A ‘health broker’ role as a catalyst of change to promote health: an experiment in deprived Dutch neighbourhoods

JANNEKE HARTING1*, ANTON E. KUNST1, ALBERT KWAN2† and KARIEN STRONKS1

1Department of Social Medicine, Academic Medical Centre/University of Amsterdam, Amsterdam, the Netherlands 2Department of Public Health Services, Faculty of Medicine, University of Toronto, Toronto, Canada
*Corresponding author. E-mail: J.harting@amc.uva.nl
†Present address: Public Health Agency Canada, Canada

SUMMARY

Urban social entrepreneurs have been suggested to play an essential part in the success of local health promotion initiatives. Up to now, roles like these have only been identified in retrospect. This prospective collaborative study explored the possibilities of institutionalizing a comparable role for a ‘health broker’ in four Dutch municipalities as an additional investment to promote health in deprived neighbourhoods. The theoretical notions of public and policy entrepreneurs as well as of boundary spanners were adopted as a reference framework. Documents produced by the collaborative project served as input for a qualitative analysis of the developments. We succeeded in implementing a ‘health broker’ role comparable to that of a bureaucratic public entrepreneur holding a formal non-leadership position. The role was empowered by sharing it among multiple professionals. Although positioned within one sector, the occupants of the new role felt more entitled to cross sectoral borders and to connect to local residents, compared to other within-sector functions. The ‘health broker’ role had the potential to operate as an ‘anchoring point’ for the municipal health sector (policy), public health services (practice) and/or the local residents (public). It was also possible to specify potential ‘broking points’, i.e. opportunities for health promotion agenda setting and opportunities to improve cross-sectoral collaboration, citizen participation and political and administrative support for health promotion efforts. The ‘health broker’ role we developed and implemented reflects the notion of systemic rather than individual entrepreneurship. Such a collective entrepreneurship may create additional opportunities to gradually strengthen local health promotion efforts.

Key words: urban social entrepreneur; boundary spanning; health promotion

INTRODUCTION

Establishing effective local health promotion initiatives is not unproblematic (Roussos and Fawcett, 2000; Merzel and D’Afflitti, 2003), and an analysis of Healthy Cities showed that an urban social entrepreneur could play an essential part in their success (De Leeuw, 1999). Such urban social entrepreneurs can be characterized as change agents in the policy innovation process (Roberts and King, 1996) or as ‘catalysts of change’ who are able to create and profit from ‘windows of opportunity’, that is, situations in which social problems, policy alternatives and the political environment interconnect in a way that enables change (Kingdon, 1995). The role
of urban social entrepreneurs may be vital to achieving the multifactorial, integrated intervention strategies needed to incorporate the social determinants in contemporary health promotion (Catford, 1998). Its critical function in creating change in the fields of public health and health promotion suggests that institutionalizing such a role could effectively produce beneficial changes at local level (De Leeuw, 1999).

Up to now, roles like these have only been identified in retrospect. As a first prospective study, we started a collaborative inquiry to experiment with the role of an urban social entrepreneur at local level in four Dutch municipalities (2007–2010). Within the scope of the third national Metropolitan Policy Program (GSB III; 2005–2009), these municipalities had committed themselves to additional investments to reduce health inequalities. They were happy to adopt the idea of an urban social entrepreneur to strengthen their efforts to promote health in deprived neighbourhoods. The concept was renamed ‘health broker’ role, referring to entrepreneurial innovators in the field of health promotion who could act as strategic brokers among stakeholders from different sectors (Kingdon, 1995; Williams, 2002). The ‘health broker’ role was additionally envisioned to operate as an ‘anchoring point’ connecting the local community and/or neighbourhood problems to local administrative and policy instruments. By ‘brokering ideas and people’, the role occupants were expected to contribute to three major prerequisites of effective health promotion: cross-sectoral collaboration, citizen involvement and political and administrative support (Hancock and Duhl, 1988). As such, the role was assumed to contribute to the development and implementation of local healthy public policies. The role occupants were additionally assumed to increase the effectiveness of health promotion by applying a phased planning model for the systematic development of neighbourhood health programmes (Ten Dam, 2006).

This paper first presents two theoretical notions that informed the experiment: that of public (Roberts, 1992) or policy entrepreneur (Kingdon, 1995) and that of boundary spanner (Steadman, 1992; Stern and Green, 2005). These notions are then used to describe, compare and reflect on the developments in the four municipalities in terms of the staffing and positioning of the ‘health broker’ role, the presentation, acceptance and content of the role and the major factors that influenced developments. This paper thus focuses on the empirical findings as a result of the collaborative inquiry rather than on the methodological challenges inherent to this type of research.

METHODS

Theoretical notions

Based on the presumed added value of an urban social entrepreneur (De Leeuw, 1999), we first adopted the concepts of public (Roberts, 1992) and policy entrepreneur (Kingdon, 1995). Since such entrepreneurial roles could benefit from boundary spanning capacities (Williams, 2002), we also adopted the concept of boundary spanner (Steadman, 1992; Stern and Green, 2005).

A public entrepreneur contributes to innovations in public sector practice through the generation of a novel idea, its practical design and its implementation in public sector practice (Roberts, 1992). Based on their formal positions, four types of entrepreneur can be distinguished (Roberts, 1992; Roberts and King, 1996): (1) bureaucratic entrepreneurs, who hold formal non-leadership positions; (2) executive entrepreneurs, who hold appointed leadership positions; (3) political entrepreneurs, who hold elected leadership positions; and (4) policy entrepreneurs, who do not hold formal positions in government. As this typology relates to issues like mandate, power and resources, the types of public entrepreneurs will differ in the instruments they can bring into play (Roberts, 1992), the strategies they are able to apply and the capacities they can build at the various levels of society (Sullivan and Skelcher, 2002). The typology also opens up the possibility of shared or collective entrepreneurship, representing greater investments of resources, time and energy (Roberts, 1992).

The concept of policy entrepreneur has been further specified in the stream theory on policy development (Kingdon, 1995). This describes how policy entrepreneurs, as ‘catalysts of change’, may be successful in opening ‘windows of opportunity’ towards policy innovations. An essential entrepreneurial activity is that of linking the three ‘streams’ of problems, policy alternatives and politics. This requires defining and reframing problems, specifying policy alternatives and brokering ideas and people to
finally make policy innovations enter the decision-making agenda. The authority of policy entrepreneurs thus also depends on their expertise, political connections and persistence (Roberts, 1992; Kingdon, 1995). Further requirements are a multi-frame perspective, proactiveness and reflectiveness (Selsky and Smith, 1994), as well as the capacity to lay out a strategic map of the three aforementioned streams (Kingdon, 1995; De Leeuw, 1999).

The concept of boundary spanner refers to the local coordinating role of a strategic broker, or ‘anchoring point’, needed to foster the collaboration between multiple entities (Craig, 2004). Boundary spanners are persons who have to interact with other people inside their own institute as well as negotiate system interchanges with other organizations (Steadman, 1992). Their role is to connect two or more systems whose goals and expectations are likely to be at least partially conflicting (Miles, 1980), and to manage the tensions at the interface between flexible, collaborative partnerships and the bureaucratic organizational structures of their partners (Stern and Green, 2005). Through such brokerage, a ‘health broker’ role may be expected to connect different networks, improve the integration and translation of different kinds of information, and thereby contribute to the social capital that may be required to improve health (Burt, 2004).

As public entrepreneurs, boundary spanners can be characterized as creative lateral-thinking rule-breakers; as policy entrepreneurs, they should be skilled at linking the streams of problems, policy alternatives and politics (Williams, 2002). In a health promotion context, however, entrepreneurs of any kind need supportive environments too (Catford, 1998).

Design and participants

We opted for a prospective, collaborative inquiry (Reason, 1999) to enable the flexible application of the theoretical notions in iterative interaction with the development and implementation of the ‘health broker’ role in practice (D’Cruz and Gillingham, 2005). The collaboration was assumed to enhance this interaction as a means to close the often identified gap between theory (associated with universities) and practice (associated with public administration and service-providing organizations) (Schwandt, 2005; De Leeuw et al., 2008). The collaborative inquiry was therefore seen as a shared learning process that would result in theoretically and practically relevant knowledge (D’Cruz and Gillingham, 2005) about the potentials of the ‘health broker’ role to contribute to the effectiveness of public health.

The collaboration involved a university research team of the Amsterdam Medical Centre and officials of the local governments of four Dutch municipalities, i.e. Den Haag (DH), Groningen (GR), Helmond (HE) and ’s-Hertogenbosch (DB), which had opened up their public domain for a practical trial of the new role. The project leader of the experiment was a senior policy advisor of the municipality of DH. The collaborative team was supplemented with a senior consultant of the National Institute for Health Promotion and Disease Prevention.

The university team’s main responsibilities were to provide a theoretical framework and to reflect on the practical developments to ensure that the practical implementation of the ‘health broker’ role would mirror the theoretical notions as much as possible. The main responsibilities of the municipal officials were to transform the theoretical notions into practice, within the possibilities and limitations imposed by reality, and to inform the research team of their practical experiences. To avoid trial-and-error, the university team also proposed the joint development of a local programme theory (Rossi et al., 2004), i.e. a causal model specifying the way in which the ‘health broker’ role would ultimately contribute to improved health.

Collaboration, data collection and data analysis

Between October 2007 and October 2008, the collaboration took two forms: bilateral meetings of the first author with one or more officials of the individual municipalities (DH 7; GR 6; HE 9; DB 10) and national meetings attended by representatives of all collaborating partners. Municipal work plans, including draft versions of local programme theories, and summaries of the municipal developments by the first author, including theoretical reflections, served as input for the meetings, as did the grant proposal and two successive versions of a theoretical framework. All meetings were summarized by the first author; minutes of the national meetings
were jointly prepared by the first author and the project secretary. Other significant documents were the interim reports prepared for the granting organization in December 2007 and October 2008, the former written by the project leader, the second the result of joint efforts of all participants.

All documents resulting from the collaborative project served as research material for the analysis of the developments in the ‘health broker’ experiment. The summary reports of the discussions during the individual and group meetings were entered into the NVivo 2.0 computer program for a primary qualitative content analysis (Polit and Beck, 2004). The first author used a pre-structured code tree to classify and organize the materials and to describe, explain and further interpret the developments in the project (Gibbs, 2002). All other documents were used to verify the results of the primary analysis and to illustrate these results in the present report (secondary analysis). A first draft of this manuscript was composed by the first, second and last authors. This draft was critically reviewed by all other partners of the collaborating team, by way of member check (Polit and Beck, 2004). The final draft was endorsed by all collaborating members.

RESULTS

Within our collaborative inquiry, the staffing and positioning of the ‘health broker’ role were based on practical rather than theoretical considerations (ALL = all four municipalities). This was due to time pressure, which did not permit an extensive collaborative preparatory stage, the flexibility adopted to allow for local tailoring, and the absence of theoretically well-informed role models. The task of simultaneously positioning, designing and implementing the ‘health broker’ role was experienced as difficult (ALL). The municipalities perceived the theoretical framework provided by the research team as helpful to reflect on rather than as a basis for the further practical developments (ALL). The role occupants saw additional training to improve knowledge (e.g. on health inequalities) and competencies (e.g. agenda setting, negotiating and networking) as more pressing than further academic efforts to strengthen the theoretical basis of their practical work (ALL). Reflections by the research team were nevertheless reported as helpful, as were the exchange of experiences between municipalities and a supportive municipal environment.

Staffing and positioning

The urban districts in which the municipalities decided to experiment with the ‘health broker’ role differed considerably in size and existing health promotion efforts (Table 1). The new role was in each case adopted by one sector, either the health sector (DH/GR/HE) or the youth and education sector (DB). Although most actors acknowledged the potential added value of positioning the ‘health broker’ role outside or across sectors (e.g. to arrive at an integrated approach to health), this was regarded as unrealistic given the vertical and bureaucratic municipal infrastructure (DH/GR/DB), and as rather uncommon for an initiative starting from one sector (ALL). All ‘health broker’ roles were positioned at a formal, non-leadership level, that is, at the level of a bureaucratic entrepreneur. Executive, political or policy levels were, although recognized as potentially more powerful, seen as unrealistic (DH), infeasible given the qualifications of the recruited officials (ALL) or unnecessary given the ambitions (GR). An additional reason was the expectation of sufficient higher level political and administrative support for this specific experiment (within-sector; DH) or for an integrated approach to health in general (across-sectors; GR). Others saw obtaining this higher level support, while perceived as currently lacking, as part of the ‘health broker’ role itself (HE/DB) and regarded starting from a less powerful position within one sector as an approach that suited current local health promotion (GR/HE/DB).

To empower the ‘health broker’ role, two municipalities shared out the role between the local public health service and municipal health officials (GR/HE), allowing local policy to be connected to the local community (GR) and to integrate insights into the procedures used in different organizations (HE). The role was seen as slightly (GR) or explicitly (DH/HE/DB) different from existing roles in health promotion, with its occupants being entitled to cross sectoral borders (DH/HE/DB) and/or to easily connect to the local residents (GR/HE). Financial restrictions meant that most role
A ‘health broker’ role as a catalyst of change to promote health

Table 1: Staffing and positioning of the ‘health broker’ role in the four municipalities

<table>
<thead>
<tr>
<th>District characteristics</th>
<th>Den Haag (DH)</th>
<th>Groningen (GR)</th>
<th>Helmond (HE)</th>
<th>’s-Hertogenbosch (DB)</th>
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<tbody>
<tr>
<td>Three districts, Schilderswijk, Transvaal and Stationsbuurt, within one quarter, Centrum</td>
<td>Den Haag 442 000</td>
<td>One district, Groningen 182 000</td>
<td>One district, Helmond 87 000</td>
<td>One district, ’s-Hertogenbosch 134 000</td>
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<td>Schilderswijk 33 500</td>
<td>Levenborg 11 000</td>
<td>Helmond-Oost 7500</td>
<td>West 20 000</td>
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<td>Transvaal 16 800</td>
<td>Stationsbuurt 8900</td>
<td>Leonardus 2500</td>
<td>Boschveld 3300</td>
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<tr>
<th>Reasons for choice of district</th>
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<tr>
<td>The ‘health broker’ role was expected to benefit from existing neighbourhood health promotion efforts (perceived as greater exposure offering more chances for the ‘health broker’ role)</td>
<td>One employee; role allocated to official with degree in public administration (0.8 fte) at level of senior policy official within municipal public health sector</td>
<td>Role shared out among three employees within municipal public health sector; role allocated to senior policy advisor (administrative level), senior health educator (coordinative level) and local health educator (operational level)</td>
<td>Role shared out among two employees shifting their responsibilities; role allocated to senior policy official in municipal health sector (0.1 fte) and to senior health educator in public health service (0.4 fte)</td>
<td>One employee; role allocated to public health officer (0.4 fte), at coordinative level within municipal youth and education sector</td>
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<tr>
<th>General perception of ‘health broker’ role</th>
<th>Den Haag (DH)</th>
<th>Groningen (GR)</th>
<th>Helmond (HE)</th>
<th>’s-Hertogenbosch (DB)</th>
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<tr>
<td>Explicitly not meant as extension of policy capacity of municipal health promotion unit</td>
<td>Seen as extension of existing neighbourhood health coordinator role at neighbourhood level</td>
<td>Seen as explicitly different from local policy officials and local health promoters</td>
<td>Seen as explicitly different from local policy officials and local health promoters</td>
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<tr>
<th>Resources</th>
<th>Den Haag (DH)</th>
<th>Groningen (GR)</th>
<th>Helmond (HE)</th>
<th>’s-Hertogenbosch (DB)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Single worker looking for support and collaboration outside municipal health sector</td>
<td>Staffing seen as sufficient and team as doing quite well</td>
<td>Shared by 1.5 persons looking for more strength in municipal organization</td>
<td>Single worker looking for access and support in municipal organization</td>
<td></td>
</tr>
<tr>
<td>Allocated time seen as sufficient, but still necessary to delineate function and activities</td>
<td>Limited time not perceived as problem, but difficult to invest available time</td>
<td>Usually experiencing time pressure</td>
<td>Permanent shortage of time</td>
<td></td>
</tr>
<tr>
<td>Initially no separate ‘health broker budget’ available; fund raising seen as part of ‘health broker’ role; later availability of small action budget for ‘quick successes’</td>
<td>Relatively slow progress seen as necessary to experiment with new role</td>
<td>Opportunity to use municipal budget for local health promotion, but initially not sure how to spend available money</td>
<td>Discussion about capacities needed to fulfil ‘health broker’ role</td>
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Continued
occupants were given only part-time positions (GR/HE/DB) and limited or no budgets (DH/GR/DB). The resulting positioning led to a limited mandate for the ‘health broker’ role (ALL), reflected by a restricted scope (DH/GR/DB), the need for formal approval (GR/HE/DB) and repeated discussions about control and authority (DH/HE/DB). For one municipality, this was a reason to reposition the ‘health broker’ role within the horizontally organized administrative body at district level (DH).

**Presentation and acceptance**

Two municipalities explicitly included the ‘health broker’ role in their local health policy plans (DH/HE) (Table 2). Three municipalities (DH/HE/DB) publicly introduced the ‘health broker’ role as a new instrument to reinforce health promotion efforts, despite debates about the appropriateness of the name (e.g. considered too woolly to be acceptable to politicians; too closely linked to ‘health’ care to work across sectors) and the difficulties the occupants encountered when presenting themselves. One municipality (GR) initially preferred to introduce the role as an additional competency in health promotion, as it had previously experimented with a similar role.

Initial responses to the introduction of the ‘health broker’ role were mixed. Most aldermen were rather positive, with one of them welcoming the initiative to reduce health inequalities with open arms (DH). This increased the expectations about the new role, which were already high (DH/HE/DB). Municipal officials initially strongly advised against the start of ‘another project’ at neighbourhood level (ALL). Local health and other officials saw the role either as complementary to existing professional roles (GR/HE) or as competing with them, while the role of ‘anchoring point’ was seen as already (partly) fulfilled by themselves (DH/DB). The latter viewpoint formed a serious barrier to implementation, as did the variety of expectations as a result of the experimental nature of the role (especially DH).

The general mechanisms through which the ‘health broker’ role was assumed to

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**Table 1: Continued**

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<tr>
<th>Den Haag (DH)</th>
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<th>Helmond (HE)</th>
<th>’s-Hertogenbosch (DB)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Small budget available for actions to increase visibility of new approach and to create goodwill among other stakeholders</td>
<td>Clarity about the various ‘health broker’ roles</td>
<td>Roles and tasks of the two occupants of the ‘health broker’ roles not always clear and no evenly shared responsibility to further develop the role</td>
<td>Confusion and debate about formal position within hierarchical structure</td>
</tr>
<tr>
<td>Ongoing debate about control, authority and responsibilities for ‘health broker’ role with various superiors and other professionals within municipal health sector</td>
<td>Decisions about choice of neighbourhood and direction of ‘health broker’ role in need of formal approval by alderman</td>
<td>Formal approval for action plan needed from municipal authorities</td>
<td>Formal approval for action plan needed from various superiors and authorities</td>
</tr>
<tr>
<td>Debate about increased mandate if ‘health broker’ role is to be situated in one of the neighbourhood’s horizontal organizational structures</td>
<td>Sufficient mandate to implement phased health promotion approach called ‘District Deal’</td>
<td>Limited formal mandate reasonably compensated by organizational and municipal commitment</td>
<td>Limited mandate within municipal organization and public health institute; hardly any mandate at neighbourhood level</td>
</tr>
</tbody>
</table>
Table 2: Introduction and specification of ‘health broker’ role in the four municipalities

<table>
<thead>
<tr>
<th>Den Haag</th>
<th>Groningen</th>
<th>Helmond</th>
<th>’s Hertogenbosch</th>
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<tbody>
<tr>
<td><strong>Local health policy plan for 2007-2010 and situation of health broker role</strong></td>
<td>Integrated approach to health, focusing on neighbourhood health promotion</td>
<td>Advocating integrated approach to health, focusing on neighbourhood health promotion</td>
<td>Local health policy plan under construction</td>
</tr>
<tr>
<td>‘health broker’ role introduced as instrument to foster cross-sectoral collaboration at neighbourhood level</td>
<td>‘health broker’ role not mentioned specifically but assumed to be integrated part of neighbourhood health promotion</td>
<td>‘health broker’ role introduced as one of three priorities of integrated approach</td>
<td></td>
</tr>
<tr>
<td><strong>Public introduction: way in which the ‘health broker’ role was announced and presented to others</strong></td>
<td>Explicit presentation of a ‘health broker’ to contribute to the reduction of health inequalities</td>
<td>Introduction of ‘health broker’ role in municipal organization</td>
<td>Unspecified</td>
</tr>
<tr>
<td>Introduction of the ‘health broker’ role in municipal organization; ‘health broker’ role announced in municipal health policy plan</td>
<td>No public introduction of the ‘health broker’ role but idea included in neighbourhood health promotion approach, called ‘District Deal’, as one element of the local public health programme.</td>
<td>Unspecified</td>
<td></td>
</tr>
<tr>
<td><strong>Public presentation of the ‘health broker’ role by alderman</strong></td>
<td></td>
<td>Introduction of the ‘health broker’ role in municipal and public health organization</td>
<td></td>
</tr>
<tr>
<td><strong>Initial reactions: responses of stakeholders within and outside the fields of public health and health promotion</strong></td>
<td>Alderman (public communication): high expectations in terms of increased life expectancy for residents</td>
<td>Alderman (general point of view): positive about local health promotion, willing to attend neighbourhood meeting on health policy and practice</td>
<td>Alderman (off-the-record personal communication): nice initiative that might contribute to integrating municipality and neighbourhood</td>
</tr>
<tr>
<td>Municipal and local professionals: competing colleague; ‘health broker’ role or role as local ‘anchorage point’ seen as already performed by others</td>
<td>Local professionals: first reluctant because of expected additional investments; later on more enthusiastic about collaborative approach</td>
<td>Municipal officials (not informed in detail): interested but reserved</td>
<td>Local professionals: competition with colleagues because ‘health broker’ role or role as local ‘anchoring point’ already performed by others</td>
</tr>
<tr>
<td>Stakeholders: ‘health broker’ role should intervene in problematic situations of individual residents as well as contribute to changing cultures and structures to break through municipal bureaucracy</td>
<td>Municipal managerial level: confusion about whether ‘health broker’ role would replace current local health promotion programmes</td>
<td>Health professionals (other neighbourhoods): valuable addition to local neighbourhood health promotion programmes</td>
<td>Public health organization: positive about broader perspective on health and health promotion</td>
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contribute to the ultimate objectives were mostly related to that of ‘anchoring point’: linking the needs, services and policies (DH/HE) or public health policy and practical health promotion (GR/DB). Another mechanism involved the diffusion of an ecological vision on health (DB). The further specifications of the ‘health broker’ role reflected a variety of ideas. The common attention to collecting, clustering and integrating local information and improving local processes mirrored the shared perception of a disintegrated local infrastructure (see below). Other specifications related to one or more of the prerequisites [e.g. involving other sectors (DH/GR), involving citizens (GR)], or to the overall ambition for the new role [e.g. agenda setting for health (DH) and contributing to

<table>
<thead>
<tr>
<th>General mechanisms (vision on ‘health broker’ role): what methods and strategies would contribute to the ultimate aim?</th>
<th>Den Haag</th>
<th>Groningen</th>
<th>Helmond</th>
<th>'s Hertogenbosch</th>
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<tbody>
<tr>
<td>Linking policy, services and needs in the domain of public health, health promotion and disease prevention</td>
<td>Linking demands (local population), supplies (local organizations) and local policy</td>
<td>Transforming integrated public health policy into integrated local health promotion by taking into account the views of residents and key figures</td>
<td>Creating citizen empowerment and changes in physical and social environment through new connections in existing local (organisational) infrastructure</td>
<td>Local diffusion of ecological approach to health at municipality and community levels</td>
</tr>
<tr>
<td>Horizontal role across all sectors to create comprehensive vision on health issues</td>
<td>Setting agenda for health, creating awareness about area-based health promotion</td>
<td>Implementing a planned approach (called ‘District Deal’) and fostering community participation in health promotion</td>
<td>Central position between three levels: demands (local population), supplies (local organizations) and local and municipal policies</td>
<td>Increasing efforts to improve physical and social environment and to include local problems in local policy</td>
</tr>
<tr>
<td>Reorganising local organization, streamlining existing initiatives, and improving information exchange and communication</td>
<td>Identifying problems, ensuring that others take responsibility</td>
<td>Implementing a planned approach (called ‘District Deal’) and fostering community participation in health promotion</td>
<td>Connecting existing initiatives, developing new and permanent health promotion programmes</td>
<td>Contributing to development and implementation of upstream interventions addressing social determinants of health</td>
</tr>
<tr>
<td>Setting agenda for health, creating awareness about area-based health promotion</td>
<td>Collecting, clustering and integrating local information</td>
<td>Establishing further links between health promotion efforts and other policy plans</td>
<td>Establishing links and strengthening joint efforts</td>
<td>Making sectors and actors take their responsibility with regard to health as well as intervening in local health sector itself</td>
</tr>
<tr>
<td>Identifying problems, ensuring that others take responsibility</td>
<td>Collecting, clustering and integrating local information</td>
<td>Specification of role depending on local situation and differences between neighbourhoods in district</td>
<td>Developing health broker methods and strategies</td>
<td>Reconnecting disconnected organisations and activities; analysing existing processes and finding sustainable solutions to problems</td>
</tr>
<tr>
<td>Debate on resolving difficulties in existing health promotion programmes or focusing on (health) problems that are currently not being addressed</td>
<td>Specifying role depending on local situation and differences between neighbourhoods in district</td>
<td>Developing health broker methods and strategies</td>
<td>Securing changes at higher administrative and political levels</td>
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</table>
upstream interventions addressing social determinants of health (DB)).

**Contextual complexity**

The development of the content of the ‘health broker’ role, a time-consuming process, was hampered by two kinds of complexities. First, it was difficult to establish a comprehensive picture of the local health situation and to capture local health inequalities. Local statistics on health as well as on personal and environmental determinants were found to be incomplete (DH/GR/DB) and/or scattered over various sources related to different municipal organizations and sectors (ALL). It was argued that providing the occupants of the ‘health broker’ role with practical insights into the health situation of the community required more data at the neighbourhood level (DH/GR), and that the fragmented information available at the municipal level should first of all be collected, integrated and interpreted from a broad perspective on health (ALL). Most occupants of the ‘health broker’ role had their doubts about the extent to which they were responsible for and able to carry out the latter task, which they regarded as comprehensive. The second complexity concerned the local situation, which was experienced as difficult to get a grip on (ALL). Local policies were perceived to be multifarious, fragmented and insufficiently integrated (ALL). Policies at a municipal level were not always coordinated with policies at the neighbourhood level (DB). At operational level, there was a myriad of local programmes and projects addressing health or its determinants (ALL). According to the occupants of the ‘health broker’ role, there were both too many programmes (lack of cooperation; duplication) and too few (unserved needs; underserved residents; ALL). Although most neighbourhood programmes had a cross-sectoral structure, they did not address health issues and had their own dynamics, which made it difficult for the ‘health broker’ role to join in with them. Municipal and organizational procedures were perceived as rigid, complex and insufficiently transparent, and the provision, combination and exchange of information were perceived as far from sufficient (ALL). No single body was considered to have a comprehensive overview of the local situation (ALL).

**Role content**

In order to deal with the complexities of the local situation and to find opportunities to intervene, one municipality opted for a pioneering approach (DH), partly from the belief that a planned and analytic approach was not typically part of the ‘health broker’ role (Table 3). This approach resulted in a ‘pioneering model’ including local demands, supplies and organizations, an action plan emphasizing the improvement of local processes (like communication and information exchange), and a second action plan that underlined the necessity of creating a coherent picture including all relevant neighbourhood aspects.

The other three municipalities used a planned approach (GR/HE/DB). In one municipality, the first step, analysis, took a whole year, so no local programme theory could be established by then (GR). The analysis, including additional data collection, nevertheless revealed some potential ‘broking points’ (see below). The remaining two municipalities started by integrating the available data and succeeded in specifying long-term health-related goals and shorter term improvements in personal and environmental determinants (HE/DB). Too much focus was, however, seen as partially conflicting with the preferred ecological perspective on health and as limiting the ability to act on ‘windows of opportunity’.

The local programme theories enabled the municipalities to identify several ‘broking points’, which could typically be characterized as local collaborations (existing or potential) with a horizontal and cross-sectoral rather than a vertical and sectoral structure. Examples of such ‘broking points’ were an intended connection between a local health centre and a neighbourhood-related consultative structure for non-health professionals (GR), the intended increase of municipal investments to preserve a neighbourhood’s liveability status (HE), the formulation of a neighbourhood prevention plan on raising and educating children (DB) and a recently started neighbourhood reinforcement program (DH). These ‘broking points’ were regarded as offering opportunities to set the agenda for health and to improve cross-sectoral collaboration, citizen participation and political and administrative support for health promotion. In this respect, the ‘health broker’ role’s function as ‘anchoring point’ was
envisioned as either establishing potential collaborations or joining already existing platforms. Specific ‘health broker’ actions could, for instance, include advocating health issues (ALL), performing a stakeholder analysis (DH), and working up to a shared vision on neighbourhood improvement and inequalities in health (DB/HE). Although the resulting action plans were perceived as still having too broad a spectrum to properly focus the ‘health broker’ role, they were nevertheless found to be useful as a reference framework for reflection.

**DISCUSSION**

Despite the absence of theoretically well-informed role models, we succeeded in implementing a ‘health broker’ role comparable to that of a public entrepreneur at a bureaucratic level. The role was empowered by sharing it out among multiple professionals. The ‘health broker’ role differed from existing roles in health promotion in that its occupants felt more entitled to cross sectoral borders and more able to connect to local residents. Developing the content of the role was difficult and hampered by the complexity of health issues and the local situation. It was nevertheless possible to specify potential ‘broking points’ providing chances for agenda setting for health and opportunities to improve cross-sectoral collaboration, citizen participation and political and administrative support for health promotion.

Starting from the theoretical notions of public and policy entrepreneur (Roberts, 1992; Kingdon, 1995), the ‘health broker’ role that resulted from our collaborative inquiry can be regarded as having relatively little authority. One could therefore question the potential of such a role to serve as an additional investment to promote health in deprived neighbourhoods. A recent discussion of the changing nature of public entrepreneurs, however, provides an optimistic perspective on this matter (Bernier and Hafsi, 2007). It argues that the term ‘entrepreneur’ has always been associated with one individual who manages to transform a vague vision into a great success. This ‘individual entrepreneur’ may, however, only be functional when an organization is new and there is a need for novel activity. As an organization develops further and loses its flexibility and ability to function effectively and efficiently, this may create the need for ‘systematic entrepreneurship’ involving various individuals at bureaucratic and executive levels. The complexity of the local situation identified in the present study may indeed reflect the bureaucracy in which ‘systematic entrepreneurship’ may contribute most to the process-based innovations needed to increase an organization’s ability to deliver health-promotion services (Bernier and Hafsi, 2007).

A second promising perspective is the suggested integration of structures and functions of public policy and administration (Skok, 1995). This framework combines the streams of problems, policies and politics (structures) with agenda setting and the formulation, implementation and evaluation of policies (functions). The resulting matrix allows all activities necessary for generating public policy to be located within the relevant functions and within the structure(s) having generated them. Traditionally, public administration is seen as primarily the carrying-out of policies (Skok, 1995), meaning that the ‘health broker’ role on a bureaucratic level that resulted from our inquiry would have a mostly advisory responsibility in the policy-making process. Empirical evidence suggests, however, that administrative officials, together with political officials, may be pro-actively involved throughout the entire policy cycle, and thus expand their bureaucratic influence across all cells of the matrix (Skok, 1995). This indicates that the still rather limited ‘systematic entrepreneurship’ built in most of our municipalities may be a valuable first step in further increasing the role’s influence on the local policy process.

In order to empower the ‘health broker’ role, two municipalities in our collaboration shared it out among multiple health sector officials. In one municipality, this collective entrepreneurship (Roberts, 1992) had the advantage of integrating the insights into the procedures used in different organizations. From a network perspective, this integration of insights may further contribute to information flows and mutual expectations of trust (Williams, 2002) in order to break out of the ‘silos of sectoral service delivery’ and ‘cope with the mess of different agencies, all with overlapping mandates to address interrelated problems’ (Craig, 2004). Such brokerage by entrepreneurial actors across social networks may build the social capital that may be required to improve health (Burt, 2004).
In the other municipality, sharing out the role was perceived as increasing the ability to operate as an ‘anchoring point’ for policy instruments and neighbourhood problems. Having the role of spanning boundaries carried out by two key individuals, at management and implementation levels, may indeed result in an ‘across and upward spanner’, to bring organizations on board and to connect issues to a policy agenda, and a ‘downward spanner’, acting as a mediator with the local communities (Rugkåsa et al., 2007). As effective ‘systematic entrepreneurship’ requires high levels of cooperation among several actors from several organizations and sectors (Bernier and Hafsi, 2007), it seems advisable to expand the ‘health broker’ role even further, for instance in order to cover more structure–function combinations (Skok, 1995). Such an extension may for instance include managers at executive level to create the essential leadership (Bernier and Hafsi, 2007) and support (Catford, 1998), as well as other bureaucratic level officials who, as was the case in our study, already perceive themselves as having a similar entrepreneurial role.

Despite the positive perspectives on collective entrepreneurship described above, it may nevertheless be valuable to further explore the possibilities of individual entrepreneurs who hold more influential positions within or outside local government. That is, the incremental innovations that can be expected from systematic entrepreneurship (Bernier and Hafsi, 2007) may still not be sufficient to accomplish an integrated approach to health promotion, as the barriers to this have repeatedly been found to be pervasive and resistant to change (Sindall, 1997; Jackson et al., 2007). Hence, establishing boundary organizations that allow employees to work cross-sectorally on a long-term basis may require more general changes in culture and more specific changes in practices (Guston, 2009), and thus more revolutionary transformations by an individual entrepreneur (Bernier and Hafsi, 2007). In the absence of theoretically well-informed role models, our experiences indicate that further experiments with individual entrepreneurship could benefit from an intensified collaborative preparatory stage in which researchers and municipal officials from different sectors further elaborate the conceptualization of the ‘health broker’ role in advance. Similarly, such initiatives should either appoint candidates with special individual entrepreneurial competencies or provide additional training to support the role occupants (Roberts, 1992; Bernier and Hafsi, 2007).

A characteristic of the present study was its collaborative nature, in which university researchers and municipal officials together explored the possibilities of a ‘health broker’ role. This method can be characterized by the metaphor of ‘building bridges’ in order to explore the relationship between theory and practice (D’Cruz and Gillingham, 2005). In our collaborative study, the ‘health broker’ role was informed by practical considerations rather than the theoretical notions specified in advance. First, the multiform conceptualization of the ‘health broker’, as described in the introduction section, may have complicated its positioning and design and contributed to the relative indistinctness of the role as we were able to implement it within the first year of our experiment. This also means that, despite the obvious dissimilarities, it is not yet possible to meaningfully compare the ‘health broker’ roles in the four municipalities. Hence, the developments in our collaboration may have limited the generation of theoretically relevant knowledge about the potentials of the ‘health broker’ role (D’Cruz and Gillingham, 2005). Second, our experiences indicate that the initial conceptualization of individual entrepreneurship, mainly by the research team, did not lend itself easily to developing and implementing a ‘health broker’ role in the participating municipalities under the present circumstances. This first collaborative experiment with a ‘health broker’ role, in which no one knew its practical manifestation in advance, resulted in systematic entrepreneurship. We therefore conclude that, for our collaboration, this concept provided the best point of departure to generate the practically relevant knowledge that should also result from these kinds of collaborations between research and practice (D’Cruz and Gillingham, 2005). The evaluation of the further achievements of our collaborative inquiry could most likely benefit from the application of nexus theories that reflect
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<tr>
<th>Method: how municipalities dealt with the complexity of health inequalities and local situations</th>
<th>Den Haag</th>
<th>Groningen</th>
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<th>’s-Hertogenbosch</th>
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<tr>
<td>Waiting for results of recently started additional collection of neighbourhood health data</td>
<td>Relying on available municipal health data and combining them with additional qualitative inquiry among key figures and target group to assess local health situation</td>
<td>Using and integrating available data on health and (social) determinants as best as possible</td>
<td>Using and integrating available data on health and (social) determinants as best as possible</td>
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<tr>
<td>Decided to refrain from developing programme theory because of difficulties due to missing information and complexity of (determinants of) health and health inequalities, as well as of complexity of neighbourhood</td>
<td>No programme theory completed within the first year, because of gradual stepwise development of ‘District Deal’ approach; focus during first year on analysis of neighbourhood health situation; programme theory is assumed to be one of the end-products of this survey</td>
<td>Programme theory based on local information: demographic figures, juvenile health monitor, adult health monitor, senior health monitor, analysis of living environment and safety situation, as well as general information on personal, environmental and social determinants of health</td>
<td>Programme theory based on local information: demographic data, housing situation, social and physical environment (including safety), socio-economic situation, partial survey of local providers, selection of local policies and local developments, and a general overview of determinants of overweight</td>
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<tr>
<td>Instead of programme theory, a three-way ‘pioneering’ model reporting on first-year survey of local demands (health and health inequality issues), local supplies (local policies) and local organization (especially structure, procedures and culture of health sector) and emerging opportunities as well as barriers to develop and implement ‘health broker’ role</td>
<td>Preliminary results of exploration phase: summary of general information on neighbourhood, selected public neighbourhood facilities and potential broking points, and examples of integrated neighbourhood health promotion initiatives</td>
<td>Programme theory depicts three health issues [see below], their relation with potential determinants of health in this specific neighbourhood and population, and the potential but unspecified relation of these determinants with local policies and political points of view; points towards local developments, organizations and (combinations of) agencies as possible ‘broking points’ to positively influence current situation</td>
<td>Programme theory depicts juvenile overweight as main health issue, influenced by sedentary lifestyle and unhealthy eating habits, which in turn are influenced by a whole gamut of personal and environmental factors, influenced in their turn by social and material deprivation, due to several neighbourhood-related socio-economic factors; points out various local initiatives and actors as possible ‘broking points’ to improve current situation</td>
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### Table 3: Content of the ‘health broker’ role in the four municipalities

- **Den Haag**: Waiting for results of recently started additional collection of neighbourhood health data.
- **Groningen**: Relying on available municipal health data and combining them with additional qualitative inquiry among key figures and target group to assess local health situation.
- **Helmond**: Using and integrating available data on health and (social) determinants as best as possible.
- **’s-Hertogenbosch**: Using and integrating available data on health and (social) determinants as best as possible.
- **Method**: How municipalities dealt with the complexity of health inequalities and local situations.
- **Development of programme theories**: Decided to refrain from developing programme theory because of difficulties due to missing information and complexity of (determinants of) health and health inequalities, as well as of complexity of neighbourhood.
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**Programme theory based on local information**: Demographic figures, juvenile health monitor, adult health monitor, senior health monitor, analysis of living environment and safety situation, as well as general information on personal, environmental and social determinants of health.

**Programme theory based on local information**: Demographic data, housing situation, social and physical environment (including safety), socio-economic situation, partial survey of local providers, selection of local policies and local developments, and a general overview of determinants of overweight.

**Programme theory based on local information**: Summary of general information on neighbourhood, selected public neighbourhood facilities and potential broking points, and examples of integrated neighbourhood health promotion initiatives.

**Programme theory based on local information**: Three health issues [see below], their relation with potential determinants of health in this specific neighbourhood and population, and the potential but unspecified relation of these determinants with local policies and political points of view; points towards local developments, organizations and (combinations of) agencies as possible ‘broking points’ to positively influence current situation.
<table>
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<tr>
<th>Overall ambition: what ‘health broker’ role should ultimately be aiming at</th>
<th>Contributing to increased life expectancy of citizens</th>
<th>Helping reduce health inequalities through improvements in (health) situation (to be specified later on)</th>
<th>Helping reduce health inequalities by reducing chronic illnesses and mental health problems</th>
<th>Helping reduce health inequalities, focusing on reducing juvenile obesity</th>
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<tr>
<td>Prerequisites: role of cross-sectoral approach, citizen participation and political and administrative support to accomplish ultimate aim</td>
<td>Focus on cross-sectoral approach by joining horizontal administrative structures and connecting stakeholders on certain themes</td>
<td>Municipal structure and public health policy perceived as integrated, but local modes of operation are not</td>
<td>All three prerequisites seen as important for success of ‘health broker’ role</td>
<td>Focusing on strengthening cross-sectoral approach as this was perceived to be most problematic</td>
</tr>
<tr>
<td>Action plans, including programme theories</td>
<td>Focusing on citizen participation to enable transformation of integrated policy towards integrated and tailored local (health promotion) approach</td>
<td>Existing cross-sectoral efforts regarded as insufficient (fragmentation), participation regarded as selective and political and administrative support as limited</td>
<td>Participation regarded as taken care of by making use of various previous consultations and surveys</td>
<td>Secondary focus on achieving political and administrative support, as climate was regarded as not favouring ecological approach to health and health inequalities</td>
</tr>
<tr>
<td>Action plan I</td>
<td>Political and administrative climate regarded as favourable for tackling health inequalities and ‘health broker’ role in general</td>
<td>Political and administrative climate regarded as being especially favourable for citizen participation and tackling health inequalities</td>
<td>Based on ecological–social model</td>
<td>Based on ecological–social model</td>
</tr>
<tr>
<td>Primary aim: systematic improvements prerequisite for local health policy: communication, information supply and policy development process (improved input and awareness of urgency)</td>
<td>Introduces stepwise ‘District Deal’ including exploring, organizing, executing, evaluating and anchoring phases</td>
<td>Main long-term objectives: contributing to health gains (healthy life expectancy, self-reported health) for residents of neighbourhood through a relative decrease (compared to regional figures) in chronic diseases (specifically pulmonary diseases, diabetes and cardiac diseases, depression and isolation)</td>
<td>Based on ecological–social model</td>
<td>Based on ecological–social model</td>
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<th>Helmond</th>
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<tr>
<td>Focusing on two predefined health problems: juvenile overweight (healthy lifestyle) and housing climate (healthy living); ‘new’ problems to be defined later on</td>
<td>Main aims: improving citizen participation in health promotion and further stimulus to cross-sectoral policy in health promotion</td>
<td>Main mid-term objectives: improved cross-sectoral collaboration, connections between public health and primary care, intensified personal lifestyle approach and improved neighbourhood structure in health promotion</td>
<td>Main objectives: development of health broker role and implementation of role in one neighbourhood, concentrating on problem of juvenile obesity</td>
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<td>Short-term objectives: identifying problems (‘signals’) and mediating solution between stakeholders within current policies</td>
<td>Main result: health remains issue on agenda of networks in neighbourhood; several of these networks identified as potential ‘broking points’</td>
<td>Main short-term objectives: looking for opportunities to implement successful health promotion programmes; supporting innovative cross-sectoral initiatives to strengthen individuals, community, living environment and social circumstances; implementing available health impact assessment instruments, integrating health issues in neighbourhood regeneration programme</td>
<td>Main aim: reducing obesity to average municipal level</td>
</tr>
<tr>
<td>Longer-term objectives: structural solutions through formal advice and policy development</td>
<td>Additional result: crystallized health broker role</td>
<td>Operational principles: citizen participation, cross-sectoral collaboration, growth model (from small-scale opportunities to larger-scale successes), financial and legal support for innovative initiatives, clustering of health promotion and disease prevention initiatives</td>
<td>Main strategies (to be further developed): meso-level interventions (in collaboration with and integrated in existing structures and initiatives); macro-level interventions (agenda-setting, lobbying, advocating, facilitating, fund raising, cross-sectoral collaboration, integrated policy and administrative and political involvement)</td>
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Action plan II
Health broker role: picking up signals, selecting and connecting signals to health or other professionals, indicating how to deal with signals together with stakeholders involved

Specific action plan expected in second year as a result of the second phase of the stepwise ‘District Deal’ approach

Potential broking points: neighbourhood regeneration programme, community centre, community primary care centre (including general practitioners), participation of committees, housing corporations and social and cultural organizations

Contextual factors identified as potential ‘broking points’: development of new municipal obesity centre, recently established centre for youth and family and existing neighbourhood health promotion programme by municipal health service

Secondary aim: preparing survey of policy development, formal policy decisions and policy implementation

Preconditions acknowledged [see also shared experiences]

Preconditions: coherent picture of all relevant aspects of neighbourhood (including demands, supplies and policy); additional preparation time to further elaborate positioning and content of health broker role as well as experiment with implementation
on the kinds of actions needed to facilitate more integration between research, policy and practice (De Leeuw et al., 2008).

CONCLUSION

The ‘health broker’ role resulting from our efforts reflects the notion of systematic rather than individual entrepreneurship. Such a collective entrepreneurial may create additional opportunities to gradually strengthen local health promotion efforts. Our findings legitimize further collaborative inquiries with innovative entrepreneurial roles as an additional investment to promote health in deprived neighbourhoods. To increase the theoretical as well as practical value of such studies, it can be recommended to start with a thorough, agreed upon conceptualization of the new role. The structural–functional framework for public policy and administration may be a fruitful starting point for such a conceptualization as well as for the formulation of testable hypotheses. This study provides a realistic perspective on the possible practical manifestations of the ‘health broker’ role and may serve as an instructive example of collaborative inquiries in this new domain.

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