Academic collaborative centres for health promotion in the Netherlands: building bridges between research, policy and practice

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A logical and promising next step for the development of an effective infrastructure for health promotion in the Netherlands are Academic Collaborative Centres (ACCs). Their aims are to bridge the gap between research, policy and practice; make better use of available knowledge and strengthen the evidence base for health promotion practice. To understand their position, they must be seen in light of the strong growth in health promotion in the Netherlands. Since the 1970s, the emphasis in health promotion has shifted from simple unidimensional interventions to much more comprehensive and integrated programmes. Comprehensive research programmes, which explicitly involve actual practice and policy, are also thus called for. These developments are described in this article.

There is considerable and widespread enthusiasm about the establishment of ACCs in the Netherlands. Experiences from the first 5 years of collaboration between research, policy and practice within the ACCs, however, shows research to still have the dominant position. The different groups of stakeholders in the public health infrastructure are also shown to perceive and appreciate the current infrastructure rather differently. These findings are similar to results found in the USA.

The predominance of research has recently led the Netherlands Organization for Health Research and Development (ZonMw) to impose stricter criteria and guidelines for the funding of such centres. These measures are aimed at eliciting a shift of power from science to practice. They seem to be a promising contribution to bridging the gap between research, policy and practice.

Keywords. Academic collaborative center, health promotion, knowledge infrastructure, research policy and practice.

Introduction

An Academic Collaborative Centre (ACC) is a long-term partnership between public health services and a university. The main purpose of such a centre is to improve the exchange of knowledge between practitioners, policymakers, researchers and the higher education. This article focuses on ACCs for public health with a main focus on health promotion. An ACC provides a means to organize knowledge in such a manner that health promotion research and practice are brought together. ACCs are considered promising for the future and, in this article, we will report on the current position of ACCs within the health promotion infrastructure of the Netherlands and identify challenges currently being faced and challenges for the future.

The problem

Health promotion in the Netherlands is strongly developed both on a national and a local level. There is a central position for the 1200 health promotion specialists who work on a local level and implement a huge variety of programmes. Most of these practitioners have a university degree in social of health sciences. The challenges they face in their daily work concern for instance the implementation of an integrated approach with attention for education, environmental changes and policies; involving and empowering of lower social economical groups; connecting individual and collective prevention programmes and connecting prevention, cure and care. Health promotion specialists are increasingly being expected and required to make use of the latest scientific findings regarding the determinants of health.
and effective interventions to improve it. The reality, however, is that this rarely happens or, if it does, only to a limited extent.\textsuperscript{1,2}

There are a number of reasons for this lack of translation into actual practice. Firstly, there is a tremendous amount of research being conducted, but the research often produces contradictory findings. Secondly, most research findings are published in scientific journals and therefore rarely read by health promotion specialists because practitioners rarely read scientific journals.\textsuperscript{3,4} Thirdly, many practitioners think that research insights are often not relevant to their working environments. Fourthly, issues that arise in public health practice are often not addressed by scientists because scientists consider the issues too general, too diffuse or too difficult to investigate.\textsuperscript{5} The result is a research agenda dominated by scientists with most questions stemming from actual practice simply left unanswered.\textsuperscript{6}

The gap between research and practice is a common problem and may never be closed completely. Scientific knowledge can hardly ever be applied directly to actual practice. For such knowledge to be applied, it must usually be adapted to specific features of the field of practice. And depending on the social and political circumstances, the call to connect research and practice can be quite pressing. There are various means to do this—connect research to practice. Clear examples are University Medical Centres where research, health care and education are approached in an integrated manner.

Description of academic collaborative centres

To promote and reinforce collaboration between scientific institutes and public health services in the Netherlands, the Ministry of Health made 14 million euros available for the establishment of ACCs. This was initially done for a term of 4 years. The Netherlands Organization for Health Research and Development (ZonMw) established then nine ACCs between 2005 and 2009. Among the themes addressed in the centres were youth care, health policy, health promotion and environmental health.\textsuperscript{7} In 2009, the Ministry of Health provided another 16.3 million euros for a second term, which will end in 2013.\textsuperscript{8}

The Netherlands Organization for Health Research and Development formulated five key elements for ACCs to have:

1. a contractual agreement to guarantee long-term partnership between public health services and university;
2. employees with double appointments at a public health service and university;
3. involvement of senior researchers and professors in the centre;
4. research based on questions relevant to everyday public health practice—an important criterion for applicants to receive funding and
5. intention for collaborative centre to continue partnership after second 4-year phase of the programme.

Position of the ACCs within the health promotion infrastructure of the Netherlands

To further clarify the position of the recently established ACC, it is helpful to see it in light of the growth of health promotion in the Netherlands since its emergence 40 years ago. Since then, health promotion has grown considerably.

In Figure 1, the development of health promotion is depicted with regard to the following elements:

1. control and financial responsibility for health promotion;
2. content, approach and focus within the field of health promotion and its infrastructure; and
3. definition of effectiveness and subsequent setting of funding priorities for research and development.

The first two columns in Figure 1 show a gradual shift since the 1970s from the national to the local levels for the control of health promotion. The idea that health promotion policy should be developed at the local political level has gained support over the years. Health promotion has since the 1990 become the responsibility of local governments, which means that the prioritization and distribution of financial resources for purposes of health promotion has also shifted to the local level.

This has led to great inequalities among levels of health promotion in the Netherlands. Some cities have comprehensive health promotion programmes devoted to all or almost all of the most important determinants of health. Other communities have only limited education programmes devoted to only a single health topic, like alcohol. In response to this, the national government has established criteria for health promotion programmes to meet and required local governments to help realize nationally set health goals. For the coming years, the identified goals are: prevention and reduction of obesity, diabetes, smoking, alcohol and depression.

The aforementioned shift of power from the national to the local level was accompanied by the development of the content for health promotion purposes and thus interventions considered most suitable for that. The development from relatively simple interventions such as the distribution of written information in the 1970s to an approach which requires the systematic planning of interventions such as courses and mass-media campaigns
with specific aims in the mid-1980s and 1990s is clear to see. Later in the 1990s, the focus gradually shifted to the broad implementation of interventions, which have been proven to be effective.

During this period, it was also increasingly recognized that, for health promotion to really make a difference, a more integrated approach would have to be adopted with programmes including a mix of interventions. In addition to the development of activities with a focus on information and education (such as a curriculum on healthy food choices or physical education), it was also necessary to work on a healthy environment by creating facilities (such as healthy school dinners) and making sensible policies (such as on school treats). The next step is to broaden the integrated approach. For successful health promotion, that is, other areas of policy—including education, security, physical planning and economics—must also be involved.

With the emergence of a health promotion infrastructure in the Netherlands some 40 years ago, development at the local level was strongly stimulated. In the 1970s, for example, the Netherlands had several dozen health promotion specialists working independently. In the early 1980s, several teams of health promotion specialists were set up. By the early 1990s, >580 prevention workers and health promotion specialists were working together in some 200 locally based teams. And by 2008, the number of locally active health promotion specialists had risen to some 1200.

Since the early 1980s, a solid national infrastructure for health promotion was created. This led to the establishment of the National Institute for Health Promotion and other national institutes with a focus on such themes as physical activity, mental health, nutrition and safety. In addition, a national quality system for health promotion was established and is currently supervised by the Netherlands Health Inspectorate. In 2006, the Centre for Healthy Living (Centrum Gezond Leven, CGL) was set up under the auspices of the National Institute for Public Health (RIVM). The aim of the Centre for Healthy Living is to ensure that the currently fragmented national support meets the needs of local practice.

Issues regarding effectiveness of interventions have also undergone some change. The evidence-based approach still dominates, and until this day, model programmes are being developed that find support for their effectiveness in research. The expectation that these programmes are easy to distribute and implement, however, proved to be an illusion. Programme

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**FIGURE 1** Developments in Health Promotion in the Netherlands since 1970

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hp = health promotion
CGL/RIVM = Centre for Healthy Living at the National Institute for Public Health
ACC = Academic Collaborative Centres
RPP = Research, Policy and Practice
Preffi = Health Promotion Effect Management Instrument
OPUS = Project Management Instrument
refka = Reference Framework for Health Promotion
ZonMw = Netherlands Organization for Health Research and Development
implementation was found to be more complicated than initially assumed and it did not occur on its own. In the 1990s, considerable work was therefore devoted to the establishment of development and implementation guidelines in addition to the development of model programmes for effective health promotion interventions (e.g. Preffi, intervention mapping and project management). During the first decade of the 21st century, however, it became clear that more was needed for the development and direction of integrated programs than guidelines on an intervention-based level. The Reference Framework for Health Promotion (Refka) and 10 principles for effective health promotion were subsequently introduced. These 10 principles address the topics of making interventions systematic (4 items), project management (2 items), ensuring participation/empowerment of the target group (1 item) and establishing administrative and political commitment (3 items). The emphasis on the implementation and sustainability of health promotion efforts clearly require administrative and political support.

The development of health promotion therefore requires active involvement of research, practice and local governments. In the 1970s, great passion and enthusiasm for the ideology of health promotion characterized the attitudes of health promotion specialists. The 1980s and 1990s were marked by the professionalization and technical development of the profession of health promotion specialist. With a focus on integrated programs and the importance given to involving other policy areas and administrators, the importance of political sensitivity is clearly highlighted, in which passion as well as technique and professionalism are equally important.

The developments in the field of health promotion are reflected in the priorities set by the Netherlands Organization for Health Research and Development over the years. Research on the effectiveness of health promotion interventions has prevailed, and it is still a major focus in research policy. Nevertheless, over the past 10 years, increased attention has been paid to implementation of interventions and the incorporation of practice-based information was ignored too often. The ‘concerns’ of public health knowledge, which included local health promotion specialists, reported a lack of capacity and opportunities to apply research knowledge and, conversely, a lack of openings to influence research. Considerable confusion about the roles to be adopted by knowledge brokers and knowledge consumers was also found in part because their roles are often diffuse and fragmented. In the same study, government and public health funders observed that researchers are the ones in power and thus the ones who set the research agenda and priorities. An unequal balance of power is thus the case. Recommendations made on the basis of this research press for the creation of stronger links between the different stakeholders and the stimulation of ‘co-creation’.

Research on current collaborations between research, policy and practice

In 2008 and 2009, research was conducted on the infrastructure for knowledge transfer within the public health sector in the Netherlands: the study of the Dissemination and Implementation of Knowledge in the Public Health-sector (DIK-study). The aim of this study was to gain insight into the wishes, interests, concerns and capabilities of various national and local stakeholders in the sector. The results showed the collaboration between research and practice to have major shortcomings, which should be addressed. The University of Wageningen conducted an interesting sub-study. They analysed 33 in-depth interviews. They classified the data using an ‘innovation systems perspective’ to attain an overview of the types of failures which occurred: infra-structural, institutional, interactional or capacity. The results showed the public health infrastructure in the Netherlands to be perceived and appreciated differently by different groups of stakeholders. The providers of knowledge, including researchers and educational institutions, were mainly interested in a debate about what constitutes ‘right’ or ‘wrong’ evidence (i.e. knowledge). These same stakeholders employed mostly passive top-down forms of knowledge exchange. Knowledge brokers thought that practice-based information was ignored too often. The ‘consumers’ of public health knowledge, which included local health promotion specialists, reported a lack of capacity and opportunities to apply research knowledge and, conversely, a lack of openings to influence research. Considerable confusion about the roles to be adopted by knowledge brokers and knowledge consumers was also found in part because their roles are often diffuse and fragmented. In the same study, government and public health funders observed that researchers are the ones in power and thus the ones who set the research agenda and priorities. An unequal balance of power is thus the case. Recommendations made on the basis of this research press for the creation of stronger links between the different stakeholders and the stimulation of ‘co-creation’.
active knowledge exchange and making knowledge that is largely implicit more explicit. These are useful strategies to focus more on implementation and using knowledge. Such efforts will also require capacity building. And it is generally assumed that ACCs can contribute on all these fronts and thus help solve the identified system failures.

Finding a balance between research and practice is a challenge for not only the Netherlands but also other countries like Australia, Canada, Scotland and the USA. To create a link between science and practice in the USA, for example, Prevention Research Centres (PRCs) were established by the Centres for Disease Control (CDC) in the 1980s and 1990s within Schools of Public Health and Departments of Community and Preventive Medicine at universities. However, research still predominated after a decade of funding for 13 such centres (1986–96). That is, the research output was strong but the centres fell short on three aspects of their original mandate: tracking their impact on practice and policy, engaging their communities of public health practice and taking their products to scale through dissemination. A stronger emphasis was subsequently placed on the assessment of impact, partnerships with public health practice and the dissemination of results. The advice of the Institute of Medicine (IOM) also stimulated the prevention research centres to collaborate within practice-based research networks. A similar development can be seen to be occurring in the Netherlands with the establishment of a Consortium for an Integrated Approach to Overweight (CIAO).

Following the initial establishment of a number of ACCs in the Netherlands (2005–09), the Netherlands Organization for Health Research and Development (ZonMw) also assessed the effectiveness of the centres. While the centres were found to be headed in the right direction, the universities still prevailed. The Netherlands Organization for Health Research and Development therefore decided to stress the importance of practice and policy even more. It was decided to have the public health services in the Netherlands become the requesters for the funding of an ACC and to push public health services to become more academic at the same time (i.e. conduct more research with issues arising from the field standing central). This is expected to lead to a tangible shift of power from science to practice. In addition, the importance of double appointments, collaboration on projects, direct contact between research and practice and the active involvement of local governments in ACCs are being emphasized.

Remaining challenges

The expectations for ACCs are high. There is considerable and widespread commitment to the idea of ACCs from both the fields of research and practice. Given the predominance of research in efforts to bring science and practice closer together in the past, however, the ACCs are going to have to prove themselves within the field of public health practice in particular. The following questions thus stand central for the future.

1. Are universities patient enough to support the development of ACCs? While working on the development of ACCs can be important for the societal impact of universities, this may occur at the expense of scientific impact—particularly during the initial establishment phase. And the question is whether universities can afford to wait?
2. To what extent can public health services be expected to conduct more research (i.e. become more academic)?
3. Will the ACCs succeed in getting the commitment, which they need from local governments?

These challenges require suitable strategy, productive coalitions and the appointment of the right people. We already have the ingredients to forge a bridge between science and practice and—by extension—policy. And if we only come halfway, we will still have come a long way.

Declaration

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