Child Health Promotion

Analyses of Activities and Policy Processes
in 25 Swedish Municipalities

Karin Guldbrandsson

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To Ebba & Karl-Olof
ABSTRACT

The Swedish municipalities are important actors that offer appropriate environments for health-promoting activities directed at children and adolescents. Enhanced understanding on how such activities develop is needed to improve local public health action. The overall objective of this thesis was to describe potential explanatory factors in municipal health-promoting measures directed at children and adolescents, in order to facilitate for national actors to support health-promoting action in the municipalities.

In the first three papers of this thesis the intentions of 25 Swedish municipalities to promote children and adolescents’ health are described. Safety promotion (Study I), health promotion in preschools (Study II) and health promotion in schools (Study III) were of primary interest. In the next step policy processes and factors that might explain municipal public health action were analysed (Study IV). Finally, data from Study I were used to test correlations between municipal safety-promoting activities and health outcome (Study V).

Although intentions to promote children’s health were in general quite well developed, there were some exceptions and variations among the municipalities. Significant correlations between municipal health-promoting activities and outcome variables were revealed on injuries (Study V) but not on youth behaviour (Study III). Municipal socio-economic status, measured as proportion adults with more than 12 years of education, did not predict the level of health-promoting measures, whereas municipal growth seemed to have a hampering effect. These results were consistently observed in Studies I-III. Faster growing municipalities reported fewer safety-promoting measures, a lower fraction of preschool staff with a university degree and a lower fraction of full-time employed teachers with a university degree than slower growing municipalities.

Five potential explanatory factors for policy process development were identified in Study IV: financial problems, perceived local needs, external funding, national and international policy documents and presence of a local public health sector. Politicians, public officials and non-governmental organisations were important actors in different phases of the policy process, with strong commitment, professional skills and powerful position in the organisation as main characteristics. The health sector in general, epidemiological statistics and evidence-based methods were seldom mentioned in Study IV.

Potential policy implications based on the results presented in this thesis are that disseminating public health-related knowledge through international and national policy documents and supporting institutionalisation of a local public health sector might be useful methods to stimulate and support municipal public health action. Further, means to introduce and distribute epidemiological statistics and evidence-based methods to the municipalities ought to be considered. Increased and improved co-operation between public health sciences and political sciences (e.g., by integrated courses and shared research projects) could be helpful in developing public health research within the municipal arena.

Keywords: Children, adolescents, health-promotion, safety-promotion, municipalities, policy development, the actor-structural approach
LIST OF PUBLICATIONS

This thesis is based on the following papers, which are referred to in the text by their Roman numerals:


II  Guldbrandsson K, Bremberg S. Municipal intentions to promote preschool children’s capabilities and health: a descriptive study of 25 Swedish municipalities. Early Childhood Education Journal. (Accepted)

III  Guldbrandsson K, Bremberg S. Two approaches to school health promotion: focus on health-related behaviours and general competencies. An ecological study of 25 Swedish municipalities. Health Promotion International. (Accepted)


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Kommunerna är viktiga aktörer i hälsofrämjande arbete riktat till barn och ungdomar. Ökad kunskap om hur hälsofrämjande insatser initieras och bedrivs i kommunerna behövs för att nationella aktörer, som till exempel Statens folkhälsoinstitut, ska kunna stimulera och stödja lokalt folkhälsoarbete. Det övergripande målet med den här avhandlingen var att identifiera faktorer av betydelse för utveckling av kommunala hälsofrämjande insatser riktade till barn och ungdomar.

De tre första studierna i den här avhandlingen beskriver 25 svenska kommuners intentioner att främja barns och ungdomars hälsa. Skadeförebyggande insatser (Studie I), hälsofrämjande insatser i förskolan (Studie II) liksom i skolan (Studie III) var av primärt intresse. Nästa steg var att identifiera och analysera policyprocesser och faktorer av betydelse för utveckling av kommunala hälsofrämjande insatser riktade till barn och ungdomar (Studie IV). Slutligen testades samband mellan kommunala skadeförebyggande insatser (data från Studie I) och utfall, mätt som barn som vårdats på sjukhus pga. skada (Studie V).

De kommunala intentionerna att främja barns hälsa var i allmänhet goda, dock fanns en variation mellan kommunerna. Signifikanta samband mellan kommunala skadeförebyggande insatser och andel barn i kommunen som vårdats på sjukhus på grund av skada framkom (Studie V). Kommunernas socio-ekonomiska status, mätt som andel vuxna med mer än 12 års utbildning, speglade inte kommunernas nivå av hälsofrämjande insatser. Kommunal tillväxt verkade dock ha en hämmande effekt. Dessa resultat återkom i studierna I-III. Kommuner med hög tillväxt rapporterade lägre nivå av skadeförebyggande insatser samt lägre andel förskolepersonal och lärare med högskoleutbildning än kommuner med låg tillväxt.

Fem faktorer av betydelse för att kommunala hälsofrämjande insatser riktade till barn och unga ska utvecklas identifierades i Studie IV: förekomst av ekonomiska problem, upplevda lokala behov, extern finansiering, nationella och internationella policydokument och en lokal folkhälsosektor. Politiker, tjänstemän och frivilliga organisationer framhölls som viktiga aktörer i olika faser av policyprocessen. Aktörerna utmärktes av starkt engagemang, professionella kunskaper och stark ställning i organisationen. Hälso- och sjukvården, liksom epidemiologisk statistik och kunskapsbaserade metoder nämndes sällan i studie IV.

Att använda internationella och nationella policydokument och att stödja institutionalisering av en lokal folkhälsosektor kan vara användbara metoder för att stimulera kommunalt folkhälsoarbete. Befintliga metoder för att introducera och distribuera epidemiologisk statistik och kunskapsbaserade metoder i kommunerna bör granskas och nya metoder utvecklas. Ett utökat samarbete mellan folkhälsovetenskapliga och statsvetenskapliga institutioner skulle kunna bredda folkhälsoforskningen på den kommunala arenan.
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STUDIES I-V
1 INTRODUCTION

What makes things happen? This question has followed me during the work on this thesis.

I started to work in the health care sector in 1977 and with public health issues in 1986. I have followed the development of public health work from downstream to upstream. From the most ill and injured as an intensive care nurse, via municipal health education activities as a keep-fit advisory official, to health policy development as a public health official in the county council. This personal history implies several years of developing thoughts, beliefs and numerous questions concerning the organisation of disease prevention and health promotion in society.

Then, what makes things happen? For example, what makes things happen regarding activities specifically designed to promote the health of children and adolescents in a municipality? Why do such things happen at all? How does a question end up on the political agenda, and who brings it there? Can we assume that a formulated policy will be implemented? In an attempt to cover this complex topic I have approached three main areas: municipal intentions to promote the health of children and adolescents, policy development in the municipalities, and outcome related to health-promoting activities.
2 BACKGROUND

A broad approach to health promotion has been widely advocated during recent decades (1,2). An important component of this approach is different welfare services. In universalistic welfare states (3), such as in Scandinavia, the municipalities have unique conditions concerning autonomy, democratic control and tax equalisation. The municipalities are responsible for considerable parts of public services (e.g., school, preschool, social services and health promoting measures) (3,4). Thus, the Swedish municipalities are important actors that offer appropriate environments for health promotion.

The Swedish government have an overall responsibility for matters of health in the population. However, many national structures are decentralised and the government cannot directly rule the municipalities. A key question in modern public health work at the state level is how to stimulate and support evidence-based health-promoting and disease-preventing measures in the municipalities.

To understand how the government could encourage municipal public health action it is relevant to study policy process development in municipalities. Within public health sciences there exists well-developed knowledge concerning what to do, i.e. evidence-based methods, but less developed knowledge on how to implement these methods. Although some studies related to this topic have been presented (5-10), not enough is known on how to stimulate health-promoting measures at the municipal level. The government therefore needs to enhance its understanding of policy process development in order to improve local public health action.

2.1 Children's health status in Sweden

Children and adolescents in Sweden are, in general, healthy. Yet, there exist various health problems, including mental ill health, allergic and infectious diseases, injuries, overweight and physical inactivity (11,12). Risk behaviours such as smoking, alcohol and drug use, unsafe sex and physical inactivity may be established during childhood and adolescence and cause ill health later in life (13). Many health problems are more common in families with low socio-economic status (11,14,15). Accordingly, developing and implementing health-promoting measures aimed at children and adolescents still remain an important issue in Sweden.
2.2 Municipal responsibilities and opportunities to promote children’s health

The municipalities offer several arenas (e.g., preschools, schools and after-school recreation centres) where children and adolescents spend considerable time. The municipalities are accountable for the main part of traffic, play and leisure environments in children’s immediate surroundings. Municipalities have responsibilities, as well as opportunities, to provide safe and health-promoting environments to children and adolescents. Therefore, the municipalities seem to be suitable arenas for health-promoting activities. However, research suggests that considerable variation exists between municipalities concerning design and volume of service provided to children and adolescents (16).

A conceptual model, based on life course epidemiology (17-19) is shown in Figure 1. Using this model, it is quite straightforward to recognise which municipal arenas that are involved in the development of children’s health and wellbeing and where in the process supporting activities might be introduced.

![Figure 1](image.png)

**Figure 1.** From childhood conditions to adult health, a conceptual model after that proposed by Bremberg (19). Marked squares demonstrate arenas appropriate for municipal health-promoting activities.
2.3 Evidence-based methods

There exist numerous evidence-based methods applicable on municipal public health work directed toward children and adolescents (13,14,20-35). Physical ill health and risky behaviour may be prevented by municipal action (e.g., by organising reduced access to harmful substances, such as tobacco and alcohol and organising increased access to that which protects, such as opportunities for physical activity within easy reach) (13). Mental health among children and adolescents could be promoted by several evidence-based methods (31,36,37). Some of these methods are common in Sweden (e.g., child-centred teaching in preschools) (38), whereas others (e.g., parent support offered by preschools) (31) are less common. Safety promotion is an example of a successful health-promoting activity in Swedish municipalities, one that has led to a relatively low injury rate compared with other countries (39-41).

Two main perspectives of health promotion with respect to children and adolescents may be discerned: a perspective focusing promotion of health-related behaviours and a perspective emphasising development of general competencies.

2.3.1 Health-related behaviours

A common method to promote the health of children and adolescents is to address health-related behaviours (such as alcohol and drug use, physical inactivity or smoking) by health educational efforts. However, long-term effects are seldom achieved (42-44). In the health promoting school approach health education is combined with modification of the school environment to support development of health-promoting behaviours (45). Health educational and environmental measures are expected to reinforce each other. The empirical evidence for the effectiveness of the health promoting school approach is limited, however (46).

2.3.2 Children’s competencies

An alternative perspective on health promotion for children and adolescents is to focus on early development of emotional, social and intellectual competencies. Education is presumed to increase a wide range of competencies in children and adolescents and, by that means, their health and social adaptation (19,36,47). Keating has shown that the wealth of a society relies heavily on the health, coping skills and competencies of its population (48). These characteristics, in turn, depend on the support and education of children.

Children in preschool are given opportunities to develop emotional, social and intellectual competencies. Research on the origins of antisocial and violent behaviour in youth has clearly pointed to the preschool period as fundamental (49). Accessibility to preschools has been found to determine
both child and adult adjustment and health (50,51). Provision of quality preschools is therefore an important public health measure, with a large potential to decrease socio-economic differences in health. Studies have been performed that might be used to formulate criteria for health-promoting preschools (38,52-61). In addition to the fact that these criteria provide a reasonable picture of preschool quality from a health perspective, they show considerable similarities with the international standards for high-quality preschool education (62).

Several studies have demonstrated that if children develop linguistic and mathematical skills, the risk of school failure decreases, which, in turn, may diminish the risk of mental ill health (55-57). Poor school achievements have also been associated with smoking (63) and physical inactivity (64). In a WHO report on young people’s health it was asserted that academic achievement is associated with fewer health complaints, good general health based on self-evaluation, greater overall life satisfaction and a lower risk of smoking (65). Consequently, education is presumed to increase children’s competencies and their health and social adaptation in turn. During the past few decades, the “effective school” concept has been central in understanding characteristics of schools that are effective in producing socially well adjusted students with good academic results (58,66-68). The characteristics of “effective schools” are effective leadership, teacher and teaching effectiveness, focusing on learning, generating a positive school culture, high expectations of achievements and behaviour, emphasising student responsibilities and rights, monitoring progress at all levels, staff development and parental involvement (69). In terms of progress gained Thomas et al. found that the school had a greater influence than the age, gender and socio-economic conditions of the students (68). Because “effective schools” promote student competencies, these schools might also be expected to promote student health. In a recent article about the evaluation of health-promoting schools the authors argued that, rather than focusing primarily on health-related measures, such evaluation should be more in line with educational dynamics of schools and research on effective schools (70). Along this line of thinking, development of health promotion at school means development of the school in its core task.

2.4 Municipal governing and the governing of municipalities

The traditional system of government is largely based on an apolitical and institutionalised civil service, internal regulation, hierarchy and rules, permanence, stability and equality. During the 1980s and 1990s an extensive rethinking of governance took place, which led to the emergence of several new governing models, including the market government, the participative government, the flexible government and the deregulated
government (71). This movement naturally has influenced Swedish municipalities. The economic recession during the 1990s also affected the municipalities (72) in Sweden. The municipal contexts in which healthy public policies are implemented include both system of government and financial circumstances.

2.5 Healthy public policy

The public health sector has moved its position during the past few decades from a mortality/morbidity approach to a perspective addressing the determinants of health. The Lalonde report (73), the Alma Ata declaration (74) and the World Health Organisation’s Health for All strategy (75) are fundamental stages in this development. In a study on health target setting in 18 European countries the authors concluded that the WHO’s strategy Health for All had influenced the health policy of almost all the countries in the study (76).

In 1986, an international health conference was held in Ottawa, Canada, and a new broader understanding of health promotion was adopted (1,77). The Ottawa Charter for Health Promotion has since influenced the public health debate, policies and practices in many countries (78-81). One strategy in the Ottawa Charter is to build healthy public policy, meaning that health should be put on the agenda of policymakers in all sectors and at all levels, directing them to be aware of the health consequences of their decisions. System changes on the societal level are more powerful than interventions aimed at behavioural change on the individual level (82). According to Bracht, the intention of the Ottawa charter is to broaden the base of health promotion so that policy, rather than behaviour and personal life-style, becomes the most important factor. Further, all systems governing social, economic and environmental conditions ought to be aware of the health implications of their activities (83).

The health services alone will not be enough to improve people’s health (84). This has led to greater governmental efforts to find multi-sectoral mechanisms for health policy. Combined with the shift from an individual perspective to a general perspective within the public health sector during the past few decades there has been an increasing interest in and significance of policy-making.
2.6 Healthy public policy in Sweden

The county councils are responsible for health care services, including those public health measures that are done within the health care services (85). Regional centres for public health are established in approximately one third of the 21 regions and county councils. Remaining county councils have established what are usually called public health units. However, county council activities are dominated by medical care while health promotion and disease prevention are often less emphasised.

The National Board of Health and Welfare is responsible for the monitoring of public health and social conditions: public health reports and social reports are published every fourth year (86). The National Institute of Public Health is responsible for the intersectoral monitoring and evaluation of public health action (87). The first public health policy report will be submitted to the Government in the autumn 2005.

The Swedish public health objectives, which were presented in 2003, are oriented toward health and health determinants rather than toward disease and individual behaviour (87). The responsibility to accomplish these objectives is divided between several sectors and different levels in society. Most likely the 290 municipalities in Sweden will become important actors, as most of the policies that influence people’s daily lives are decided on by municipal politicians and administered by municipal public officials. Knowledge about factors that affect municipal public health efforts is needed to achieve the public health objectives. In order to understand how the government and its authorities could encourage municipal public health action it is relevant to study policy process development. One aim of this thesis was therefore to describe policy processes and potential explanatory factors in municipal public health activities directed toward children and adolescents.

2.7 Strategy and study design

In the first three papers included in this thesis the intentions of 25 municipalities to promote children and adolescents’ health are described. Safety promotion (Study I), health promotion in preschools (Study II) and health promotion in schools (Study III) were of primary interest. In the next step policy processes and factors that might explain municipal public health action were traced and analysed (Study IV). Three municipalities with different levels of activities detected in the first three studies were selected to take part in study IV. The purpose of this selection was to include municipalities with different emphasis on public health issues in the study. Finally, data from study I was used to test correlations between municipal safety promoting activities and health outcome, measured as injury-related hospitalised children (Study V) (Figure 2).
Figure 2. Design of the thesis.
3 THEORETICAL FRAMEWORK

In the theoretical background a brief summary of policy developmental theories and approaches is given. Stage models, implementation and the actor-structure approach are discussed.

There are many definitions of policy and concepts related to policy, both in the public health and political science literature (8,84,88-92). At its simplest level “policy” means “plan of action”, its roots originating from the Greek and Latin words for government and citizenship (45). In a public health science dictionary policy is defined as “on principles based acting or course of action” (93). Premfors means that in everyday language the word policy refers to a set of clearly stated guidelines aimed at specific activities and for measures taken in order to realise these guidelines (91).

“Policy is rather like the elephant – you recognise it when you see it but cannot easily define it” (94).

Policy is the thread of conviction that keeps a government from being the prisoner of events” (95).

Walt has stated that policy involves the decision to act on a particular problem, subsequent decisions concerning implementation, and finally, maintenance of an activity. Policies usually involve a series of decisions, where previous decisions affect present policies (84). The pattern of policymaking may depend on political events occurring centuries ago. Thus, history can influence policy. The ranges of grounded practices that arise from day-to-day work constitute policy in themselves (89). In such cases policy decisions move backwards from implementing organisations to the policy formulators, and policy documents tend to be statements of current practice. Non-policy-making is a method to keep certain issues off the political agenda. As Spicker noted, non-decisions are decisions not to decide anything but to maintain conditions as they are (92). Policies may also be what Vedung calls “a powerful knock in the air”, i.e. symbolic (96).

A basic question in policy development is if an experienced problem is a “real” problem, and if it is, finding the best solution. To be able to manage a problem the government must have the right to intervene, have sufficient resources, personnel and infrastructure and the most important interest groups must be positive, or at least not negative (84). According to Bäck and Soininen, a political proposal has to pass several obstacles before obtaining any result. First, it has to be anchored in a system of political ideas to reach the policy agenda at all. Second, it has to be advocated and supported by different actors. Finally, if it reaches the policy agenda and a decision is reached, the implementation still remains to be accomplished (97).
Policies exist within paradigms or policy cores (98,99). These function as sorting systems in which all new ideas must be possible to arrange. A policy proposal is thus surrounded by a political “possibility frame”. If a proposal doesn’t fit within this frame, it will not even be discussed. Small changes in policy practices are the most common type of change. Such changes occur in what Sabatier calls secondary aspects or what Janson calls the policy periphery. These changes could be described as “normal politics”. Hence, the closer to the policy core, the more difficult it becomes to introduce a new policy or to change an existing one. Lindblom described this periphery decision making in a similar manner when stating that policy emerges from a series of small changes (100). Green and Thorogood have also expressed the view that policy merely changes at the margins while the fundamental principles are seldom questioned (89).

3.1 Policy developmental theories and approaches

In order to study policy processes it is helpful to use concepts developed within social science. However, a single theory that fully explains policy development does not exist. In Study IV a number of concepts from different theories were used to explain policy processes. According to John, there are broadly five approaches that can explain how policy is made and implemented: institutional approaches, group and network approaches, socio-economic approaches, rational choice theory and the ideas-based approach (101).

3.1.1 Institutional Approaches

An institution might be described as a collection of norms, rules, understandings and routines. Institutions are also defined by their stability and their capacity to influence individuals (102). There exist institutional expectations for individual behaviour within institutions. The behaviour is reinforced when appropriate and sanctioned when inappropriate. Thus, institutions will harden their values over time. Some expectations may apply to all members of the institution, while others will be specific to single individuals or positions. Peters described routines as stable patterns of behaviour, and rules as means of structuring political systems. Bäck and Soininen stated that it is institutional rules that shape and legitimise organisations, interest groups and professions. Such rules define appropriate economic, cultural and political measures. Because a set of rules gives collective meaning, institutionalising might be defined as a process by which actors and activities successively are taken for granted (97). Cultures, political decisions, rules and structures, represented by institutions and often introduced long ago, influence policies (101). Institutions are not static: they adapt to the political environment and change their role over time. Therefore, history is important for the institutional account.
3.1.2 Group and Network Approaches

Group and network approaches consider the importance of the interactions between participants in the policy process (101). Networks are based on the development of knowledge and trust and relationships facilitate the exchange of ideas within networks. When actors learn to trust each other and exchange policy ideas, there is a potential for policy innovation. Colebatch described expertise as an important way of organising policy activity (88). People who are concerned with a particular policy area share the same knowledge and address the same problem. Although, different fields of expertise may address the same question in different ways (e.g. drunkenness could be managed as a social issue, a police issue or a health issue). According to Colebatch, policies often originate outside the central policy framework, such as in community groups or professional associations. Policy collectives are relatively stable aggregations of people from a range of organisations thrown together on a continuing basis to address a specific problem. Many groups outside government try to influence policy on particular issues and at various stages of the policy process. Walt described interest groups as groups that attempt to influence public policy without wanting political power. Groups organised around common interests will be quick to react to policy change (84).

3.1.3 Socio-economic Approaches

Based on theories by Marx, Weber and Durkheim, John suggested that social and economic factors explain behaviour and that the interest of the most powerful determines the political system (101). Thus, public policy reflects stability and change in economic and social relationships. Walt agrees that elite groups control policy-making (84). On the other hand, actors outside the elite groups in society try to influence policy. This implies that actors of the narrow elite rule the political agenda while other actors influence issues of lower politics. Any policy that is backed up by legal, financial or moral sanctions, whether it relies on reward or punishment, can be seen as an exercise of power (92).

3.1.4 Rational Choice Theory

Rational choice theory posits that individual choice is the basis of political action and that policy development should be perceived from the perspectives of the individuals rather than from the organisation (101). Consequently, what is rational from an organisation’s point of view might not be rational for the individuals within the organisation. However, individuals are capable of altruism and emotional behaviour and do not always choose courses of action that maximise their utility. Because rational choice theory models individual choices within the context of institutions, it provides a dynamic link between the micro and the macro levels. This link is, according to John, often missing in other approaches.
3.1.5 Ideas-based approach

Ideas can act as “road maps” and thus guide actors’ behaviour (101). Political decision-makers need ideas to give meaning in politics and help shape their identity in the political context. Policy ideas could strengthen networks, and instead of socio-economic structures, ideologies might govern how power is exercised.

3.2 An integrated framework

Institutional approaches assume that structures and norms influence the policy process, whereas group and network approaches rely on actors and their relationships. Macro socio-economic approaches explain policy processes as reflections of power, rational choice theory stress the strategic choices of individual actors and ideas-based approaches emphasise the importance of ideologies in the policy process. Each approach has advantages and disadvantages. However, single approaches are too narrow and fail to explain policy development (101). Instead, an integrated approach might better explain policy change. The policy streams approach (103) and the punctuated equilibrium model (104) are integrated models, which were used in study IV.

3.2.1 Policy Streams Approach

The policy streams approach, developed by John Kingdon, assumes a continual interaction between all elements in the policy process (103). Ideas are not uniquely associated with one person or organisation; instead, they arise from the sharing of agendas between decision-makers. Kingdon regards policy formation as the result of a flow of three “streams”: problems, solutions and politics. Problems are public matters requiring attention, solutions are proposals for change and politics influence how opinion-formers define problems and assess solutions. An idea often “catches on” and moves rapidly onto the political agenda, especially if what Kingdon calls a policy window opens. These windows of opportunities might not be open long, so actors who promote specific solutions, often named the policy entrepreneurs, must act rapidly before the opportunity passes by. As decision-makers shift their attention from one problem to another, policy entrepreneurs keep to their issue. The policy streams approach explains the role of all the actors in the policy process, even of lower-level bureaucrats (103).

3.2.2 The Punctuated Equilibrium Model

In policy sectors there are periods of stability followed by periods of public and media interests. Baumgartner and Jones described this as stable periods of policy-making “punctuated” by policy activism (104).
describes it, policy shift could be generated when decision-makers, organisations or the public assigns a new concern (101). If an unstoppable issue expansion (a “bandwagon effect”) starts, the equilibrium will be punctuated. The punctuated equilibrium is a “bottom up” model in which people outside the policy process can challenge the prevailing pattern of decision-making. In the punctuated equilibrium model, policy changes come quickly and dramatically rather than incrementally. In line with this pressure groups have to “find an incident” on which to focus (92).

“Scandal has had much more immediate effect on policy than research ever has.” George Bernard Shaw (92).

3.3 Stage models

There are several policy process stage models described in the literature. Walt identified four stages of policy-making: problem identification, policy formulation, policy implementation and policy evaluation (84). Premfors summarised the policy process stages with the following concepts: problem, alternatives, recommendations, decision, implementation, evaluation and feedback (91). Colebatch’s suggestion of stages includes: determining goals, choosing courses of action, implementation, evaluation and modifying of the policy (88). Spicker proposes: awareness of the problem, salience, definition of the problem, specification of alternatives and choice between alternatives (92). Obviously, there exist a number of policy process stage models. However, several researchers argue that stage models might give a false impression because they suggest that the policy process is linear and rational (84,89,101).

3.4 Implementation

The political process does not end with the formation of a policy. Policies still have to be put into practice. Traditional implementation analysis predicts it is very hard for a policy to be implemented at all (105). This is a well-known account, first stated by Pressman and Wildavsky, who suggested that the more decision points there are the greater is the risk that a policy fails (106).

In the book “Implementation” Pressman and Wildavsky describe how a problem (massive unemployment in Oakland) and a demand (need of immediate use of governmental funds) started a causal chain of events, but in the end yielded little results. What seemed to be a simple program turned out to be a very complex one, involving numerous actors, several perspectives and many complex decision points. Obviously, all actors agreed with the policy of developing jobs for unemployed minorities in Oakland. Then why did the program run into so many obstacles? Pressman and Wildavsky list seven points that might be of importance: direct incompability with other commitments, preference for other programs,
simultaneous commitments to other projects, dependence on others who lack a sense of urgency in the project, differences of opinion on leadership and proper organisational roles, legal and procedural differences, and finally, lack of power. One important lesson from the experience in Oakland, as Pressman and Wildavsky understood it, was to make the difficulties of implementation a part of the initial formulation of a policy.

Logically, a technically simple policy is easier to introduce than a complex one (84). According to Walt, successful implementation is more likely to be realised if the policy goals are clearly stated, if there is one major objective, if the policy is quickly introduced and if only a few actors control the implementation. On the other hand, disagreement in the organisation might result in delayed implementation. A policy might also be symbolic, i.e. not expected to be implemented. Walt further proposed that management and administrative skills are important resources, and where these are lacking, implementation may be slow or distorted.

Policy decisions are realised by individuals who in their daily work turn decisions into practice. These “street-level bureaucrats” are in direct contact with the clients of the organisation (e.g., pupils in school) (88). Bäck and Soininen discussed the importance of protecting the skills and engagement of the staff without losing control over the process (97), and Lundquist listed three significant characteristics (understanding, capability and desire) of the implementing actors to achieve successful policy implementation (107).

The implementation research often discusses the policy process from either a top-down or a bottom-up approach (108). The top-down implementation approach comprises clear objectives, causal theory, a structured implementation process, committed and skilful implementing officials, support of interest groups and changes in socio-economic conditions that do not undermine political support or causal theory. The bottom-up approach, on the other hand, uses a network technique to identify local actors and provide a mechanism for moving information from street-level bureaucrats to policymakers. Top-downers are preoccupied with policy decisions and might overemphasise the importance of the centre, whereas the bottom-uppers are preoccupied with the policy problem and might overemphasise the ability of the periphery (108).

3.5 The actor-structural approach

One vital question is if a social science phenomenon derives from the individual (the actor) (109,110) or from the individual’s environment (the structure) (111) and how the actor and the structure might influence one another.
The influence of the individualistic approach was strong within social science during the 1960s and 1970s, whereas the structuralism dominated during the 1980s (112). The combined actor-structural approach offers an alternative to individualism and structuralism and underlines that both actor and structure act as generative mechanisms (8,107,112-116). A core idea underlying the actor-structural approach is that both actors and structures must be considered. Rothstein claims that structures set the borders but that the actors have numerous options and are capable to act in different ways (113).

According to Peters, rational choice theory could explain components of the actor-structural approach (102). Utility maximisation might be a strong motivation of individuals, but they may realise that their goals can be achieved most effectively through institutional action. Individuals, as well as nations or other collectives, might gain from institutional membership. Thus, Peters claims that if there is a logical need for an institution, it will be created, given that the actors are capable of manipulating the structure. In the long run, preferences of both the institution and the actors may change to correspond with what the institution has found that it can accomplish.

One example of actors' change of structures is non-conformity, as illustrated by the non-violent resistance of Mahatma Gandhi and Martin Luther King, who achieved fundamental transformations of social and legal institutions by not complying with the existing political order. Another example is exceptional personal capabilities to create institutional change, one such actor is Margaret Thatcher (102).

Individuals within the same structure tend to be socialised in a similar way, acquire similar information and be confronted with similar restrictions and possibilities (117). This will also make individuals act in a similar manner. Consequently, it is neither possible to understand the actors without paying attention to the structures, nor to interpret structures without seeing them as influenced by actors. To conclude, the actor-structural approach helps to combine interests, positions and interrelationships of participants in the policy process with contextual and institutional factors in the policy environment. This combined approach was useful in Study IV in this thesis.
4 Objectives

The overall objective of this thesis was to describe potential explanatory factors in municipal health-promoting measures directed toward children and adolescents, in order to facilitate for national actors to support health-promoting action in the municipalities.

Five subordinate objectives were formulated:

1) To investigate the extent and variation of intended evidence based health-promoting measures directed toward children and adolescents in 25 Swedish municipalities (Studies I-III).

2) To investigate whether socio-economic and demographic characteristics of these municipalities affected the level of intended health-promoting measures (Studies I-III).

3) To investigate two perspectives of school health-promotion, one focusing health-related behaviours and one emphasising general competencies (Study III).

4) To describe policy processes and potential explanatory factors in the development of municipal health-promoting measures aimed at children and adolescents (Study IV).

5) To investigate whether intended municipal health-promoting measures influenced selected outcome variables (Studies III and V).
5 MATERIAL AND METHODS

Studies I, II, III and V comprise 25 of 26 municipalities (in average 42 000 inhabitants) in Stockholm County. Stockholm municipality was excluded because of its size (approximately 760 000 inhabitants) and its town district committees, which made it difficult to compare Stockholm municipality with the other municipalities in the county. The selection of municipalities for Study IV was based on results from Studies I-III. Study V is an outcome study in which register data were compared with data from Study I.

5.1 Study I

The purpose of this study was to investigate two elements of the community approach to safety promotion for children and adolescents. The first concerns whether there is any correlation between safety-promoting activities in different municipal settings, and the second whether socio-economic and demographic characteristics affect the level of safety-promoting activities.

The study design was cross-sectional. The extent of safety-promoting activities was studied using different questionnaires in four municipal settings: the municipal setting in general, the traffic setting, the pre-school setting and the school leisure activity setting. The prerequisites in the selection of safety-promoting activities to be included in the questionnaires were that they had to be evidence-based, bear upon the environment, be present in Swedish municipalities and be accessible by the method used in the study. The questions were formulated to capture activities governed from the central municipal level. The questionnaires were pre-tested in five municipalities. The answer of each question was based on percentages, rating scales and dichotomous variables. Data on nine demographic and socio-economic characteristics of the municipalities were collected from public statistics. From these characteristics fraction adults with more than 12 years of education were appointed to mirror the socio-economic status of the municipalities; population growth and population size were chosen as demographic variables. The statistical analysis was performed using Pearson's correlation coefficient (118,119).

5.2 Study II

The objectives of this study were to examine the intentions of 25 Swedish municipalities to develop emotional, social and intellectual capabilities through activities in preschool and to relate these intentions to municipal socio-economic and demographic conditions.
The study design was cross-sectional. As in Study I, questionnaires and public statistics were used to collect data. The questionnaire was pre-tested in four municipalities located outside Stockholm County. The questions were designed to capture activities governed from the central municipal level and targeted to promote growth of intellectual, emotional and social capabilities of preschool children. Additionally, five preschool system variables alleged to mirror general municipal investments in preschool (fraction of registered preschool children aged 1-5, fraction of children aged 1-5 registered in preschools outside the municipal preschool system, fraction of staff with a university degree, number of registered children per employee and municipal cost per registered preschool child) were collected from the Swedish National Agency for Education. The coding procedure was similar to that used in Study I. The statistical analysis was performed using Spearman rank correlation analysis (118,119).

5.3 Study III

One aim of this study was to investigate two perspectives of school health-promotion, a perspective focusing student health-related behaviour and one addressing student general competencies. A further aim was to relate level of activity within each perspective to general adolescent health outcome with control for municipal socio-economic status.

The study design was cross-sectional. As in Studies I and II, questionnaires and public statistics were used to collect information. The questions were developed to capture activities that were governed from the central municipal level and aimed to promote student health-related behaviour and enhance their competencies. The questionnaire was pre-tested in six municipalities located outside Stockholm County. Two school system variables thought to mirror general municipal investments in school (municipal cost per student and full-time employed teachers with a university degree) were collected from the Swedish National Agency for Education. Outcome data (fraction of students qualified for upper secondary school, fraction of students with high alcohol intake and fraction of 15-18-year-olds under suspicion of crime) were collected from public statistics. The coding was made similar to the coding procedure in Studies I and II, and the statistical analysis was performed using Spearman rank correlation analysis (118,119).

5.4 Study IV

The objectives of this study were to describe the development of municipal health-promoting measures directed at children and adolescents and to identify factors that might explain the development of such measures.
Based on the results from Studies I-III, three municipalities with different levels of health- and safety-promoting activities were selected. Two municipalities with an activity level over the county mean and one municipality with an activity level below the county mean were asked to take part in Study IV. The purpose of this selection was to include municipalities with different emphasis on public health issues in the study. A conceptualisation of the policy process, based on the actor-structural approach, was accomplished using semi-structured interviews and content analysis of written documentation (120-123). An interview guide, based on concepts from social science approaches (101,103,104), was elaborated and one test interview was conducted with a retired city manager.

City managers in the three selected municipalities served as first informants. They were asked to select three activities each aimed at children and adolescents in their municipalities. Four selection criteria were detailed: the activities should be ongoing, broad, relevant to the health of children and regarded as successful. The choice of city managers as first informants made it possible to obtain immediate admission into the municipal administrations. In addition, the city managers had a general view over the entire municipal public sector. The interviewer proceeded with the interviews using the snowball method (124), i.e. each informant suggested further informants within the frame of each activity. All interviews were performed and transcribed by the same person (KG). Written documentation (e.g., plans of action, evaluations and minutes) was collected.

To structure the data a policy process matrix (123) was established, in which four stages of the policy process and three aspects of the actor-structural approach were represented (Table 1). A fourth aspect, performance, was added to detect if any measure was empty talk rather than real action. Each aspect of the actor-structural approach was examined within each stage of the policy process: for example, empirical data concerning a specific actor in a specific case was followed and scrutinised from the policy development stage to the institutionalisation stage.

<table>
<thead>
<tr>
<th>Table 1. The policy process matrix.</th>
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<tbody>
<tr>
<td><strong>Three aspects of the actor-structural approach and one control aspect</strong></td>
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<tr>
<td>Context</td>
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<tr>
<td>Institution</td>
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<tr>
<td>Actor</td>
</tr>
<tr>
<td>Performance</td>
</tr>
</tbody>
</table>

27
The transcribed interviews and the documents related to each activity were read and significant unities were underlined. These unities were turned onto labels and placed in the policy process matrix. Nine case studies based on the information in the policy process matrix were written. By means of these case studies the development of municipal health-promoting measures directed toward children and adolescents were described and potential explanatory factors were assessed.

5.5 Study V

The aim was to study municipal variations in children’s injury risk and to assess the impact of safety promotion measures on injury outcome in general municipal, preschool and school and leisure activity settings.

Study V is a cohort study with a population consisting of all children between the ages of one and fifteen years who were residents in one of 25 municipalities in Stockholm County on 31 December 1994, 1995, 1996, 1997, and/or 1998, according to the Total Population Register. Each child was followed up one year from those dates. The study base included 450,481 person-years of individuals between the ages of one and six, and 605,583 person-years of individuals between the ages of seven and fifteen. Data on injuries (transportation-related injuries excluded) were obtained from the Hospital Discharge Register for the period 1995 to 1999. Data on each municipality’s degree of urbanisation were obtained from Statistics Sweden while variables describing the occurrence of municipal evidence-based safety promoting efforts were acquired by questionnaires (Study I). Three municipal settings were studied: the municipality setting in general, the preschool setting and the school/leisure activity setting. Individual and ecological data were linked via geographical codes for the municipalities.

To investigate how individual-level determinants were related to injury outcome bivariate analyses were performed using a logistic regression technique (125). The final phase in the statistical analysis involved multilevel logistic regression modelling (126). The conceptual basis for this two-level model was that the effect of individual-level variables, in this study the child’s age and the mother’s receipt of social allowance, differs between level 2 units, in this case between municipalities. Three models were estimated for the age groups 1- to 6-year-olds and 7- to 15-year-olds. The first model investigated the effect of safety measures controlling for the child’s age; in the second model individual level covariates were introduced and the final model controlled for degree of urbanization.
5.6 Validity and reliability

Traditionally biomedical research methods are not always sufficient within public health research (127-129). According to Nutbeam, the use of a diverse range of data sources will generally provide more relevant and sensitive evidence than a single, “definite” study. Thus, it might be relevant to develop study designs that combine the advantages of both qualitative and quantitative research methods. Validity and reliability are interpreted and dealt with differently in quantitative and qualitative research. In the studies included in this thesis the concepts validity and reliability were applied and experienced to be constructive.

In Study I comparisons were made between questionnaire responses on the municipal setting in general and questionnaire responses on similar questions in a national survey of municipal safety promoting activities performed by the National Institute of Public Health (130). This comparison indicated that the respondents’ answers were reliable. In Study II reliability controls were carried out about six months after the public officials had completed the questionnaire. Seven of the questions were re-asked by telephoning seven (28%) of the public officials who had answered the questionnaire, and one question was compared with information in the local telephone directory. Questions that demonstrated low agreement were excluded from the data set. In Study III the clustering of school measure variables within each of the two main approaches supported the validity of the variables. Finding that the outcome variables in Study III correlated as expected with the socio-economic status control variable supported the validity of the outcome variables as well.

Triangulation was used as a validating method in Study IV (121,129,131,132). Interviews, written documentation and “overall interviews” were used as sources of triangulation. The “overall interviews” were performed with one public official, who should be well informed about local activities in general - though not involved in any of the specific cases - in each of the three municipalities. The triangulation sources in seven of the nine cases generally supported each other. In two cases the “overall respondent” offered comprehensive additional information. To assess the coding reliability (122,133) an independent re-coding was performed in three of the nine cases. An independent re-coder was given a written summary of the cases, access to all data, clear definitions of the theoretical framework and the coding principles the first coder used. When the independent re-coding was completed, the agreement with the original assessment was set. A re-coding agreement of between 75 and 100% is considered high (134). The coding agreement between the original assessment and the re-coding was 77%. The definition of the aspect performance was ambiguous and therefore clarified after re-coding of the first case. The coding agreement was improved to 85% once this obscurity became clarified.
In Study V hospital admission for injury was used as a proxy for injury. Socioeconomic status, severity of injury, children’s residence and distance to hospital and data quality of the Hospital Discharge Register might influence the validity. The results might be diluted and the injury rates presented would in that case be higher. The municipal safety-promoting measures in Study V was based on the same questionnaire as used in Study I.

5.7 Ethical considerations

The data collection in Studies I-IV was made from municipal administrations. Neither questionnaires nor interviews have affected single individuals and no registers have been created.

In Study V municipal measures to prevent injuries were related to injury-induced hospital care of children in the studied municipalities. Socioeconomic information about the injured children was collected from registers at the Epidemiological Centre, the National Board of Health and Welfare. The Epidemiological Centre compiles routinely information about in-patient care in a register including personal identification numbers. This register is routinely linked to the national registration, the education register and the social allowance register. The linked and matched computer files are then unidentified. In Study V one such routinely compiled and unidentified data set was used.

Thus, ethical application was assessed to be unnecessary. The regional research ethic committee confirmed this assessment.
6 RESULTS

6.1 Study I

A study of safety-promoting activities for children and adolescents in 25 Swedish municipalities.

Questionnaire answers were obtained from all 25 municipalities. Weak correlations were demonstrated between safety-promoting activities in different municipal settings. Though, safety-promoting activities in the municipal setting in general, the pre-school setting and the school-leisure activity setting were associated with the total of municipal safety-promoting activities. Safety-promoting activities in the traffic setting, however, were not related to activities in the other settings. These findings lend some support to the community approach to safety promotion, though with the restriction that the extent of traffic setting safety initiatives did not vary with the other activities investigated.

Socio-economic characteristics, measured as proportion adults with more than 12 years of education, did not predict the extent of safety-promoting activities. However, faster growing municipalities, with a large proportion of children and adolescents, reported fewer safety-promoting activities than slower growing municipalities.

6.2 Study II

Municipal intentions to promote preschool children’s capabilities and health: a descriptive study of 25 Swedish municipalities.

Questionnaire answers were obtained from all 25 municipalities. The municipalities rather frequently used preschool activities designed at the municipal administrations to promote preschool children’s emotional, social and intellectual capabilities. However, preschool activities aimed at physical activity, parent support and children’s influences in preschool were not prioritised. The preschool system variables exhibited wide-ranging disparities. For example, the yearly municipal cost per registered preschool child varied from 89 400 SEK to 64 200 SEK between the municipalities with the highest and lowest cost, with a mean of 77 740 SEK (1000 SEK ≈ 110 EUR).

The extent of intended preschool activities was apparently not determined by municipal socio-economic status. Though, faster growing municipalities had a lower fraction of preschool staff with a university degree than slower growing municipalities.
**6.3 Study III**

Two approaches to school health promotion: focus on health-related behaviours and general competencies. An ecological study of 25 Swedish municipalities.

Questionnaire answers were obtained from all 25 municipalities. The municipalities generally were quite well supplied by health-promoting activities, though the variation was considerable. Activities aimed to support student competencies generally occurred more frequently than activities aimed to promote student health-related behaviours. This finding was expected, as “effective school characteristics” are very close to the core business of the ordinary school. The variables connected with the health-related behaviour perspective were found to cluster and so did the variables connected with the general competence perspective. This finding may indicate that the municipalities mainly concentrated on one of the two approaches. In other words, if the decision makers in a municipality focus on, for example, control and follow-up academic achievement in a school, they tend to focus less on, for example, promotion of physical activity. A negative correlation between the determinants linked to the health-related behaviour perspective and the determinants linked to the general competence perspective are compatible with a competing relation between these two perspectives. Only tendencies were detected concerning the outcome variables.

There were no significant correlations between municipal socio-economic status and the health- and competence-promoting activities in the municipalities. However, faster growing municipalities had a lower fraction of full-time employed teachers with a university degree than slower growing municipalities (R = 0.541, p = 0.005, data not accounted for in Study III).

**6.4 Study IV**

What makes things happen? An analysis of the development of nine health-promoting measures aimed at children and adolescents in three Swedish municipalities.

Fifty interviews were conducted and nine municipal health-promoting activities were traced, resulting in nine case studies, summarised in Table 2. The number of interviews in each case was determined by the snowball method. A compilation of the most mentioned factors, based on the actor-structural approach, is shown in Table 3. Contextual, initiating and institutional factors were used as sub-categories in the structure-oriented approach and a subdivision into policy development and policy implementation phases was done to mirror the actors’ shifting role during the policy process.
Often mentioned factors were financial problems, perceived local needs, external funding, national and international policy documents and local public health agents. Several respondents remarked that the financial crisis in the 1990s led to growing needs within different municipal sectors. Examples of perceived local needs were increasing social problems and needs for road safety measures. In seven of the nine cases the respondents stated that external funding was important, “When a lot of extra millions drop down, one could do what one couldn’t do before, ideas are set free and there is space for testing” (politician). National and international policy documents were referred to in six cases, e.g. “The politicians decided to raise the United Nations Children’s Convention, it is enlisted in the municipality’s aim and budget ...” (politician). Other policy documents discussed in the interviews were school plans including quality controls and governmental norms for disabled children. Local municipal public health agents (public health plans, public health groups and health planning officers) were mentioned in six cases. Public health core concepts such as epidemiological statistics and evidence-based measures were rarely mentioned in this study.

One case differed totally from the others in that the respondents did not refer to any financial problems, local needs, external funding, national and international policy documents or public health agents. Instead, the municipal context seemed to be suitable for individual ideas and enthusiast outside the municipality were responsible for the activity.

Politicians and public officials were the most often mentioned actors. However, non-governmental organisations also seemed to have had an impact, mostly during the implementation and maintenance phases. Municipal inhabitants were referred to in four cases and the health care sector in two cases. Characteristics of the most mentioned actors were strong commitment, professional skills and having a powerful position in the system.
Table 2. Case descriptions and respondents in three municipalities in Stockholm County.

<table>
<thead>
<tr>
<th>Municipalities and cases</th>
<th>Short case descriptions</th>
<th>Respondents</th>
</tr>
</thead>
</table>
| Municipality A, case 1   | Promoting physical activity among children and adolescents by organising yearly sport events | Chairperson of a non-profit association  
Head of the municipal cultural and leisure activity administration |
| Municipality A, case 2   | Creating favourable conditions for growing up through increased general support in school and leisure time activities | Chairperson of the social welfare committee  
Chairperson of the educational committee  
Head of the cultural and leisure activity administration  
Head of the educational administration  
Head at the social welfare administration  
A public official at the cultural and leisure activity administration |
| Municipality A, case 3   | Decreasing the use of tobacco, alcohol, and other drugs among children and adolescents by organising a contest ranging over school year six | A project leader  
An administrative director  
An information secretary  
The chief of police  
Head of the social welfare administration  
A representative for a non-profit drug prevention association |
| Municipality B, case 4   | Improving the Swedish language among children 3-5 years old and their mothers outside the pre-school system by organising a language school | A pre-school director  
Head of the education administration  
The project leader  
A community planner  
Chairperson of the educational committee  
Two pre-school teachers (interviewed together) |
| Municipality B, case 5   | Improving traffic and playground safety, sun protection in pre-school children, and an overall improvement of children’s rights | Chairperson of the technology committee  
Head of the technology administration  
Head of the traffic department  
The administrative secretary  
A landscape architect |
| Municipality B, case 6   | Increasing the influence of adolescents by establishing a municipal youth council | Vice-chairperson of the municipal council  
Chairperson of the education committee  
Two politicians  
Head of the education administration  
A headmaster  
An adolescent  
The project leader |
| Municipality C, case 7   | Establishing a resource unit to support children with special needs | The manager at the children and adolescent administration  
A psychologist at the children and adolescent administration  
Head of the resource unit  
A public official at the resource unit |
| Municipality C, case 8   | Preventing crime by elaborating a safety plan and establishing a safety council | The project leader  
The municipal commissioner  
A youth centre manager  
A public official  
A family centre leader  
A health planning officer  
The chief of police |
| Municipality C, case 9   | Increasing the influence of adolescents by offering an arena where adolescents could meet | An administrative official  
Head of the leisure administration  
A social welfare secretary  
The project leader |

“Overall interview”: a health planning officer

“Overall interview”: a health planning officer

“Overall interview”: an administrative director
Table 3. Often mentioned factors and actors in the development of municipal health-promoting activities (Case 1-9) in three municipalities (A, B, and C) in Stockholm County.

<table>
<thead>
<tr>
<th>Factors and actors</th>
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<th>A2</th>
<th>A3</th>
<th>B4</th>
<th>B5</th>
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<th>C7</th>
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<tr>
<td><strong>Structure-oriented approach</strong></td>
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<td>Financial problems</td>
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<td>Previous activities (e.g., drug prevention and club activities)</td>
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<td>Initiating factors</td>
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<td>Perceived local needs</td>
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<td>Institutional factors</td>
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<td>External funding</td>
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<td>National and international policy documents</td>
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<td>A local public health sector (public health plans, public health groups or councils and health planning officers)</td>
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<td>Innovative local funding</td>
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<td><strong>Actor-oriented approach</strong></td>
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<td>Public officials</td>
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<td>Non-governmental organisationsa</td>
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<td>Local police</td>
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<td>Municipal inhabitantsb</td>
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<td>During policy implementation</td>
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<td>Politicians</td>
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<td>X</td>
<td>X</td>
<td></td>
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<tr>
<td>Non-governmental organisationsa</td>
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<td>X</td>
<td>X</td>
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<tr>
<td>Local mother and child health service and regional community medicine</td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td>X</td>
</tr>
</tbody>
</table>

a Sports clubs, drug prevention associations, Save the Children Fund, Rotary club, Workers’ Educational Association.

b Pupils, parents, adolescents, inhabitants
6.5 Study V

Association between childhood community safety interventions and hospital injury records: a multilevel study.

Municipal injury rates in this study varied between 3.84 and 7.69 per 1000 person-years among 1-6-year-olds, and between 0.86 and 6.18 among 7-15-year-olds. In the younger age group children whose mothers received social allowance were at higher risk compared to children whose mothers did not receive social allowance. Likewise, children of mothers with a low education level, 11 years or less, were at higher risk compared to children of mothers with a university degree.

Implementation of multiple safety measures in a municipality had a significant effect on the risk of injury for preschool children. High level of municipal safety measures correlated with a low rate of hospital admissions for injuries. In municipalities that implemented few safety measures the risk of injury was 33 percent higher than in municipalities that implemented many. A comparable tendency was observed in the school-aged children. These findings suggest that the way municipalities organise their safety activities in fact does affect injury rates. Introduction of potential confounders into the model did not affect the relation between municipal safety measures and rates of injury, which indicates that municipal safety measures are quite independent of other municipal aspects.

6.6 Summary of results

Based on the results from Studies I-III, intentions to promote children’s health were generally well developed, though some exceptions and variations among the municipalities could be noted. Significant correlations between municipal health-promoting activities and outcome variables were revealed on injuries (Study V) but not on youth behaviour (Study III).

Municipal socio-economic status, measured as proportion adults with more than 12 years of education, did not predict the level of health-promoting activities aimed at children and adolescents in the municipalities, whereas municipal growth seemed to have had a hampering effect. These results were consistent in Studies I-III. Faster growing municipalities reported fewer safety-promoting measures, a lower fraction of preschool staff with a university degree and a lower fraction of full-time employed teachers with a university degree than slower growing municipalities.

A summary of socio-economic and demographic characteristics, standardised activity scores (Studies I-III) and injury outcome (Study V) of the 25 municipalities are shown in Table 4. Correlation analyses between the activity scores in Studies I-III were performed in an effort to reveal any
organisational pattern, i.e. if a municipality that is active in, for example, safety promotion is also active in preschool or school health promotion. However, no significant correlations were found between the activity scores in Studies I-III.

It was possible to trace municipal health-promoting activities by the method used in Study IV. Five potential explanatory factors for policy process development were described: financial problems, perceived local needs, external funding, national and international policy documents and presence of a local public health sector. National and international policy documents and presence of a local public health sector were highlighted in Study IV because these factors were assessed to be the most useful for central actors in promoting local public health action. Politicians, public officials and non-governmental organisations were important actors in different phases of the policy process, with strong commitment, professional skills and powerful position in the organisation as chief characteristics. The health sector in general and epidemiological statistics and evidence-based methods were seldom mentioned in Study IV.
Table 4. Socio-economic and demographic characteristics, standardised sum scores of health- and safety-promoting activity variables and injury outcome rates from 25 municipalities in Stockholm County.

<table>
<thead>
<tr>
<th>Municipalities</th>
<th>Study I</th>
<th>Study II</th>
<th>Study III</th>
<th>Study V</th>
</tr>
</thead>
<tbody>
<tr>
<td>No.</td>
<td>SES (a)</td>
<td>Growth (b)</td>
<td>Population (c)</td>
<td>Safety promotion (d)</td>
</tr>
<tr>
<td>1</td>
<td>22</td>
<td>1.7</td>
<td>72 153</td>
<td>0.87</td>
</tr>
<tr>
<td>2</td>
<td>61</td>
<td>0.0</td>
<td>29 636</td>
<td>0.58</td>
</tr>
<tr>
<td>3</td>
<td>35</td>
<td>2.6</td>
<td>21 943</td>
<td>0.68</td>
</tr>
<tr>
<td>4</td>
<td>21</td>
<td>1.2</td>
<td>68 610</td>
<td>0.65</td>
</tr>
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<td>5</td>
<td>29</td>
<td>1.8</td>
<td>82 870</td>
<td>0.90</td>
</tr>
<tr>
<td>6</td>
<td>31</td>
<td>0.6</td>
<td>60 188</td>
<td>1.49</td>
</tr>
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<td>7</td>
<td>51</td>
<td>0.5</td>
<td>40 630</td>
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</tr>
<tr>
<td>8</td>
<td>40</td>
<td>1.3</td>
<td>73 976</td>
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<tr>
<td>9</td>
<td>20</td>
<td>1.0</td>
<td>52 103</td>
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</tr>
<tr>
<td>10</td>
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<td>22</td>
<td>0.3</td>
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<td>34 766</td>
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<tr>
<td>14</td>
<td>41</td>
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<td>57 610</td>
<td>1.72</td>
</tr>
<tr>
<td>15</td>
<td>41</td>
<td>0.3</td>
<td>55 988</td>
<td>0.89</td>
</tr>
<tr>
<td>16</td>
<td>35</td>
<td>1.4</td>
<td>33 387</td>
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<tr>
<td>17</td>
<td>23</td>
<td>1.0</td>
<td>76 624</td>
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</tr>
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<td>18</td>
<td>28</td>
<td>1.4</td>
<td>38 580</td>
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<td>19</td>
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<td>0.8</td>
<td>37 116</td>
<td>1.34</td>
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<td>1.5</td>
<td>8 888</td>
<td>0.67</td>
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<tr>
<td>24</td>
<td>28</td>
<td>3.0</td>
<td>30 319</td>
<td>0.25</td>
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</tr>
<tr>
<td>Mean</td>
<td>32</td>
<td>1.2</td>
<td>42 387</td>
<td>1.00</td>
</tr>
</tbody>
</table>

(a) Socio-economic status measured as fraction adults with >12 years of education, 1999 (%)
(b) Annual population growth, 1990-1999 (%)
(c) Total population size, 1999
(d) Sum scores (Standardised with mean 1.00)
(e) Injuries/1000 person-years 1-6-year-olds
(f) Injuries/1000 person-years 7-15-year-olds
The main findings in this thesis are:

- The municipalities were generally quite well supplied by measures to promote children and adolescents’ health, though variation among the municipalities was considerable (Studies I-III).

- Municipal socio-economic status did not predict the level of municipal health-promoting measures directed toward children and adolescents, whereas municipal growth seemed to have had a hampering effect (Studies I-III).

- The perspective focusing on promotion of student health-related behaviours and the perspective emphasising development of student general competencies seemed to be competing rather than complementary (Study III).

- External funding seemed to contribute to the development of municipal health-promoting measures directed toward children and adolescents (Study IV).

- National and international policy documents seemed to contribute to the development of municipal health-promoting measures directed toward children and adolescents (Study IV).

- Presence of a local public health sector seemed to contribute to the development of municipal health-promoting measures directed at children and adolescents (Study IV).

- The health sector in general and epidemiological statistics and evidence-based methods seemed to have been of minor importance for the development of municipal health-promoting measures directed toward children and adolescents (Study IV).

- Outcome, measured as hospital admissions for injured children and adolescents, was significantly related to municipal safety-promoting measures aimed at children and adolescents (Study V).

Municipal health-promoting measures aimed at children and adolescents were generally comprehensive, although there was a certain amount of variation among the municipalities (Studies I-III). This variation did not seem to depend on the socio-economic status of the municipalities. In many countries municipal resources are dependent on the affluence of their inhabitants. However, in Sweden socio-economic status of municipal inhabitants is not a relevant factor because of an extensive system for equalising municipal resources (135). Such a system takes into account, among other things, the average income of the inhabitants and the proportion of children and elderly people. Yet, before 2005 the system did
not compensate for municipal growth (136). This fact may help to explain that the level of safety-promoting activities, the fraction of preschool staff with a university degree and the fraction of full-time employed teachers with a university degree were lower in faster growing than in slower growing municipalities. This is notable because the fraction of children was higher in faster growing than in slower growing municipalities. It is plausible that the tax equalisation system before 2005 adjusted for basic differences in socio-economic conditions, but that it did not compensate municipal growth. However, other components related to municipal socio-economic status (such as well-educated inhabitants tend to express their needs more often) could not be explained by this interpretation.

Municipal intentions to promote health-related behaviours and support general competencies among students are described in Study III. These two perspectives were found to be competing rather than complementary. If this result is confirmed in other studies, it will be an important finding with certain policy implications.

Factors revealed in Study IV that might explain the development of municipal health-promoting activities were financial problems, perceived local needs, external funding, national and international policy documents and presence of a local public health sector. National and international policy documents and presence of a local public health sector were particularly noted because these factors might be useful according to a national actor (e.g., the National Institute of Public Health). The results regarding external funding were ambiguous. Two cases with mainly external financing or total financing for a limited period noted problems when the external financing ended, whereas two successful cases received no external funding. Thus, further research is needed about the importance of external funding in health-promoting activities directed at children and adolescents.

Bäck and Soininen have analysed 10 immigrant policies in three Swedish municipalities (97). There are several similarities between their study and Study IV. Bäck and Soininen stated that local ownership of a problem and local actors ready to solve the problem are prerequisites for local activity. Local ownership, as described in Bäck and Soininen's study, is comparable with perceived local needs as described in Study IV. The importance of single individuals is striking in both studies. Even though municipal activities are planned, decided on and completed by politicians and public officials, these individuals need enabling structures to act. Bäck and Soininen mean that institutional rules create legitimacy by defining economic, cultural and political meaning for the actors. The national and international policy documents may be parts of such legitimacy. A concept highly emphasised by Bäck and Soininen is equifinality, i.e. to reach the same conclusion from different points of departures (97). Presence of a local public health sector in which actors from different organisations and
administrations meet (e.g., in public health groups) with a mutual purpose to promote health may exemplify equifinality: “The public health group was important. We learned from each other and we discussed a great deal, which helped me to create a way of thinking about public health issues” (public official).

It might appear peculiar that the health sector was seldom mentioned in Study IV. Public health matters may be channelled through municipal public health agents, such as local public health groups, in which health care representatives use to be included. Another explanation could be the shift from a mortality/morbidity approach in the public health sector to an approach addressing the determinants of health (1,2,87). Public health researchers, policy makers and practitioners have all emphasised epidemiological statistics and evidence-based measures as important challenges to health promotion. These concepts, however, were rarely raised in Study IV. This finding may have the same explanation as the relative absence of the health care sector, i.e. such factors are largely “hidden” in local public health work. It is reasonable to suspect that if these concepts had been explicitly asked for in the interviews they might have emerged more clearly. However, the respondents spontaneously produced statements about national and international policy documents and presence of a local public health sector. The fact that evidence-based methods were actually applied in the municipalities, as shown in Studies I-III, makes it difficult to draw any conclusions about this finding at this time.

Municipal safety-promotion significantly influenced injury outcome among 1-6-year-olds but not among 7-15-year-olds. This might be explained by proposing that older children expand their living environments, often outside the municipal borders. This makes potential associations between municipal safety-promotion and injury outcome more difficult to capture among older children and adolescents than among younger children. However, tendencies in Study V pointed in the same direction for children aged 7-15 years as for those 1-6 years of age.

7.1 Methodological considerations

As discussed in the background chapter, we know quite well what to do within the public health arena, but less about how to implement evidence-based methods. Obviously, there exist many approaches and methods to study this topic. However, public health research often requires other methods than the “golden standard” of randomised controlled trials.

A general problem in public health research concerns the often long causal chains in public health interventions (127). For example, in Study III the causal chain extends from municipal policy to local school plan to classroom activity to student health-related behaviour and general competence, and finally, to health outcomes. Thus, the distance between
measures and potential effects is great with several intermediate links. This might explain the lack of significant outcomes in Study III.

The results from Studies I-III and Study V are based on reports of a limited number of variables, which were collected using different questionnaires and where the number of questions varied between settings and activity variables. Thus, the assessments for each setting and each activity variable might have had too low precision to allow for the detection of relations. However, this lack of precision does not seem to be the case in that the correlations were not stronger when there were many questions than when there were few questions. Therefore, having too few questions probably cannot account for the pattern of results. Nevertheless, an insufficient inclusion of questions could result in undetected associations. To cope with the complexity and the weakness of single variables all activities measured in Studies I-III were weighted independent of quality of evidence or level of reach into the municipalities. This was done with the purpose to find not single significant relationships, but rather complexes of activities that could better mirror the organisational perspective.

The disparities between the municipalities could be explained by a failure to use valid questions. Because there were no valid instruments available at the time of the studies, questionnaires were developed for Studies I-III. Each of these questionnaires was pre-tested in municipalities outside Stockholm County. Dalman and Bremberg have described considerable variation between Swedish municipalities concerning design and volume of service provided to children and adolescents (16), which is consistent with the results obtained in Studies I-III. Socio-economic and demographic variables, which were collected from reliable national registers, also showed large variance between the municipalities.

Socio-economic status often influences public health outcomes (137-139). One could expect that municipal socio-economic status would influence municipal public health activity as well. If the fraction of well-educated inhabitants is high, the tax paying capacity is also high and, consequently, diverse municipal activities ought to be easier to realise. Moreover, well-educated inhabitants more often express their requirements (e.g., in elections), which could also influence municipal action. However, there were no significant correlations between municipal socio-economic status (measured as fraction adults with more than 12 years of education) and intended activities in Studies I-III. Because the outcome variables in Study III correlated as expected to the socio-economic status control variable (high fraction adults with more than 12 years of education correlated significantly positive with fraction of students qualified for upper secondary school and significantly negative with fraction of 15-18-year-olds under suspicion of crime) it is likely that the socio-economic control variable was reliable.

The selection of municipalities for Study IV was based on health and safety activity levels from Studies I-III. The purpose of this selection was to
include municipalities with varying emphasis on public health issues. No findings based on these assumptions were however noticed.

A methodological consideration in Study IV is that politicians and public officials often know the “right answers” and could formulate these in terms that agree with the predominant paradigm /117). Narrations might disagree with what is really happening. To direct questions against critical issues and to scrutinise and compare different sources are, according to Lundquist, necessary. These methodological concerns were dealt with by using an interview guide to direct critical issues and by triangulation to scrutinise and compare different data sources.

“Outliers”, i.e. deviant observations, are treated differently in qualitative and quantitative research. In quantitative studies outliers are carefully examined and sometimes excluded from the analyses. In a qualitative study, however, the researcher pays close attention to exceptions within the data set in order to test the emerging results (121). In study IV one case was different from the others in that the respondents did not advert to any financial problems, local needs, external funding, national and international policy documents, or local public health agents. Instead, the municipal context seemed to have been suitable for individual ideas at the time when this activity was initiated. Further, enthusiasts outside the municipal administration were responsible for the practical accomplishment of the activity. This case was initiated in the early 1960s, i.e. in another temporal context than were the other eight cases in Study IV.

7.2 Reflections on the theoretical framework

The theoretical framework adapted for Study IV was found to be useful in approaching the multifaceted topic of municipal policy processes. The institutional approach, the group and network approach, the macro socio-economic approach, the rational choice theory, the ideas-based approach (101), the policy streams approach (103) and the punctuated equilibrium model (104) were all useful means to underpin the study design and to develop the interview guide. The policy process matrix, which was based on stage models (84,89,101) and the actor-structural approach (8,107,112-116), was a valuable tool when coding and categorising the data. In the analysing phase of the research process it became clear that the theoretical frame was relevant because the final nine cases in Study IV easily could be related to the theoretical framework.

The institutional and ideas-based approaches could be illustrated as underlying perspectives, i.e. they are not explicitly emphasised. The significance of networks (e.g., public health groups or team-working managers) goes back to the group and network approach, whereas the heavy commitment of several actors could be related to the altruistic version of rational choice theory. John Kingdon’s policy streams approach contends that ideas arise from the sharing of agendas between decision makers (103).
This was apparent in case two in which fruitful discussions between politicians and managers seemed to be of frequent occurrence: “... then the idea is there. It is articulated by somebody first, but we all felt the same thing” (politician). Two other concepts originating from Kingdon’s theory - policy windows and policy entrepreneurs - are easily related to the empirical data. External funding is one example of a policy window and policy entrepreneurs were represented in nearly all the cases. The punctuated equilibrium model (104) was less salient. In some cases “incidents” were identified in the policy process history. However, these “incidents” seemed to be minor components of the policy processes.

The actor-structural approach made it possible to combine actors, including who they were, their driving forces and when in the process they operated, with contextual and institutional factors in the policy environment. It was evident that single individuals (politicians, public officials and others) played central roles in the development of municipal health-promoting activities, though in different stages of the policy process. Bäck and Soininen found a similar result in an analysis of municipal immigrant policies (97). According to Walt, the political system could hardly function without the administration. It appears that bureaucrats may play an important function in policy-making because of their expertise, knowledge and competence, especially in systems where public officials remain in their position when politicians change (84). This point is exemplified by the following statement as told by a municipal commissioner: “The professional skill is a strong driving force ... one needs clever and professional public officials who have good ideas and know what to do. When this process works ... enormous confidence in each other’s work is achieved”.

Symbolic policies (i.e. policies not expected to be implemented) and arrested or delayed policies caused by “street-level bureaucrats” were not discernable in Study IV, perhaps because the point of departure in the study was already ongoing municipal activities.

7.3 Reflections on municipal governing and the governing of municipalities

In an ideal situation rational decision makers consider possible solutions of a problem, estimate consequences and choose the alternative that most likely will reach their goal and solve their problem. One prerequisite for such rationality is information. Rational decision makers have to be familiar with the entire range of potential solutions and their consequences.

The demise of rational planning started with Herbert Simon’s book “Administrative Behavior” (140). Simon’s standpoint was that decision makers are neither aware of all possible ways of acting nor of which consequences that may follow on each possible line of conduct. Simon developed an alternative model, bounded rationality, which alleges that
decision makers at least intend to be rational. Charles Lindblom’s theory of “muddling through” could be considered as the next step in the history of rational planning (100). Lindblom stated that policies emerge from a series of small changes depending on political power rather than on rational decisions. Still, these incremental changes became co-ordinated and rational in the same way as co-ordination in the market place resulted in unintended collective rationality.

The “garbage can model” was elaborated by Cohen, March and Olsen (141) and developed by Kingdon in the policy streams approach (103). This might roughly be considered as the third and fourth steps in the history of rational planning. The garbage can model describes a chaotic style of policy-making as decision makers deal with a changing array of problems and solutions and gradually leave these behind for others to settle. The policy streams approach assumes continual policy change. Kingdon regards formation of policy as the result of three “streams”: problems, solutions and politics. The policy decisions are, according to these models, based on a complicated mix of problems, demands, accessible choices and potential solutions rather than on a single rationality.

The concept of rational planning thus seems to be a planning ideal that since the late 1940s has demonstrated disagreement with practice. Often, in both private and public sectors, there is a belief in rationality. Within the public health sector rational and linear approaches to planning are apparently present (87,142,143).

The use of evidence and epidemiology are instances of rational behaviour, as is the Swedish public health goals, the follow-up indicators and the forthcoming public health political report. These concepts were not discernable in the municipal discourse as revealed in Study IV. Instead, the cases in Study IV were more in line with the garbage can and the policy streams approaches. Rational evidence-based methods were in fact applied in the municipalities (Studies I-III), but not one of the 50 interviewees mentioned evidence (Study IV). This observation reveals a discrepancy. One interpretation could be that there are several simultaneous municipal discourses in progress, each with its own limited “rationality”. Thus, it might be possible to contribute to existing discourses: for example, to discuss safety promotion in the “child safety discourse” or in the “school health discourse”. On the other hand, it might be meaningless to discuss safety promotion in, for example, the “school administration discourse”.

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7.4 Reflections on the healthy public policy in Sweden

The national public health objectives in Sweden are oriented toward determinants of health (87). Because many of the policies that influence children and adolescents’ daily lives are decided on by municipal politicians and administered by municipal public officials, the municipalities are important actors in accomplishing these objectives.

The results presented in this thesis suggest that the municipalities already make big efforts to promote the health of children and adolescents. However, there exist seemingly inexplicable disparities between the municipalities. These disparities show that there is a potential for improvements, constituting a challenge for the Swedish government and its institutes, in particular for the National Institute of Public Health.

The use of epidemiological data and evidence-based methods has been emphasised in public health work (144,145). As shown in Study IV, none of these concepts was described to be of immediate importance in the development of municipal health-promoting activities. The apparent absence of epidemiological data and evidence-based methods might be related to the presence of national and international policy documents and local public health agents. For instance, epidemiological data may be processed in a public health group, presented in a public health plan and acted on by public health officers. The perceived local needs that were mentioned in eight of nine cases might be an additional factor camouflaging the use of epidemiological data. None of the cases in Study IV was told to be based on evidence. This fact gives rise to questions concerning how municipal decision makers pick and choose between different methods. One possible reason might be that municipal policy issues often are highly complex and therefore evidence-based methods are not available or difficult to apply. Another reason could be that the public health sector has failed to advertise evidence-based health-promoting methods to the municipalities. Further, it is possible that evidence-based methods are managed in greater detail than other methods, which may hold back municipal decision makers.

The interviewees in Study IV seldom mentioned the health sector. This could be based on the same reason as the non-mentioning of epidemiological data and evidence-based methods described above. It could also depend on a paradigm shift, from a mortality/morbidity approach, in which the health sector obviously has a main role, to a perspective addressing the determinants of health, in which a number of actors have a common responsibility.
In this thesis an attempt was made to describe what makes municipal child health-promoting activities actually happen. Three main areas were studied: municipal intentions to promote children and adolescents’ health, the development of municipal health-promoting activities and outcome related to such activities. One finding was that the municipalities in general offer a wide range of evidence-based health-promoting activities aimed at children and adolescents. Another finding was that municipal socio-economic status does not predict the level of such measures, whereas municipal growth apparently has a hampering effect. Further, national and international policy documents and presence of a local public health sector may contribute to municipal health-promoting action. If confirmed by other studies, the results presented in this thesis might be useful means for national actors to stimulate and support municipal public health efforts. Interdisciplinary research was a valuable experience, which makes me believe in the benefits of continued and improved collaboration between public health sciences and political sciences.
9 FUTURE RESEARCH AND POLICY IMPLICATIONS

Future research within this area might address methods to capture determinants of health-promoting measures ruled from municipal administrations. Implementation studies in collaboration with political science researchers are desirable.

Potential policy implications based on the results presented in this thesis are that disseminating public health-related knowledge through policy documents and encouraging institutionalisation of a local public health sector could be constructive methods to support health-promoting activities in the municipalities. Further, means to introduce and distribute epidemiological statistics and evidence-based methods to the municipalities ought to be considered. A final policy implication is that increased and improved co-operation between public health sciences and political sciences (e.g., by integrated courses and shared research projects) could be helpful in developing public health research within the municipal arena.
I wish to thank all those who have helped and supported me in completing this thesis. Especially I want to acknowledge:

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