-capacity' approach.

Towards a new conceptualisation of health

Determined not to allow for the atrocities of WWII to emerge ever again, health came to be defined as "*a state of complete physical, mental and social wellbeing, and not merely the absence of disease*

or infirmity" (WHO, 1948).[2] A definition that was groundbreaking in 1948, especially since acute diseases presented the main burden of illness at that time. But the WHO definition also contributed – unintentionally - to the further medicalization of society (Huber, 2014: 47). Medical care has become a never ending story of new treatments and screening technologies and it has practically become impossible to operationalize and measure 'complete' health. By emphasizing *complete health* as the 'gold standard', it opened the door for more and more screening and treatments and since access to these should be on an equitable base, the threshold for access to new screening technologies and interventions was lowered considerably.

As explained by Huber et al., (2014, 2011), the WHO definition of 1948 was helpful when the main burden of disease was illness caused by acute diseases (cardiac and vascular diseases and cancer). But for dealing with chronic diseases and co-morbity, the main burden of illness in our time, the WHO definition is not very helpful. Investments in medical curative treatments and screening technologies have crowded out investments in 'capacitating' services that enable citizens to acquire the skills needed to deal with their health. Not only to make 'healthy' choices but also to be able to deal with their chronic 'health problems' in a more healthy and productive way. Based on a literature review and deliberative consultations with 38 international health experts, Huber et al. In 2011 suggested an alternative conceptualisation for health. Instead of health being '*a state of complete physical, mental and social wellbeing'* the authors suggest to conceptualise health as: "*The capacity to adapt and self-manage when dealing with the social, physical and mental challenges in the life course.*" (Huber, 2014; Huber et al., 2011). In contrast to the absolute and static WHO definition, this definition is both dynamic and situational in the sense that it emphasizes health as being a dynamic balance between opportunities and limitations, shifting through life and affected by external conditions such as social and environmental challenges. By successfully adapting to an illness, people not only feel better, but they are also able to work or to participate in social activities and feel healthy despite limitations. Finally, it opens up new areas for investments and interventions (outside the medical sector) that may contribute in a positive way to our health but that our currently not recognized for this.

The new 'health-as-a-capacity' also appeals to the 'salutogenesis' approach as an alternative order to the pathogenetic medical system. In salutogenesis (Antonovsky, 1979, based on psychotherapy practices) professionals and services tap into the individual and collective resources in identity groups and society at large in order to mobilize a temporary support system during life challenges such as illness, unemployment or other traumata. This approach seems promising, but its consequences are unknown and surrounded with much strategic uncertainty. Faced with an ageing population and chronically ill patients, healthcare systems that were initially designed to respond to acute, episodic illness, increasingly need to care for patients with ongoing conditions in their home situation, where the goals include preventing complications, rather than clinical treatment. An ageing population not only demands other types of care, but probably also other types of housing and supporting social and community care. The growing difficulties that people have need to reconcile work and family life (including informal care) also has consequences for the need for child care services.

[2] Preamble to the Constitution of the World Health Organization as adopted by the International Health Conference, New York, 19-22 June, 1946; signed on 22 July 1946 by the representatives of 61 States (Official Records of the World Health Organization, no. 2, p. 100) and entered into force on 7 April 1948.

In order to successfully to bring this new concept on health towards health policy (and its stakeholders), deliberative consultations with health experts alone will not suffer. In the words of Huber et al.: "*Redefining health is an ambitious and complex goal; many aspects need to be considered, many stakeholders consulted, and many cultures reflected, and it must also take into account future scientific and technological advances.*" (Huber et al., 2011). The question is, how and to what extent (and in what ways) can this new concept on health be further developed *within* a policy-making context? According to Weir (1992: 169), there are two distinct ways in which conceptual ideas are useful in accounts of policy making. The first way is captured by the concept of a 'public philosophy', expressing broad concepts that are tied to values and moral principles and that can be represented in political debate in symbols and rhetoric. A second usage of the term 'idea' refers to a more programmatic set of statements about cause-and-effect relationships and the framing of perceptions of the actors involved and the broader public. Public philosophies play a central role in organizing politics, but without ties to programmatic ideas or without any reference to (public) administration, their influence is difficult to sustain in the sense that they may be politically strong but technically impotent.

Towards a new social order in health?

In contrast to the former WHO definition, the health-as-a-capacity approach has more potential to align the domains of public health and medical care with other domains of the welfare state and other models for solidarity (Bekker, 2014). Although its exact meaning is open to debate, one can found many examples in contemporary social policy discourses, in various contexts, that emphasize the importance of investing more in citizen's capacities to adapt and self-manage, instead of relying on curative treatments (repair) and insurance. Health-as-a-capacity opens the door for 'capacitating services' that support people in managing their health and life more effectively. In the European context, it has affinity with the 'social investment state' approach or related concepts (such as, social development, the social developmental welfare state, the enabling state, inclusive liberalism), all introduced in the 1990s and 2000s and aimed at reconciling social policy goals with economic goals in the EU (Morel, Palier and Palme, 2012). On a more philosophical level, there is a link to the capability approach and a more pragmatist approach towards health and its determinants.

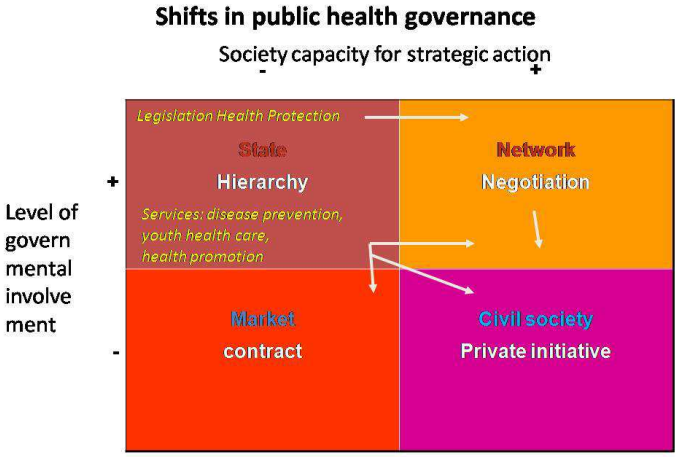
To be sure, many of these affiliated concepts and ideas are contested on their own account (think of the skepticism surrounding the participation society or the big society). Health as a capacity to self-manage is in many ways surrounded with ambiguity and ambivalence, its socio-political and policy consequences can hardly be overseen yet. It also reflects the continuous struggle over what the government's role in relation to health should be, that is, what is the 'public' dimension of health? The past decades have brought new forms of governance and new interactions between public and private actors, and novel collective bargaining arrangements. In the process, the classical distinction between state, markets and families and individual choice, obligations and responsibilities, have become ever more blurred. In addition, new forms of welfare provision have been established that go beyond the traditional territorial boundaries of the nation-state, both via downward devolution of competencies to local governments, and through upward movement toward EU-level regulation, coordination, and other forms of trans-national social policy agenda-setting.

Policy makers normally work within an established framework of ideas and standards that specify not only their values, goals and instruments, but also the very nature of the problems that they are meant to address. These cognitive and normative frameworks, Hall argues, can be conceived of as policy *paradigms*, quite similar to Kuhn's scientific paradigms (Hall, 1993). Following Kuhn, Hall maintains that the movement from one paradigm to another is likely to involve the accumulation of anomalies, policy failures and policy experiments that precipitate a paradigm shift. Third order changes, moreover, are likely to be accompanied by shifts in the balance of power towards those policy actors capable of acting on 'windows of opportunity' to impose a new policy paradigm. Issues of political authority are likely to be central to the process of third order changes. However, an overemphasis on scientific analogy contradicts basic assumptions of democratic politics about legitimate conflicts, citizens' participation and representation, free public discussions of ends and identities as well as means, and the primacy of popular sovereignty in the event of conflict. Pure paradigms are dangerous traps in politics and policy. Rather, human agents are looking for hybrids in order to combine the best of both (Sabel, 1995: 10).

The more complex dynamics of social and economic policy transformation are better captured by the concept of *welfare recalibration* (Ferrera, Hemerijck and Rhodes, 2000; Hemerijck, 2012). Welfare recalibration is based on an explicit recognition that welfare states are multidimensional policy systems, made up of interdependent social and economic policy repertoires. *Functional recalibration* concerns the changing cognitive identification and diagnosis of the social risks against which the welfare state aspires to protect (Esping-Andersen et al, 2002; Taylor-Gooby, 2004; Bonoli, 2005; 2006). Functional recalibration is mediated and diffused by expert knowledge from international organizations (such as the WHO) or academic communities that contribute to a de-politicization of salient social policy issues, in an attempt to overcome normative and interest conflicts. The work that Huber and colleagues have done on the new definition of health, is an example of this. *Normative recalibration* involves the changing normative orientations underpinning these functional ideas and accompanying policies, including their definition of what is supposed to be 'good' health. *Distributive recalibration* concerns the re-balancing of provisions and entitlements across the different policy beneficiaries. *Institutional recalibration*, finally, concerns the institutional reforms that come along with this: the assignment of roles and responsibilities, levels of decision-making, and the responsibilities of states, markets, communities, families, and interest associations. Reconciling the deep-seated norms, values and behaviors with the new challenges of the post-industrial welfare state, therefore, can only be done in a painstakingly slow process of learning-by-doing and it is only through a long-term process-tracing analysis that we are able to gauge the broad direction of incremental, cumulative, reforms across interdependent policy domains (Hemerijck, 2012).

It is at this point that a re-turn to Pragmatism is required. We should start with acknowledging that health systems (including the subsystems of healthcare and medical care) can best be conceived of as polycentric systems (Addy et al., 2014; Dubé et al., 2014). Polycentricism refers to multiple leveled social systems that have many decision centers, each of these decision centers having limited and autonomous prerogatives, operating under an overarching set of rules (Aligica and Tarko, 2012). Polycentric governance thus allows for the coexistence of multiple centers of decision making with different objectives and values, which sets up the stage for an evolutionary competition between the complementary ideas and methods of those different decision centers, and their agents, linked by externalities. Polycentricity refers to a spontaneous self-organizing and self-correcting order under an overarching set of rules. Hence, operational rules are embedded in collective choice rules, which

are embedded in constitutional rules, which are embedded on their turn in meta-constitutional rules. In the words of Elinor Ostrom: "*What is a whole system at one level is part of a system at another level … Consequently; the institutional analyst faces a major challenge in identifying the appropriate level of analysis relevant to addressing a particular puzzle and learning an appropriate language for understanding at least that focal level and one or two levels above and below that focal level.*" (E. Ostrom, 2005: 11-12). The final system's dynamic behavior at any scale, is the product of the events taking place on all scales.



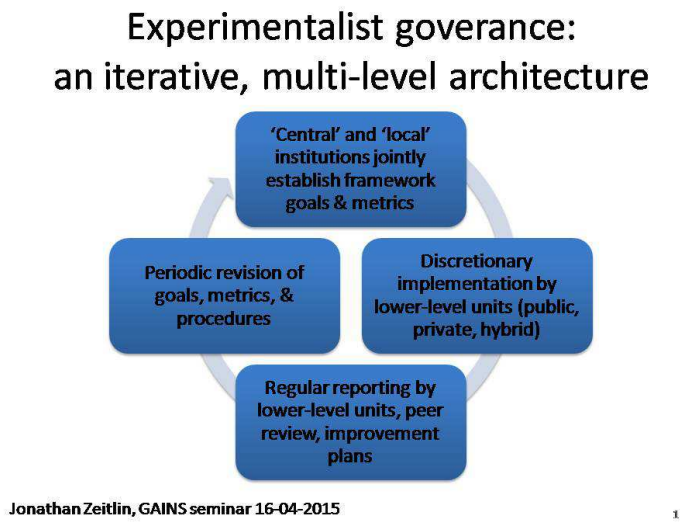
Polycentric governance views individuals, states, markets and communities, forming a civil society, as part of the same complex adaptive system. Actors within such systems self-organize into *nested hierarchies* that operate at multiple scales (from the local to the global), within multiple institutional configurations, so that single and collective efforts to maintain or transform the status quo determine both single and system level outcomes (Dubé et al., 2014: 202). The reference to nested hierarchies should not be mistakenly interpreted for a state top-down hierarchical authoritian perspective on policy making. Hierarchies in polycentric systems evolve from the lowest level up, as the systems learn and adapt, and the purpose of a nested hierarchy is to help lower level subsystems to perform better (Ibid.: 208). Hierarchy is in place to balance (rather than impose) the welfare, freedoms, and responsibilities of the subsystems and the overarching system. Such a perspective departs from the typical macro level focus of institutional theories by acknowledging that institutions essentially have their roots in micro-level human decision making and action (E. Ostrom, 1998), highlighting the importance of trust, reciprocity and reputation as the primary drivers of collective action. Individuals are not only empathic, but they are also able to craft and learn from norms and rules in collaboration with others.[3] This not to say that competition and hostile relations do not exist, but it does say that with a certain amount of trust and reciprocity, individuals do care about their reputation, and these drivers help them to overcome the temptations of short-term self interest. It also points to the importance of giving individuals the right to self-organize and to devise their own

[3] At the core of the behavioral explanation that underlies this modified theory of collective action are the links between the trust that individuals have in others, the investment others make in trustworthy reputations and the probability that participants will use reciprocity norms. Levels of trust, reciprocity, and reputations for being trustworthy, are on their turn, positively reinforcing mechanisms. That is, if initial levels of cooperation are moderately high, then individuals may learn to trust one another, and more individuals may adapt reciprocity norms. When more individuals use reciprocity norms, gaining a reputation for trustworthy is a better investment (E. Ostrom, 1998).

rules and supporting institutions. Individuals should be free not only to play the game and to self-enforce the rules of the game, but also to change those rules in an orderly way.

Towards experimentalist governance

It is at this point that a pragmatist governance may be of help. In experimentalist governance regimes, discretion is given to 'local units' to pursue generally declared policy goals in ways that fit to local circumstances. The 'center' then monitors local performance, pools information in disciplined comparisons, and creates pressures and opportunities for continuous improvement at all levels. With its emphasis on learning and adaptation, experimentalist governance regimes aim to stimulate and organize deliberative engagement among officials and stakeholders (Sabel and Simon, 2011). Conditions for experimentalist governance; a) joint framework of goals and metrics; b) decentralization and discretionary implementation; c) local reporting, peer review and improvement; and d) periodic revision of goals, metrics and procedures.



In the realm of cognitive and normative uncertainty, policy aims and the best ways to achieve them, have to be discovered in the course of problem solving. Inquiry (or recursive learning) is the term that fits best with this approach. Inquiry requires the voluntary cooperation between actors using a series of jointly-agreed tools - objectives, guidelines, indicators, benchmarks and good practices – to improve policies at national and regional levels. Experimentalist governance makes full use of the differences in cognitive and normative orientations and interaction modes in order to increase responsiveness and legitimacy (Sabel, 1993, 2004; Sabel & Zeitlin, 2008, 2012). Essentially, experimentalist governance goes beyond a temporary experiment as it focuses on the institutional consolidation of those arrangements that promote the confrontation of differences. '[R]egulation (…) increasingly takes the novel form of contestable rules to be understood as rebuttable guides to action even when they are also taken as enforceable sovereign commands.' (Sabel & Zeitlin, 2008: 275). In the process of multi-actor deliberation, new forms of accountability emerge that are more consistent with the adaptive character of goals, requirements and procedures. Such dynamic accountability anticipates the transformation of rules in use. 'Accountable behaviour in this setting

no longer is a matter of compliance with a rule set down by the [unilateral] principal (…), but rather provision of a good explanation for choosing, in the light of fresh knowledge, one way of advancing a common, albeit somewhat indeterminate project' (ibid: 305). By allowing uncertainty; rather than reducing problems to one set of relations, it acknowledges the multiplicity of practices, and builds on this to allow multiple problem framings and recursive learning.

We now turn to an example of a policy program that may have the potential to develop such experimentalist conditions for early health problem detection, cross-domain problem solving, and a true and sustained health impact.

The Dutch National Prevention Program "Everything is Health"

Above, we have highlighted how at the global and the European level, public health has been reframed from a 'Health for All' perspective towards the more policy-oriented HiAP approach and how health came to be incorporated at the European level in its social investment perspective and Horizon2020 program. We have also touched upon how these more comprehensive approaches towards health require governments to think of new governance strategies. The strategic uncertainty inherent in such a governance approach urges policymakers to call for robust evaluation, assessing impacts as well as guiding the developmental process. These programs pose specific challenges to evaluation as they consist of complex configurations of varying interventions at different levels, by multiple actors, with diverse objects and subjects at the same time. To that end, the WHO has embraced the WoG/WoS approach whereas in the EU, the OMC and the European Semester are the main governance infrastructures (although the Innovation Partnership perhaps comes most close to a European WoS approach). But in the end, it all comes down to the levels where it really makes sense to speak of a 'Whole of Society' approach, that is, where the tradeoffs between equity, quality and costs (and between investments and insurances) have to be made.

An example of such a new governance arrangement in the Netherlands is the National Prevention Program 'Everything is Health' in the Netherlands (2014-2016). The governance approach fits wider societal developments reorganizing responsibilities through (corporate) social entrepreneurship and the new welfare state. The NPP-Health aims to link up existing and new initiatives thus increasing impact. Through this program, the government calls upon societal partners to engage themselves in a 'social movement for a healthier and more vital Netherlands'. It aims to bring coordination to a fragmented health promotion field in which it is hardly detectable whether efforts are effective and collective means are invested efficiently. Six Ministries are involved in the program, which resulted from a one-year consultation process with a broad representation of interests in Dutch society.

Long term health goals have been established to guide consolidation after the program has ended. By 2030, the main health trends in smoking, alcohol abuse, obesity, depression and physical exercise must at least be halted or reduced, and the growing health disparities must be countered. The program is categorized in four settings: school, work, living neighborhood, healthcare, and separate attention is paid to health protection. More specific goals and objectives are to be formulated by the pledgeholders themselves. Currently it is unclear whether that actually is done, pledges are hardly monitorable. The cabinet positions the government as a partner equal to all other 'pledgeholders' in

the network and delegates the coordination of the program to a small Program Office located in Amersfoort, at a distance of the political centre of government. The Office consists of two Ministry appointed officers and four part-time accountholders for the four domains identified. Each of these accountholders was selected based on broad administrative experience and a huge network in the domain. There are two part-time co-workers made available by organizations involved such as care insurers. Other arrangements are the partner platform of representatives that is aimed at sharing and learning from experience ; a number of ambassadors among the Dutch celebrities in sports, architecture (healthy urbanism), social entrepreneurship. There are regular meetings and an annual conference presenting the pledges and their progress. According to the Program Office co-workers, the NPP mainly consists of a marketing strategy with extensive use of social media such as Twitter, and making publicly visible the contributions of partners and offering opportunities for networking. Partners seem to engage themselves mainly based on these motivations. Currently government (and the Program Office) seem to be very careful not to put standard criteria on pledge formation, implementation and progress reports in order to position government as equal to the other partners, and in order to attract as many partners as possible.

Partner commitment to the program manifests itself in a 'pledge': 'a public statement by which an organization expresses commitment and an active contribution to the realization of the NPP-Health goals by conducting specific focused activities.' Currently there are about 180 pledges signed by over 600 organizations, mainly in the domains of healthcare and neighborhood. There are as of yet mostly single-party pledges, which means that cross-domain pledges are not yet developed although that is one of the ambitions. Also many of the pledges currently involve already existing activities, and there is a clear indication and recognition that the focus on pledge formation should now shift from quantity and creating a 'critical mass' to quality and progress. Responsibilities are kept decentral, making partners account for their activities among themselves in a dynamic and horizontal review: 'Each partner is responsible for the activities and results in their own domain, can be peer reviewed by other partners, and will be publicly held accountable'.

The voluntary basis and horizontal peer review imply that new forms of governance and accountability will have to be developed among the partners themselves. As of yet it seems to be too early to put this ambition into practice, activities remain limited to the implementation f the pledge rather than sharing experience across pledges. There are, however, three different monitoring trajectories set out by the Dutch organization of Health Research and Innovation ZonMw. There is a small quantitative monitoring trajectory focusing mainly on process indicators (no.'s of pledges, partners, activities, etc); a qualitative organizational and governance evaluation trajectory- in which we are involved-; and an evaluation trajectory of implementation and health outcomes in nine specific pledges. There are also indications that the dominant governmental culture of control and supervision in the context of political accountability places tension on the realization of the trust-based principles and strategies underlying the program. Preliminary conclusions then consist of the presence of potential enablers of a shift in public health governance towards 'whole of society' under experimentalist conditions, although much work is yet to be done to actually implement and realize the potential of those enablers.

The NPP as an arrangement for experimentalist governance?

In the perspective of experimentalist governance, the NPP may be considered an 'enabling, capacitating service' in the new welfare state. In the old welfare state, social insurance no longer provides a sustainable solution to health and income risks because the recipients now are structurally rather than temporarily dependent. In the new welfare state, there is a renewed focus on the prevention of risk, and insurance is replaced by an integrated bundling of tailored services. These enable recipients to anticipate and adjust more flexibly to the structural risks of unemployment, disease and age. The NPP offers opportunity to collect and share knowledge and experience on how citizens, consumers and employees deal with these risks, where and when they are in need of support, what Works and what doesn't, and how the groups most at risk, such as care avoiders, can be effectively reached. This king of knowledge could help municipalities design the operations and services of the new integrated neighbourhood teams, and how they can be adjusted to changing circumstances and user experiences. Health is merely one of the components. The NPP may serve as an arrangement for coordination, learning and revision by all parties involved who have a stake in healthy functioning students, clients or employees.

The NPP harbours a number of experimentalist conditions: Polycentrism; a global level of ambitions guiding action; a 'decentralisation' of responsibilities or in this case: a 'public-ation' or collectivisation of private initiatives; and a requirement committing to transparent monitoring and peer review in order to account for practices and cosequences in a dynamic way. As said, early observations however do not indicate (yet) the actual development of, and compliance to these conditions into an experimentalist infrastructure. As of yet there is no evidence of an adaptive process, systematically learning from user feedback and experiences and jointly accounting for performance.

That leaves us with one remaining question on the NPP potential to engage new publics? The literature on experimentalist governance also refers to the potential of 'democratic experimentalism' (Sabel, 2012). The deliberative infrastructure and the adpative character of service provision could create conditions for the emergence of new publics, or the emancipation of old ones. That would shed more light onto the value orientations and needs of these relatively unknown groups. We have not yet come across empirical desciptions of this part of the theory. Still, in the rise of a new concept of health that touches upon the experiences of exactly these groups there may be opportunities to empirically follow the course of this new concept in NPP practice. Several pledges have been signed committing partners to the dissemination and consolidation of the concept in working practices of preventive and primairy care providers and care insurers. We will engage in a qualitative monitoring of a selection of pledges in the Fall of 2015. Does, and in what ways does this concept of health succeed in opening the door to new groups in the deliberation on what health means to different groups in society, and how this appeals to group participation in an inclusive manner?

Experimentalist public health governance: a research agenda

This theoretical perspective on experiment governance leads to a number of research questions in analysing practicesand shifts of public health governance:

1. To what extent are responsibilities actually decentralised?

2. To what extent does the national framework of ambitions and priorities provide actual guidance in practices?

3. To what extent and how do arrangements for knowledge sharing and peer review actually take shape in practice?

4. Does the national government succeed in staying clear from governance incentives that are contradictory to developing social and private responsibilities in health?

5. Which institutional bottlenecks are identified in practice, and how are these addressed?

6. To what extent are all stakeholders involved or represented in the deliberative arrangements for public health policies? Both nationally and locally?

7. To what extent does governance practice lead to knowledge about the resources of social institutions and private businesses that Carry out policies, and about citizens as co-producers of their own health and the health of those in direct surroundings?

8. To what extent are citizen(s) representatives involved in the deliberations?

9. To what extent does that lead to adjustments and revisions in behaviour and the utilisation of those resources by the targeted groups?

10. To what extent does this knowledge lead to rendering pillarised services into integrated bundles of tailored services in support of citizens capacitating them to flexibly deal with life challenges?

11. To what extent does this knowledge lead to a bottom up feedback flow from user groups and service providers to put obstructive regulations and structures on the political-administrative agenda?

Research should also encompass the normative dimensions of public health governance (Green, 2014):

1. Analyse both affect and effect in different stakeholder groups
2. Analyse the streams, relationships and linkages between interventions and context instead of artificially separating them
3. Focus on process and structure in order to find out whether structural relationships between different groups are actually reproduced rather than revised.
4. Which goals or outputs are favoured over others? 'There is room for open explorations of the range of well-beings that are produced, reduced, modified, legitimated, permitted or forbidden by interventions.' (Green,)
5. The ethical dimension: 'If we are mapping all the well-being consequences of an intervention, what are the ethical limits to fostering one kind [of intervention] over another or one group's autonomy over that of another?'

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