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# The State of Service

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An Appraisal of Four Years of Reporting by the Health Council



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No. A02/02E, March 17, 2008

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The Health Council of the Netherlands, established in 1902, is an independent scientific advisory body. Its remit is “to advise the government and Parliament on the current level of knowledge with respect to public health issues...” (Section 22, Health Act).

The Health Council receives most requests for advice from the Ministers of Health, Welfare & Sport, Housing, Spatial Planning & the Environment, Social Affairs & Employment, and Agriculture, Nature & Food Quality. The Council can publish advisory reports on its own initiative. It usually does this in order to ask attention for developments or trends that are thought to be relevant to government policy.

Most Health Council reports are prepared by multidisciplinary committees of Dutch or, sometimes, foreign experts, appointed in a personal capacity. The reports are available to the public.



The Health Council of the Netherlands is a member of the European Science Advisory Network for Health (EuSANH), a network of science advisory bodies in Europe.



**INAHTA**

The Health Council of the Netherlands is a member of the International Network of Agencies for Health Technology Assessment (INAHTA), an international collaboration of organisations engaged with *health technology assessment*.

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This report can be downloaded from [www.healthcouncil.nl](http://www.healthcouncil.nl).

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## Preface

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This document is the first self-evaluation report that the Health Council has produced following introduction of the Advisory Bodies Framework Act. It relates to the period 1997 to 2000.

By way of preparation for the self-evaluation exercise, we instructed EJ Schoten and JH Stegeman, secretaries to the Health Council, to undertake a limited survey of our main clients, in order to gather feedback on their views on the performance of the Council. The results of that survey are presented in this report. The Health Council's Presidium Committee has made a critical examination of the Council's organisational processes from the insider's viewpoint, and has made a number of important suggestions regarding their further streamlining. We are very grateful to all the interviewees and to the Presidium Committee members for their cooperation with this self-evaluation exercise.

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Given that the period covered by the evaluation is 1997 to 2000, the exercise should have been completed in 2001. However, the size of the Council's work programme and the urgency of some of the unscheduled requests for advice sometimes were such that we decided to prioritise the performance of the Health Council's primary task, i.e. the provision of science-based advice in support of policy.

The Hague, 27 September 2002

(signed)  
Professor J.A. Knottnerus,  
President

Dr. M. van Leeuwen,  
General Secretary

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# Contents

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## A Self-Evaluation of the Health Council's Performance in the Period 1997 to 2000 63

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1 Aim and working method 65

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2 Principal conclusions 67

2.1 Speed and responsiveness 67

2.2 Advisory reports that are relevant to several departments 70

2.3 Preparation and follow-up 70

2.4 Risks 71

2.5 The provision of advice regarding current scientific thinking and developments 71

2.6 International activities 72

2.7 The Presidium Committee 73

---

## Survey report 75

---

1 Remit, approach and methodology 77

1.1 Advisory Bodies Framework Act 77

1.2 Evaluation reporting 78

1.3 Evaluation method 79

1.4 Levels of evaluation 80

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2	The views of the Health Council's clients	81
2.1	The quality of the advisory reports	81
2.2	The Council's sphere of activity	83
2.3	The scope and lead times of advisory reports	87
2.4	Formulation of requests for advice	90
2.5	Follow-up support requirements	94
2.6	Product differentiation	95
2.7	The Health Council's international activities	95
2.8	Analysis	96

---

3	Views held within the Secretariat and Council	99
3.1	The secretaries' views	99
3.2	The views of the Presidium Committee	100
3.3	Analysis	103

---

4	The challenge	105
4.1	Two perspectives	105
4.2	The Evaluation Advisory Bodies Framework Act	106
4.3	Knowledge management and learning organisations	107

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	Annexes	111
A	The departmental discussion partners	113
B	The Presidium Committee	115

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# **A Self-Evaluation of the Health Council's Performance in the Period 1997 to 2000**

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## Aim and working method

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On the following pages, the President and the General Secretary of the Health Council examine the feedback from the interviews. Particular attention is given to conclusions regarding matters that the interviewees identified as plus points that should be retained, and regarding matters that required improvement.

When devising the approach to be taken with this first self-evaluation exercise, we have concentrated on the opinions of the direct users of Health Council reports, as represented by senior civil servants at the ministries that commission the bulk of those reports.

In view of the purpose of (self-)evaluation, we felt that this first report should pay particular attention to the views of the parties that commission our reports, or sometimes receive unsolicited reports from us. It is certainly not our intention to suggest, however, that the way Health Council reports are received by others does not matter. The Council's reports are circulated widely, both in printed form and – we believe – via the website.\* We are aware, for example, that Council reports on medical subjects are familiar to members of the relevant professions, who either read the reports themselves or see articles on them and references to them in the academic press. It is also known that the recommendations contained in some such reports are taken up by the relevant professions, even if no explicit policy decision to that effect is made. Such 'direct' implementation is commonplace in the field of environment and health as well. An argument could therefore

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\* No reliable data are available regarding the frequency with which Health Council reports are downloaded.

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have been made for considering the views of various other groups in our evaluation, including the general public, which often shows considerable interest in the Council's reports. Such an approach could well be taken in a subsequent evaluation. In this context, it is worth pointing out that an independent scientific study is currently being conducted into the impact of Health Council reports. The results of this study, which is being led by Professor Wiebe Bijker, are to be published in book form in October 2002, to mark the centenary of the Council's foundation.

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## **Principal conclusions**

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The findings of the evaluation indicate that the Council's performance was broadly satisfactory. The Council is regarded as authoritative, and the quality of its reports is considered to be high, which is important both for the Council and for policy, since it may be expected to facilitate implementation of measures based on Health Council reports. Nevertheless, there are matters that require further attention from the Council and Secretariat.

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### **2.1 Speed and responsiveness**

A recurrent theme of the feedback was that clients would sometimes like to be able to obtain advice more quickly. Although much admiration was expressed for the thoroughness of the advisory reports, and a recognition that the committee process helped to ensure outcomes that could count on general support, there were undeniably situations in which policy would be (better) supported by the availability of less comprehensive but earlier advice. The interviewees indicated that the priority should be retention of the quality that they were used to and very appreciative of. Nevertheless, they felt that a streamlining of the Council's processes would be beneficial.

## Analysis

A typical Health Council advisory report is both broad and deep. 'Deep' in that literature research and problem analysis are very thorough, and 'broad' in that problems are examined from various angles, taking scientific, social, ethical and sometimes legal aspects into account. The committee process is easily the best means of producing such a report. The conscientious use of this instrument requires time, because the experts making up the multidisciplinary committees need to learn to look at things from one another's viewpoints and to understand the problems associated with one another's disciplines. However, the resulting group dynamic has two important benefits. First, the opportunity to interact with other scientists is one of the things that make membership of a Health Council committee attractive. The importance of such an incentive for participation must not be underestimated; serving on a committee involves a major time commitment, and the financial rewards are very modest. Second, as various interviewees themselves pointed out, a report produced by such a committee can normally rely on broad support among experts in the field, since its conclusions and recommendations are those of their peers.

The Health Council committee is therefore an institution that should be held in respect. We regard it as a unique work form, a positive distinguishing characteristic of the Council. However, it is important that the Council can also provide advice quickly when the need arises. That ability has already been demonstrated by the Council: the two pertussis reports and the recent report on breast cancer screening, for example, were all produced within a matter of weeks. There have been numerous other occasions when the Council has delivered advice – like the aforementioned reports, prepared by a committee of experts – at relatively short notice. Looking back, it appears that it is mainly technical scientific topics that lend themselves readily to a quick response. Although, as the examples cited above demonstrate, the committee process is by no means incompatible with short-notice reporting, it is the case that committee-based working is most suitable for the examination of complex issues that require input from experts from a wide variety of disciplines. This process simply needs to be allowed the time that it requires.\*

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\* It is worth noting that the preparation of reports by the US Institute of Medicine, which employs a similar working method, is no less time-consuming.

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The interviewees' observation that reports sometimes take what they regard as an unduly long time to prepare must be taken seriously. The implication is that the Health Council needs to have at its disposal a full range of tools for processing requests for advice. Where certain more 'one-dimensional' problems are concerned, examination by a multidisciplinary committee is not necessary or, at least, a less efficient option. However, selection of the most appropriate reporting method depends on effective communication between the Health Council and the commissioning department in order to obtain complete clarity regarding the latter's needs and expectations. Equally important is that the nature of the advice sought is consistent with those needs and expectations.

One suggestion that has sometimes been made – although it was not made in the interviews conducted for this evaluation – is that the Council should produce 'summary reports'. We do not generally favour such an approach. The proper scientific justification of conclusions and recommendations is the defining characteristic of any Health Council report. All the evidence therefore needs to be thoroughly examined before a report can be produced, whether in summary form or not. Ordinarily, therefore, summarisation is possible only at the conclusion of the reporting process, as presently happens with the executive summary that is included in every Health Council report. In other words, if the Council confined itself to the publication of a good summary report, the reporting process would not normally be any shorter. Time savings could, however, be achieved by limiting the breadth of the subject: a *narrow and deep* report requires less preparation than a *broad and deep* report. The formulation of appropriate requests for advice requires thorough advance consultation between the Council and the commissioning department.

#### Conclusion:

*It is important that the Council can respond appropriately to various types of request for advice. To this end, the Council should more systematically consider a variety of working methods, so as to optimise the response time without compromising quality. Possibilities include the targeted use of working conferences, horizon scanning and other mechanisms capable of yielding an outcome in a relatively short time frame. Particular attention should be given to careful matching of the commission and the working method. Although the 'classic' committee process will undoubtedly remain the Council's primary work form, and will always be time-consuming, the scope for optimising each phase of the process needs to be examined.*

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## 2.2 Advisory reports that are relevant to several departments

The breadth of many Health Council reports is such that they are relevant to several government ministries. In some cases, the cross-departmental significance of an issue is recognised at the outset of the reporting process, and the request for advice is accordingly made in the name of more than one minister. In other cases, advice is requested by a single minister or state secretary, but ‘for-information’ copies of the finished report are also submitted to other members of the government at the volition of the Council’s President.

Ideally, a report that is addressed to more than one minister should receive a coordinated (formal) response. The interdepartmental coordination involved requires considerable attention. Our own views on this matter are confirmed by the feedback from our interviewees. Primary responsibility for such interdepartmental coordination naturally lies with the ministries concerned. Where a report is addressed to one minister or state secretary, but also submitted for information to other members of the government, the commissioning ministry should liaise with the others concerning any response that may be considered appropriate.

Conclusion:

*It is important that the interdepartmental nature of a (draft) request for advice is emphasised in the context of the usual advance discussions amongst officials. It may also be helpful in certain situations for civil servants from the relevant ministries to sit in an advisory capacity on the Health Council committee set up to prepare a response. The resulting report’s recommendations, and the selection of ministers to whom it is to be addressed, should take explicit account of the inter-departmental relevance of its content.*

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## 2.3 Preparation and follow-up

Brief reference has already been made above to the discussions among civil servants that precede the formulation of a request for advice. Proper consultation is very important and should seek to ensure, amongst other things, that requests are consistent with the Health Council’s statutory duties and capabilities, and that the Council is fully informed about the policy considerations that have led to the request being made. After publishing a report, the Health Council Secretariat should monitor further developments.

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## Conclusion:

*The interviews did not identify any problems with the preparation and follow-up of reports. Nevertheless, a few interviewees did make the point that they wish the Council to actively monitor subjects that it has previously reported on. We regard this feedback as encouragement for continuation of our existing policy in this area, which is geared to the early identification of new developments that have policy implications.*

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## 2.4 Risks

A number of ministries stressed the importance of risk analysis and early warning concerning (new) risks. These activities are relevant to policy insofar as they help the ministries to deal effectively with problems they are already aware of, and to anticipate and prevent new problems. Risk analysis, risk management, prevention and risk perception are important in the context of numerous policy domains, such as environmental management and health care. There is also an obvious relationship with the behavioural sciences, which is considered in more detail below.

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## 2.5 The provision of advice regarding current scientific thinking and developments

One of the interviewees made the interesting point that questions are sometimes rightly put to the Health Council, even though, strictly speaking, few if any scientific evidence is available on which to base an answer. In relation to such enquiries, it was suggested that the Health Council could do more in terms of the productive utilisation of experience-based knowledge. We agree that such knowledge should indeed be utilised and we would draw attention to the many reports in which experience-based knowledge has played a vital role, such as *The Diagnosis and Treatment of ADHD* (2000), *Day Care for Persons with Profound Multiple Disabilities* (1999) and the forthcoming report on contraception for people with mental disabilities, and prior to the evaluation period *Dyslexia* (1995) and *The homeless* (1995). Where all these subjects were concerned, a synthesis of the hard scientific evidence did not afford an adequate basis for advice, and experience-based expertise was therefore used to supplement the data sources.

The interest in experience-based information ties in to a degree with the desire for the Council to pay more attention to the behavioural sciences.

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Conclusion:

*We see the comments regarding experienced-based knowledge and the behavioural sciences as validating our policies of ensuring that relevant practical experience finds appropriate expression in Health Council reports, and that behavioural scientists are adequately represented on our committees. The latter policy is important not only because it facilitates the utilisation of valuable scientific knowledge, but also because the behavioural sciences employ a specific methodology for dealing with uncertainties and experience-based knowledge.*

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**2.6 International activities**

Science is by definition international. International academic journals and data-banks are among the most important sources of knowledge that the Health Council draws upon. Furthermore, most of the problems that the Council reports and advises on are not unique to the Netherlands. Not surprisingly, therefore, the Council, represented by its staff, has for many years maintained a variety of international contacts in fields such as toxicity, nutrition, ethics and health technology assessment. Although the international dimension of the Council's work was mentioned in the interviews, it was not given any great emphasis.

This may reflect the fact that the interviewees, being familiar with the considerations outlined above, take it for granted that the Health Council is active outside our national borders. Our international activities will continue in the years ahead. The Council intends to further expand its European network, for the obvious reason that Dutch health and environmental policies are increasingly shaped by European legislation and regulations. Thus, the Council will work with its colleagues in other countries on matters relating to environment and health policy, nutrition, ethics and health technology assessment. In the latter field, it is worth noting that, over the last ten years, the Health Council and various other bodies have successfully invested in the creation of an international network of similar institutes: the International Network of Agencies for Health Technology Assessment, or INAHTA. We are now in a position to start enjoying the payback on that investment. A consensus has been reached regarding the main methodological criteria that an assessment should satisfy. The practical experience of the last few years has been not only that the questions addressed by the affiliated agencies are very often the same, but also that the conclusions of their reports show a considerable degree of consistency. Therefore, if good foreign evaluation studies are available, we see no reason why a Health Council committee should not use them as the starting point for its deliberations. We endorse John Eisen-

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berg's words: "Globalize the evidence, localize the decisions." Such an approach should significantly speed up the reporting process in appropriate cases.

Conclusion:

*Existing international contacts will be intensified where appropriate. The Health Council will continue to explore the scope for further cooperation within Europe.*

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## **2.7 The Presidium Committee**

The Health Council has a Presidium Committee, made up of the vice-chairmen of the standing committees and the Vice-Presidents of the Health Council, chaired by the Council's President. One of the Presidium Committee's main tasks is to advise the Council President on strategic matters; it will also play a role in the development/implementation of the initiatives described above.



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# Survey report

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E.J. Schoten / J.H. Stegeman

Secretarial support: R. Aksel-Gauri, W.Y. Lee, C.J.M. Vianello

Layout: M. Javanmardi, J. van Kan

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# Remit, approach and methodology

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There is a long history of research into the performance of governmental advisory bodies. This report begins with a brief outline of the studies performed in the past.

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## 1.1 Advisory Bodies Framework Act

In 1990, the then Speaker of the Lower House of the Dutch Parliament began a process of political, governmental and constitutional reform. As part of this exercise, the role played by external advisory bodies (standing committees and councils that advise on matters of legislation and state governance) was re-examined. Such bodies had become much more numerous since the 1960s, as the social issues of the day became increasingly complex, as government involved itself in more and more aspects of life and as the so-called ‘polder model’, with its emphasis on stakeholder consultation, grew in influence. Despite its many advantages, the drawbacks of this advisory system had become increasingly apparent to government and parliament alike: there was an increasing risk of proliferation; it was difficult to maintain an overview of how the various bodies related to one another; and the complexity of the advisory and consultation mechanisms left less and less scope for decisive government. As a result, reform of the system came to be regarded as a necessity.

Such reform was realised through the Advisory Bodies Framework Act, which was passed on 3 July 1996 and came into force on 1 January 1997.

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Its aims were the downsizing and transparency of the advisory system; the separation of the advisory and consultation processes, and thus the restoration of political primacy; and improved political supervision of the new or reformed advisory bodies. A study commissioned by the Ministry of the Interior and Kingdom Relations (BZK) concluded in 2001 that these objectives had to a large extent been achieved, although the researchers considered that political control of the system could still be improved.\*

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## 1.2 Evaluation reporting

Section 27 of the Framework Act requires that advisory bodies publish evaluation reports every four years. The requirement applies to the Health Council, which was given a fresh start by an amendment to the Health Act, effective from 1 January 1997. The Act is non-prescriptive in terms of the form that the evaluation should take.

The Health Council's statutory role is to inform the government and parliament about current scientific thinking and developments in relation to issues of public health. At present, the Council has 209 members. Its reports are usually prepared by multidisciplinary ad hoc committees of Dutch and sometimes non-Dutch experts, appointed in a personal capacity.

In the context of this first evaluation, which covers the period 1997 to 2000, the President and Executive Director of the Health Council ('the Board') asked us to focus particularly on the primary relationship, that between the Council and the commissioning departments. Health is relevant to numerous government policy domains. Not surprisingly, therefore, various ministries consulted the Health Council during the period under review. In addition to the Ministry of Health, Welfare and Sport (VWS) – the largest commissioning department – the Ministry of Housing, Spatial Planning and Environmental Management (VROM), the Ministry of Social Affairs and Employment (SZW) and the Ministry of Agriculture, Nature and Food Quality (LNV) have frequently turned to the Council for support. We accordingly asked senior civil servants at each of these four ministries for their opinion of the Council's performance (see annex A). The Board also wanted to know how the Council's activities were viewed by its own members. This angle was accordingly covered at a special meeting of the Presidium Committee, whose members include experts from all parts of the Health Council (see annex B).

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\* BZK. *De staat van advies* (The State of Advice). The Hague, 2001.

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We had to give up the idea of considering the image that other bodies, such as related councils, research institutes, professional associations and umbrella groups, have of the Health Council. Nor have we been able to accurately assess how familiar the Council is to the media or the general public. We have nevertheless observed that many of the Council's publications make front-page news and receive considerable exposure on broadcast current affairs programmes.

Finally, an investigation of the political and social impact of the Council's reports was not part of our remit, except insofar as observations regarding impact were made by the Council's clients at the audit meetings. We can nevertheless relate that our general impression, as based on ministerial responses to Council reports, is favourable: recommendations made by Council committees are usually accepted. It should be pointed out that, as part of the activities marking the Health Council's centenary, a research team at the University of Maastricht is looking closely at the factors that influence the effectiveness of the advisory process. Their report is due to be published in October of this year.

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### 1.3 Evaluation method

As indicated above, the evaluation had to be based primarily on the views of the relevant senior civil servants and of the Presidium Committee. Those views were ascertained as follows. In preparation for an open interview in October 2001, we wrote to each of our departmental discussion partners identifying a number of themes that we regarded as important. The themes related to aspects of the advice provided or of the advisory process:

- What is your assessment of the policy support that the Health Council has provided to your ministry? (Are the Council's advisory reports to the point?)
- Are the opportunities for support being utilised to the full?
- With which types of issue do you consider seeking the Health Council's assistance?
- How satisfied are you with the way the requests for advice are prepared (scope, alignment with policy programmes, frequency of preparatory meetings)?
- Is there sufficient opportunity for interaction between the Council and the Ministry during the advisory process (role of advisers, transparency, progress reporting and consultation)?
- What is the position with regard to follow-up support requirements?

The interviews (of which a total of six were held) were taped and transcribed verbatim. We then analysed the transcriptions to identify themes and assess the tone

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of the meeting. This was done individually and then collectively, building on the separate analyses, in order to do justice to the material and its elements and nuances.

From the interviews with the civil servants, it was apparent that one particularly prominent issue warranted further exploration in the context of a group meeting with the Council's (scientific) Secretariat. The subject of this meeting was the preparation of requests for advice and the pros and cons of a Secretariat that involved itself with clients' preparatory activities. In two sessions, both held in October 2001, the secretaries were given the opportunity to express their views.

The Presidium Committee met in December 2001. Prior to the meeting, the committee members were given an outline of the six interviews with the Ministerial representatives.

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#### **1.4 Levels of evaluation**

The report on the interviews and group discussions, in thematic form with examination of focus points and nuances, forms the first level of evaluation. Chapters 2 and 3 are devoted to this report. In chapter 4, the assessment moves to a more general level. While the Health Council is unlike other advisory bodies in certain important respects (it never holds plenary sessions, works mainly through ad hoc committees and serves several government departments), it nevertheless has a certain amount in common with other knowledge-intensive organisations in the public domain (e.g. other councils, planning offices, research institutes and departments). A great deal has been written about the characteristics of such organisations in recent years. This literature serves as an interpretative context for our findings and can help the management of the Health Council to identify ways of satisfying its clients.

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## The views of the Health Council's clients

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In October 2001, we met senior civil servants from the Ministries of VWS, VROM, SZW and LNV. The common characteristic of these meetings was the emphasis on conceptualisation. As previously indicated, both advice-related and process-related aspects are relevant in this context. The image that the Health Council's clients have of the Council is shaped by the products it supplies, by what the Council can potentially offer and by the way in which the Council's products are produced. These subjects were covered in almost all the interviews, albeit to differing degrees and from differing perspectives.

More specifically, we have identified the following themes from the transcripts: the quality of the advisory reports; the Council's sphere of activity; the scope and lead times of advisory reports; the formulation of requests for advice, follow-up support requirements, product differentiation; and the Health Council's international activities. The feedback that we received from our discussion partners on each of these themes is summarised below (insofar as anything was said on each topic). The chapter concludes with a brief analysis of our findings.

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### 2.1 The quality of the advisory reports

Oudendijk (VWS):

'Do we feel that the Health Council has provided us with good policy support through its reporting activities? Generally speaking, yes, I certainly do.'

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During the interview, Oudendijk said very little to qualify this positive general assessment. Apparently, the Council's products are as a rule well received by the Ministry.

**Pont (VROM):**

'One can confidently refer socially pertinent issues to the Health Council.'

Studying a list of published reports, Pont concluded that VROM always exercised appropriate care and consideration when commissioning reports from the Health Council, and that the Council discharged its responsibilities in a similar fashion. Particular value was attached to reports that were genuinely advisory (i.e. which contained opinions and recommendations based on current scientific thinking and developments) as opposed to reports that merely presented information. Pont saw such reports as existing at the interface of science and policy and suggested that advisory bodies should be expected to take a somewhat pioneering line.

**Holtkamp (VROM):**

'Overall, we are very pleased with the Health Council's advisory reports. I think I can say that unconditionally.'

Holtkamp described the Health Council as a body whose reports were authoritative, transparently produced, accessible and normally of practical value. The Council's reports were said to play a role in shaping opinion and supporting policy development within the department.

**Noordam (SZW):**

'The quality is good and the reports enjoy considerable support, I always find. It is very important for the Ministry to have authoritative advisory reports.'

Health Council products have an excellent reputation at home and abroad, according to Noordam. Furthermore, the Netherlands has been using a three-stage procedure for a quarter of a century\*. First, the Health Council looks at a

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\* SZW, Health Council, SER. The Limits of the MAC. Conference to mark the 25<sup>th</sup> anniversary of the MAC procedure. The Hague, 20 November 2001. The Health Council has participated in the three-stage procedure since 1994.

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substance and calculates a health-based recommended occupational exposure limit. Next, the Social and Economic Council considers whether the recommended limit is economically realistic. Finally, the State Secretary for Social Affairs and Employment sets a legal limit. The Health Council's advisory reports form a sound basis for this process.

Koopstra (LNV):

'The Health Council is regarded as an authoritative body. If the Council says something, people take notice.'

Koopstra's remarks were of a general nature, supported by one or two examples. A number of advisory reports had been published that in his view had had 'a profound influence on the policy of the Ministry'. One such report was that on antimicrobial growth promoters.\*

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## 2.2 The Council's sphere of activity

Oudendijk (VWS):

'We need to take a good collective look at what the Health Council has to offer. I mean, I'm not sure I know the answer myself.'

The fact that Oudendijk was unsure what the Council had to offer suggests that he believed new fields of activity might be possible. To date, the prevailing impression has been of a body that advises principally on technical medical matters. Many of its reports come under the heading medical technology assessment (MTA). Oudendijk recognised that the Health Council took a broader view (the Council sees MTA as including the ethical, legal and social aspects of medical technologies), but indicated that technical or biological matters were the Council's main field of expertise.

The fact that the Health Council is rarely, if ever, asked to advise on matters concerning, for example, nursing and supportive care, the public health care system or behavioural science, is not the consequence of a conscious decision against seeking the Council's advice. Rather, it results largely from ignorance of the range of expertise possessed by the Council. It would be worthwhile exploring the possibilities together, Oudendijk suggested.

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\* Health Council. Antimicrobial Growth Promoters. Health Council: The Hague 1998, no 1998/15.

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### Van Lieshout (VWS):

‘I don’t think that the Health Council is really on the radar of many people working in directorates such as Nursing and Supportive Care and Disability Policy.’

As previously indicated, contact between VWS and the Health Council is mainly through the Directorate-General for Health. Hence, the Council is relatively unfamiliar to other parts of the Ministry. Van Lieshout saw this as a historical artefact; some years ago, there was considerable distance between the Directorate-General for Health and the Directorate-General for Welfare and a corresponding distance between the curative and supportive care domains. Policy initiatives in the former domain took little account of developments in the latter domain. However, things are now changing. The broad distinction between curative and supportive care as a fundamental organisational principle is gradually giving way to more subtle policy themes focused on specific groups of clients or patients. Where older people or people with disabilities are concerned, one needs to consider not only their infirmities (supportive care issues), but also their disorders and the associated diagnostic and therapeutic options (curative care issues). Van Lieshout said that the department was in the process of adopting a more integrated view.

Asked what role the Health Council could play in this context, Van Lieshout indicated that the Council could perhaps focus more on disabilities in future. Scientific research in this field falls partly under the heading of rehabilitative medicine, but the whole area is very fragmented and there is a real need to make productive use of experience-based knowledge. With its expert committees, the Health Council could well take on such a role.

### Holtkamp (VROM):

‘The Council’s horizon-scanning role could perhaps be strengthened, particularly at the interface between the natural sciences and the social sciences.’

In recent years, experience has been gained in the field of horizon scanning: the preparation of unsolicited reports on topics or developments that do not yet have a place on the policy agenda, but that the Health Council believes need to be taken into account. Holtkamp said that he certainly didn’t think that the Council was missing opportunities in this regard. Nevertheless, he felt that it was a good idea for the Ministry and the Council to consider together how the horizon-scanning process could be improved. This was considered a valuable move partly in

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connection with a forthcoming policy document, which would give added impetus to activities in the domain of health and environment. There is an increasing belief that it is necessary to look beyond technical and natural science matters if policy is to enjoy general support within the community. People's attitude to risks often appears to have a major influence on debate surrounding environmental problems and acceptable solutions. The ministry therefore has an increasing need for advice on behavioural science issues. The Health Council could be more pro-active in terms of its approach to the latter domain.

Taking public perceptions into account also implies considering ethical issues concerning the development and application of technologies. Holtkamp suggested that environmental policy had traditionally maintained a very technical scientific focus. Furthermore, such policy was influential in many respects: environmental rules provided the framework within which activities could develop. Gradually, however, things are changing. Present policy processes increasingly weigh up environmental considerations against economic and other considerations. There were many examples involving policy developments in the field of biotechnology. Holtkamp said that he thought the Health Council might in the future be explicitly asked to examine both the technical and ethical aspects of certain issues.

Noordam (SZW):

'How do we improve our awareness of new risks? The Council doesn't seem to be focused on that question, on our behalf or anyone else's.'

New risks facing workers and employers – Noordam cited the rise of allergies as an example – are attracting more and more attention, with particular emphasis on prevention and insurability. Against this background, the early identification of such risks is increasingly important for the department. Noordam observed that the Health Council was not very active in this field, but added that the department had not so far encouraged the Council to take a more active role. Information is presently obtained mainly from organisations such as the Netherlands Centre for Occupational Diseases and the Netherlands Organization for Applied Scientific Research (TNO). The Health Council's role could be data synthesis and trend analysis, according to Noordam.

In principle, Noordam also felt that the Council could make a contribution in relation to occupational disability, particularly topics such as screening, RSI and burnout.\* However, the political focus was mainly on gatekeeper constructions: arrangements designed to limit admission to the WAO system. Noordam believed that, in view of the emphasis on implementation modalities within the department, there was no great inclination for consultation with the Health Council regarding technically detailed matters. However, lack of familiarity with the Council was also a factor in the department's limited use of the Council's services. Introduction to the directorates responsible for other policy domains could help the Health Council to define its strategic position more precisely.

#### Koopstra (LNV):

'The main problem is that the Health Council is, I feel, active in a field that is somewhat peripheral to the focus of our ministry.'

According to Koopstra, many people at the department regard the Health Council as remote. Although many policy issues have a public health dimension, the LNV is so preoccupied with other matters that few people consider consulting the Health Council. The image that people have of the Council is of a body with a predominantly medical focus, he said.

Much of the interview with Koopstra was devoted to subjects that the Health Council could in principle provide advice on. Keywords in this regard were 'risks' and 'health claims'. As in other ministries, a great deal of work is being done at the LNV in the fields of risk assessment and risk management. The ministry has, for example, been working on the risks involved in food production chains for some time. Koopstra indicated that the Ministry would like to identify the weak links in such chains and where new problems are liable to arise. 'I can imagine that the Health Council would sometimes be able to assist us with such matters as well,' he commented. The words 'as well' highlight the fact that the LNV already consults other bodies on such matters, including the National Institute of Public Health and the Environment (RIVM), the Institute of Food Safety (RIKILT) and the Food and Consumer Product Safety Authority. He recognised that appropriate demarcation between the various bodies was therefore important.

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\* The Health Council has from time to time turned its attention to such matters already. In 1993, it produced a report entitled *Keuren en voorspellen* (Screening and Prediction, no. 1993/11) and in 2000 it published a report on RSI (no. 2000/22). Furthermore, the Council's work programme for 2002 identifies the psychological causes of occupational disability as a possible topic for examination.

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Koopstra felt that the need for support from the Health Council was perhaps greater in relation to the assessment of health claims made in connection with novel foods. He said that the department lacked sufficient expertise in this field and that acquiring it was not easy. By contrast, the Health Council was well equipped to make such assessments.

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### 2.3 The scope and lead times of advisory reports

Oudendijk (VWS):

‘If you want a ‘quick and dirty’ job done, you don’t want to go to the Health Council.’

If you ask scientists to tell you all about something, you usually get what you are after: a thorough analysis with little overlooked. Oudendijk felt that that was all very well, but that politicians weren’t always prepared to wait for the time it took to give such a response. Government and parliament nowadays often want advice at short notice. In this context, a lot depended on the scope of the questions posed. Oudendijk accepted that it was important to ensure that requests for advice were carefully formulated. As he put it: ‘What are we after; what exactly is it we want to know?’ The issue of request formulation was examined from various angles during the course of the interview and is considered in its own right later in this report.

Oudendijk indicated that his comment about not using the Council for ‘quick and dirty’ jobs was an observation, rather than a criticism. This was backed up by other statements made during the interview. Within the department, it is perceived that multidisciplinary consensus-seeking committees cannot easily streamline their procedures. Oudendijk suggested that it would in any case be a mistake to compromise scientific diligence in the interests of process acceleration.

Pont (VROM):

‘If I were the Health Council, I would make more use of the advisory role. However, you shouldn’t take things too far, or you risk undermining your relationship with your clients.’

As the above quotation indicates, Pont believes it is important that an advisory body is prepared to be bold in its reporting. He also said, ‘If you call something an advisory report, it needs to contain advice.’ Pont nevertheless showed that he was an administrative realist. Sometimes a department wants to maintain close

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control of the reporting process. To this end, they will deliberately formulate their requests for advice so as to ensure that there is little scope for more general reflection or for looking at alternative policy options. Under such circumstances, contriving to interpret the reporting remit more broadly or otherwise depart from the commission will be counterproductive. However, situations can also arise, Pont suggested, where the Health Council can constructively play a more active role in the definition of its brief – subject to the understanding that a distinction needs to be maintained between the role of the Ministry and that of the advisory body. It would be quite appropriate, Pont indicated by way of example, for the Health Council to put forward ideas for a ‘flexible standardisation philosophy’, under which exceeding limits on exposure to environmental factors could be acceptable, provided certain conditions were fulfilled. Naturally, it should ultimately be up to political decision-makers whether any such proposals were taken up.

Pont was not concerned about the preparation of advisory reports being a prolonged process, especially where complex issues are concerned. ‘Six months more or less doesn’t make that much difference,’ he said. Speedy reporting was critical only where ‘hyped’ subjects were concerned.

Holtkamp (VROM):

‘The Health Council does all it can to provide us with the tools needed to translate knowledge into policy.’

Holtkamp said that scientists and policy-makers should not confuse their respective roles, but that he had never seen any evidence of such confusion in the relationship between his department and the Health Council. On the contrary, the Council’s advisory reports provided the department with excellent support when decisions were required regarding action or, indeed, inaction. Holtkamp was also positive about the way the reports dealt with uncertainties. In his experience, matters of uncertainty were highlighted and specified, but not unnecessarily allowed to prevent the Council making decisive statements or recommendations. ‘In short, the Council does not produce equivocal advisory reports’.

One problem in Holtkamp’s view was the time taken to produce advisory reports. Whether one saw this as slowness or thoroughness depended on one’s viewpoint. Where reports were seriously delayed, the department sometimes had to make judgements without the Council’s advice. ‘And then we just have to hope that when the report ultimately appears, it isn’t seriously at odds with the

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line we have decided to take. Surely it must be possible to find some way of providing a faster service under appropriate circumstances?’

Noordam (SZW):

‘In my experience, the reporting process can be rather slow sometimes. However, maybe that is an inevitable consequence of the way the Council works, and we simply have to accept it.’

During the interview, Noordam repeatedly returned to the issue of the length of the advisory process. Scientific thoroughness, editorial requirements, review by a standing committee and the public consultation procedure were all identified by Noordam as contributing to the length of the process.\* While recognising the importance of each factor, he questioned whether it was not possible to organise things so that advisory reports could sometimes be completed more quickly. However, he was very positive about the public consultation system, considering it an important means of enabling workers’ and employers’ representatives to influence the content of the Council’s reports before they are finalised.

Thinking out loud, Noordam went through various options, giving particular consideration to the possibility of interim reports. ‘Wouldn’t it sometimes be possible to produce a provisional version of a report, to indicate the general lines the Council is thinking along?’ he asked. He could see, however, that such an approach would have drawbacks: the Council’s credibility could be affected if it had to go back on an opinion expressed in an interim report. Another idea floated by Noordam was that the Ministry should use a parallel consultation system when advice was needed urgently, were other bodies were asked to provide outline information at short notice. The Health Council system could then be reserved for situations where thorough analysis and reporting was required.

Noordam’s final observation was that there was little scope for influencing the speed at which individual reports were prepared; he felt that things could be improved by, for example, agenda management and topic prioritisation (the prioritisation of reports on certain substances).\*\*

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\* The public consultation procedure involves releasing a draft version of a report and then allowing outsiders three months to respond to the Council’s provisional health-based assessment of a substance.

\*\* Since 2000, the SZW has been contributing more to the funding of the Health Council and the Council’s duties have been defined more broadly.

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Koopstra (LNV):

‘I quite understand that preparing an advisory report takes time. Nevertheless, perhaps it would be possible to look at ways of improving the procedures.’

Koopstra said that there was a general feeling that there was sometimes a significant delay in responding to requests for advice. He was unsure whether the subject matter could actually be processed more quickly, but suggested that procedural improvements could perhaps be made. He did not think it was desirable for the client to interfere with the advisory process once it was in motion.

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## 2.4 Formulation of requests for advice

Oudendijk (VWS):

‘I believe that both sides have put in a lot of effort and that enormous progress has been made. I should say we are 90 per cent of the way there.’

The comment reproduced above relates mainly to the definition of the work programme: the list of subjects that the Council is to examine in the period ahead, either at the request of one or more ministries, or on its own initiative. Oudendijk gave the current collaboration nine out of ten, but suggested that things had not been as positive earlier in the evaluation period. Oudendijk began with a number of critical remarks. A few years ago, the definition and selection of reporting topics had been much too haphazard. Management of the relevant processes, he acknowledged, was the responsibility not only of the Health Council, but also of the departmental policy directorates. Oudendijk said that departmental personnel had regularly been communicating their wishes to the Council on an ad hoc basis, without any senior-level consultation regarding prioritisation. However, prioritisation is essential in the context of the final discussions with the Minister (who formally approves the work programme). Inevitably, there is a lot of time pressure on the necessary preparatory meetings. As a result, strong process management is required. Eighteen months ago, a step was taken in the right direction: a so-called ‘structured portal’ was established, in the context of which clients’ wishes could be aligned with the possibilities more effectively. In passing, Oudendijk made the point that the portal could also serve to increase familiarity with the Health Council within the Ministry.

Oudendijk also made various comments regarding the detailed definition of subjects within the work programme. As indicated above, he felt that the policy

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directorates needed to ask themselves what exactly they wanted to know. In this context too, early consultation with the Health Council was felt to be desirable. Time and energy invested in the preparatory phase, Oudendijk contended, always paid dividends.

#### Van Lieshout (VWS):

‘Shopping around and putting yourself forward helps, of course. But otherwise it is a more drawn-out process here too.’

Van Lieshout felt that the Health Council was ‘always quite dominant’ during the informal phase of preparing the work programme. He immediately qualified this by adding that there was something to be said for such an attitude: ‘You have to take your field of responsibility and try to increase it’. So the Council should forge contacts with policy directorates within the Directorate-General for Care. At the same time, the directorates in question need to define their requirements more precisely, Van Lieshout argued. That also implied more intensive consultation with the Directorate-General for Health.

#### Pont (VROM):

‘It is important to enable political decision-makers to see the big picture.’

A prominent theme of the interview with Pont was his consistent call for ‘a more integrated and proportional view’ to be taken – within both the Health Council and his own ministry. Unfortunately, he said, all too often the policies associated with social themes are highly compartmentalised. This is liable to result in the development of barriers to efficient action. Pont cited the example of lead in drinking water, a subject that the Health Council had reported on, at the request of his ministry.\*\* The crux of the problem was that the homes in many old urban districts still had lead water pipes, and consequently the lead concentrations in the drinking water were sometimes high enough to cause mild developmental impairment in infants. When the problem was expressed in such terms, he said, the answer was obvious: replace the lead piping as a matter of priority. ‘That looks like the only option,’ he said. Nevertheless, Pont contended, it was open to question whether that was actually the best way to help the people concerned. In the context of the overall health status of the relevant population groups, there

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\* Health Council. Lead in Drinking Water. Health Council: The Hague 1997, no. 1997/07.

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might actually be more beneficial ways to spend all the money it would cost to replace the pipes. One needed to be prepared to 'think proportionally' (to place things in order of priority) and to make judgements on the basis of the 'net pressure' on a population group and the 'net effect' of policy measures. According to Pont, similar issues existed at the interface between environmental management and spatial planning. In other words, where those domains meet, it was also worth placing things in a broader context from the outset. In his view, a flexible standardisation system was consistent with such an outlook.

Pont recognised that his vision had political ramifications. Politicians and policy makers sometimes have reasons for separating things that other people want to see in combination. He felt that the Health Council had an important role to play in that regard: as an independent advisory body, the Council could present problems in a structured manner and highlight associations. This would enhance the quality of political debate, even if the government ultimately decided not to adopt the solution proposed by the Council. It is therefore advantageous for the Health Council to consult the department about the nature and scope of requests for advice at an early stage.

#### Holtkamp (VROM):

'We have often asked the Health Council whether it can help us make our highly compartmentalised policy more coherent.'

Compartmentalisation exists at various levels. The first being within the Directorate-General for Environmental management itself, where problems are, for example, categorised by theme, such as 'acidification, 'fertiliser pollution' and 'dispersal', or by environmental compartment, such as 'soil', 'water' and 'air'. Nevertheless, Holtkamp said, people at the Ministry were well aware that complex interrelationships often existed between things that were administratively separate. This was why the Health Council was repeatedly asked to advise on ways of taking account of the fact that people and ecosystems were exposed to a plethora of environmental factors. And the consistent response from the Council was that the department was not yet doing so successfully.\* Looking at the department as a whole, it was apparent that the Directorate-General for Environmental Management and the Directorate-General for Spatial Planning often went separate ways, even where collaboration should have been automatic. In our

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\* An advisory report describing current scientific thinking and developments in this field has recently been published: Exposure to combinations of substances: a system for assessing health risks (no. 2002/05).

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densely populated country, numerous environmental problems had a ‘considerable spatial dimension’, according to Holtkamp. The plans to incorporate certain ‘environmental matters’ into the Spatial Planning Act were therefore something that he supported. However, the Health Council could perhaps also provide the Ministry with appropriate ideas.

Generally speaking, Holtkamp was happy with the Council’s willingness to develop ideas with the Ministry. There was regular contact, including discussions about the content of the annual work programme. Nevertheless, the need for more coherent policy activities and the wish to sometimes obtain advice relatively quickly meant that better-structured consultation arrangements were desirable. According to Holtkamp, the Health Council was regarded as ideally placed to take an overview of developments and to make sense of them. The pressure of day-to-day activities meant that the policy directorates were often unable to stand back and take in the bigger picture. He immediately added, however, that the directorates needed to put more energy into the coordination of their activities. Clearer agreements needed to be reached with the Health Council about the relative priority of different subjects and about the preferred timing for the delivery of advisory reports. Such matters had implications for the type of question that it was appropriate to put to the Council, Holtkamp recognised. In his view, there was a range of options. In some cases, questions needed to be more precisely formulated. In others, the time pressure was such that it was inappropriate to ask the Health Council for advice. In yet other circumstances, where the policy horizon was more distant, ‘broader’ advisory reports had their place. In this context, Holtkamp referred back to his earlier remarks about ‘technology and ethics’. Theoretically, you could separate requests for advice on these two dimensions. However, that would tend to work against the integrated approach that was just starting to get established. ‘I’m not sure that that would be helpful,’ he said.

Noordam (SZW):

‘Various advisory reports have proved valuable to us, but perhaps it would have been better if we had been actively approached beforehand, so that we could have some input to the request for advice.’

When making these comments, Noordam was referring to more general advisory reports on the toxic properties of substances (carcinogenicity for example) or on standardisation systems. In the context of the Health Council’s work programme, such themes are often examined from the perspective of environmental protection (i.e. in consultation with the VROM), but are frequently relevant to the SZW’s policies on occupational exposure. Where such matters are concerned,

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Noordam would like the Council to keep both ministries informed about relevant developments and about matters that could be addressed in an advisory report.

Koopstra (LNV):

‘Before a request for advice is made by any ministry, there should be consultation with other departments that have an interest in the subject, and with the Health Council itself. In our experience, it is perfectly possible to organise things on this basis.’

Koopstra is an advocate of integrated request formulation. He felt that consultation on the request for advice regarding so-called functional foods went well.\* Thorough talks took place between the Health Council and the Ministries of LNV and VWS at the ‘shop floor level’. In other situations, things could nevertheless be improved, he felt. One example being the annual meeting that the Health Council management had with the Directors-General at the various ministries (the ‘DG meetings’). Koopstra described the meetings he had attended so far as being too much of a ritual courtship. If what you wanted was coordination and prioritisation, such a meeting was a unique opportunity. Furthermore, he suggested, the Health Council and the LNV should hold high-level meetings fairly regularly – maybe twice a year – to discuss ongoing matters, recent developments and the possible updating of advisory reports.

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## 2.5 Follow-up support requirements

Oudendijk (VWS):

‘For the Minister, the way that a report is going to be received by the outside world is an important consideration.’

Although advisory bodies and government departments have distinct responsibilities, Oudendijk believes that thought should be given during the advisory process to problems that might arise following publication. A pre-emptive approach was particularly important, he suggested, where socially sensitive issues were concerned.\*\* More specifically, he indicated that perhaps the Health Council

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\* The request for advice regarding health-promoting food additives was received on 18 October 2001.

\*\* Oudendijk cited as an example the report Prenatal Screening: Down's syndrome, neural tube defects, routine-ultrasonography (no. 2001/11).

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should more often be engaged for ‘support-seeking rounds’ with appropriate community actors.

Holtkamp (VROM):

‘We think it is very useful if the Council maintains an ongoing interest in a project.’

Unlike the Directorate-General for Health, the Directorate-General for Environmental Management does not wish the Health Council to provide additional support with the implementation of policy on matters concerning which the Council has reported. The provision of such support would compromise the demarcation of responsibilities, Holtkamp contended. However, he was in favour of the regular updating of advisory reports, as happened where the subject of electromagnetic fields and health was concerned.

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## **2.6 Product differentiation**

Oudendijk (VWS):

‘Policy does not always require in-depth advice.’

Oudendijk was speaking in general terms when he made the above comment, but was also referring to an established practice within the Health Council, namely the publication of occasional horizon-scanning reports. Such reports deal with less wide-ranging issues or issues that are less significant in policy terms. Such ‘lighter’ reports are usually based on the opinions of a small number of experts, rather than a broad-based committee. It was up to the Council *and* the Ministry, Oudendijk suggested, to develop procedures and working methods that provided a real prospect of reports being delivered within the agreed period (which can vary considerably).

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## **2.7 The Health Council’s international activities**

Holtkamp (VROM):

‘It is worth exploring the possibility of strengthening European cooperation.’

The Netherlands was to some degree dependent on what scientific bodies in Brussels advised, Holtkamp said. The Ministry has little insight into any rela-

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tions that might exist between such bodies and the Health Council. He did not doubt the desirability of such ties, however.

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## 2.8 Analysis

It will be apparent that the various themes were not all given equal attention in the talks with the representatives of the various departments. The matters dealt with under the headings 'The Council's sphere of activity', 'The scope and lead times of advisory reports' and 'The formulation of requests for advice' dominated the interviews. Themes such as 'product differentiation' and 'The Health Council's international activities' were only explicitly raised on a handful of occasions.

We will begin this analysis by making a few observations regarding the latter points. We recognise that the international position or possible international positioning of the Health Council is currently a topical matter within VROM. This is understandable, because many of the Council's reports to this Ministry concern environmentally hazardous substances, which are increasingly controlled at an international level. In other policy domains, in particular the health care domain, national identity and the associated administrative traditions are more influential. Brussels is not irrelevant to such domains, but increasing the Health Council's focus on European developments is not seen as a requirement. We believe that this may be interpreted in two ways. Either the commissioning departments are happy with the way things are at the moment (i.e. with the scientific contacts that the Council already has with various international organisations); or they have limited insight into the international scientific network and its potential. In the latter eventuality, opportunities are perhaps being missed.

Although 'product differentiation' featured as a theme in its own right only once, that does not tell the whole story. A thematically related request – to the effect that ways of providing reports more quickly should be explored – was made under the heading 'The scope and lead times of advisory reports'. Furthermore, the Health Council's products and the process of product development are closely related matters, as may be concluded from the comments of our discussion partners. Nevertheless, we believe that with their remarks on these topics, the interviewees were raising a more fundamental question: should the Council provide several distinct types of product, or should the only sharp distinctions be in the breadth of the remit and in the length and exhaustiveness of the process?

Returning to the general tone of the interviews: the interviewees had nothing but praise for the quality of report content. Nevertheless, our discussion partners

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consistently placed the emphasis on strategic issues, i.e. on what organisations are required, able and willing to do. What the Health Council is required, able and willing to do is of course not the same as what the ministries are required, able and willing to do. Indeed, there are differences among the ministries in this regard. However, while acknowledging the differences, one must not overlook the consistent themes:

- There is a degree of uncertainty as to the Health Council's technical and procedural capabilities.
- In principle, the departments welcome input from the Council when formulating requests for advice. Day-to-day pressures mean that they often have little time for consultation, however.
- Clearer arrangements are required with regard to prioritisation, demarcation and report delivery dates. Consequently, the Council needs to develop management tools to enable it to adhere to such arrangements.

In chapter 4, these points are examined in a broader context. First, however, an analysis is made of the views that prevail within the Health Council concerning the organisation's activities and performance.



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## **Views held within the Secretariat and Council**

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Understandably, a different picture of the Health Council's performance emerges from the views held by members of the Health Council's Secretariat and Presidium Committee (referred to below simply as 'the Committee'). The feedback from these people tended to highlight issues associated with the production of advisory reports.

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### **3.1 The secretaries' views**

Asked about the way in which requests for advice were formulated, the secretaries reported a very varied picture. In some cases, apparently, presentation of the ultimate request for advice was preceded by detailed discussions, while in others requests had been received completely out of the blue. Most secretaries regarded consultation as preferable. Although it was time-consuming, it did give the Council an opportunity to exercise some influence over the commission, at least in principle. Sometimes, consultation was organised through supra-departmental or supra-directorate meetings, and led to more broadly formulated requests. On occasions, consultation enabled the Council to persuade the client that it was more appropriate to refer certain matters to other organisations.

According to the secretaries, the room for manoeuvre depends not only on the political urgency of the subject, but also on the culture of the requesting ministry. The nature of the first of these factors needs little explanation: sometimes, an issue is socially and politically so clearly defined that the content of a request

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for advice is almost predetermined. In such cases, there is often considerable pressure to report quickly, allowing little opportunity for more general reflection. However, even in less urgent situations where there is more political scope for movement, detailed consultation on the request is not a foregone conclusion. The secretaries considered it to be in everyone's interest to promote such consultation between the Council and the ministries.

Is there interest in more wide-ranging subjects? The secretaries indicated that in contacts with civil servants from VWS, the strategic issues that the department deals with were rarely discussed. Furthermore, although both the LNV and the VROM had a strategic policy directorate, contact between the Council and these directorates were at best extremely superficial. Certainly, consultation had never resulted in the Council actually being asked to advise on strategic matters. Where the SZW was concerned, the focus was almost entirely on toxicity assessments.

The points made regarding consultation with and within the departments apply equally to consultation within the Secretariat: the early exchange of views regarding possible report subjects and regarding the matters that should or should not be covered in the context of a report is operationally advantageous, many of the secretaries said. They also felt that the expertise within the Secretariat sometimes went unused. Another problem they identified was that an individual was sometimes asked to manage the production of a report, despite not having been involved in the preparatory activities; this was felt to hamper the smooth processing of requests for advice.

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### **3.2 The views of the Presidium Committee**

This subsection begins with a résumé of the Committee's views on a number of themes introduced in Chapter 2. The feedback from the Committee is presented after that.

#### **The Council's sphere of activity**

During the discussion, the emphasis was less on what the Health Council could undertake, and more on the Council's relations with other organisations that the various departments can call on for advice. These include policy advisory bodies, such as the Council for Public Health and Health Care (RVZ), the sectoral councils (which advise on research programming) and bodies such as the Health Care Insurance Board (CVZ), the Netherlands Organisation for Health Research and Development (ZonMw), the National Institute of Public Health and the Environ-

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ment (RIVM) and the Netherlands Organization for Applied Scientific Research (TNO). According to the Committee, it is important to prevent duplication in the commissioning of reports. This was felt to be the responsibility not only of the ministries, but also of the Health Council itself. The Committee also highlighted the positive side: there was perhaps scope for better activity coordination with other organisations and for working with corresponding bodies in other countries.

### The scope and lead times of advisory reports

The Committee members spoke at length about the scheduling and depth of the Council's advisory reports. They indicated that reports were almost never ready by the target dates defined at the outset. However, they did not think that this was unavoidable. Distinction was made between topic-related delays and process-related delays. Although a client sometimes asked for wide-ranging advice, which might well necessitate an exhaustive response, the value of a report as a policy support resource was not usually increased by detailed and time-consuming scientific analysis. Furthermore, spending excessive time on one subject inevitably meant delays in addressing other items in the Health Council's work programme. The Committee was convinced that precise remit definitions developed in consultation with the client could lead to better process management. 'In most cases, reports could be more concise and produced more quickly.'

The Committee also felt that alternative working methods – i.e. methods not based on the traditional committee model – could be employed more often. While the committee model had many advantages, it also had the drawback that the incidental absence of individual committee members could seriously delay progress towards consensus. Various alternative working methods were considered. In some cases, it was felt that a one-day working conference, or a conference lasting a few days, could be a viable option. The participants would then be away from their normal jobs for a longer continuous period, but the individuals concerned would normally expect spells away from their desks to attend scientific congresses and such like. The attraction of participating in a working conference could perhaps be increased by allowing committee members to present papers in a personal capacity on specific aspects relevant to the theme under review. The success of such a working conference did, however, depend on the availability of reasonably well-developed discussion documents. Therefore, while such a working method might reduce the time needed for committee deliberations, it would usually increase the time required for preparatory work within the Secretariat.

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With the latter consideration in mind, another option was put forward: the use of external support in situations where there was significant pressure of time. In principle, the Committee felt that this was a viable option; indeed, the point was made that external expertise was already used in some cases. However, the use of such expertise was not only subject to budgetary constraints, but also brought potential ‘process-technical’ problems. In practice, it has been found that committee secretaries, with their experience of viewing issues in the round, play a vital role in combining the specialist input of the various experts. In other words, the secretaries occupy a pivotal position, facilitating and encouraging the necessary discourse within their committees. So, while bought-in expertise can be valuable, it can only ever serve as a supplement to the Council’s in-house expertise.

#### The formulation of requests for advice

A number of points relevant to the formulation of requests for advice – liaison with other organisations, topic demarcation and the definition of clear delivery timescales – have already been introduced under the previous two headings and in the subsection setting out the secretaries’ views. Like various other people we spoke to, the Committee members also raised the question of how far the Health Council should go in terms of agreeing the content of requests for advice with client departments prior to their submission. Their feeling was that consultation on the formulation of a request was appropriate, as long as the Council did not involve itself in the underlying policy problems. It was not felt practicable to give general guidance: it was necessary to consider how best to match the wishes of the commissioning ministry with the capabilities of the Council on a case-by-case basis.

#### Follow-up support requirements

The subject of follow-up support was only briefly touched upon. The Committee favoured a cautious approach to contact with stakeholder groups. While the Health Council could explain its recommendations as and when required, it was considered to be the ministries’ role to liaise with the wider community on the principles underpinning their policy. Nevertheless, the Committee believed it could sometimes be worthwhile organising public hearings in the course of the advisory process, but made the point that such hearings could also be problematic. Representatives of stakeholder groups were not always inclined to make

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subtle distinctions between science and politics or between advice and policy, with the result that hearings could generate false expectations.

#### Other comments

The Committee emphasised the importance of draft reports being reviewed by standing committees (permanent committees that advise on particular fields). Nevertheless, in the Committee's experience, the existing structure was not as flexible as it might be. It was suggested that perhaps sometimes Health Council members should be given the opportunity to pass comment on draft reports outside the steering committee system.

The Committee also indicated that it could itself play a greater role. Committee members indicated that they would like to be consulted more often about matters with long-term implications and of strategic significance for the Health Council.

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### **3.3 Analysis**

Whereas the Health Council's clients were concerned mainly with possible ways of shortening the advisory process, the secretaries and the Presidium Committee tended to focus on ways of improving management of the advisory process. Among the options they identified were prompt consultation regarding the exact aim and content of requests for advice, coordination with other organisations that advise the government and parliament, the use of reports prepared by bodies in other countries and accelerated report development procedures, such as short working conferences. It is apparent that within the Council a lot of emphasis is being placed on the more systematic use of such process management tools.





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## The challenge

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Chapter 2, which summarised the views of the Health Council's main clients, ended with three conclusions, each of which contained a challenge for the Council. In chapter 3, further light was shed on those conclusions by the views of members of the Council and its Secretariat. The Council's management must therefore respond to these challenges, in which context we believe that it is helpful to examine them from two perspectives.

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### 4.1 Two perspectives

The Health Council is one of twenty-three advisory bodies covered by the Framework Act. Last year, as mentioned in the introductory chapter, the BZK published a report on the new advisory system. The Council for Public Administration (ROB) subsequently produced a commentary on the Ministry's evaluation report, which was followed by a response from the Minister of BZK a few months later.\* We have accordingly sought to place the challenges facing the Health Council in perspective first by considering how the ROB/BZK conclu-

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\* BZK. De staat van advies (The State of Advice). The Hague, 2001; Council for Public Administration. A report on the Evaluation Advisory Bodies Framework Act. The Hague, 19 December 2001; BZK. Response of the Minister of BZK to the report by the Council for Public Administration regarding the Evaluation Advisory Bodies Framework Act. The Hague, 8 April 2002.

sions regarding the Health Council compare with those regarding other advisory bodies.

Second, the Council and its Secretariat form a classic example of what is often referred to as an 'organisation of knowledge workers'. The key phrase in modern analyses of the governance of such organisations is 'knowledge management'. In this context, 'knowledge' is a broad concept, embracing not only factual knowledge, but also methodological knowledge, social knowledge and procedural knowledge. An organisation that succeeds in developing these forms of knowledge effectively and flexibly is referred to as a 'learning organisation'. In recent years, management experts and organisational advisers have been searching industriously for tools with which to stimulate such learning. The insights and ideas thus developed can be valuable to the Health Council, certainly if the feedback from the secretaries is anything to go by.

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## 4.2 The Evaluation Advisory Bodies Framework Act

Reform of the advisory system has been successfully completed and the political primacy restored; that was the central message of the Minister of BZK's first report on the effectiveness and impact of the Advisory Bodies Framework Act. Nevertheless, it was felt that political management of the advisory bodies could be improved further. The evaluation report stated that 'in most cases, coordination and communication between the ministries and strategic advisory bodies regarding requests for advice and the further advisory process did not proceed smoothly'. Like the ROB, the Minister of BZK felt that advisory bodies and ministries needed to make better arrangements regarding the advisory and work programme and regarding the formulation and timing of requests for advice. Furthermore, government departments should consult each other more closely concerning requests for advice that were relevant to several sectors, the Minister said. In this context, the ROB suggested that the compartmentalised internal organisation of advisory bodies was regrettable, since it was an obstacle to integrated policy and cooperation between advisory bodies. The minister emphasised the importance of removing barriers and taking an inter-sectoral approach at the national level, but urged the advisory bodies to play their part as well.

The points made above are, however, valid mainly in relation to the so-called strategic advisory bodies, which advise on basic policy principles. The assessment of the so-called specialist technical advisory bodies was more positive: they generally have good relations with their clients. The evaluation report also indicated that the impact of these bodies' advisory reports was more measurable and

visible. Within the advisory system, the Health Council is deemed a specialist technical body.

Comparing the Minister's assessment with our own findings, definite parallels emerge. There is universal interest in collaborating on the formulation of commissions, which is not felt to imply the inherently undesirable entanglement of the various parties' responsibilities. There is also a general sense that the advisory process cannot run smoothly without proper interaction: the client and the advice provider, each having its own responsibilities, need to find ways of improving communication and coordinate their activities more effectively.

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### 4.3 Knowledge management and learning organisations

Communication, consultation and coordination are all very well, but it is important to ensure that general procedures, declarations of intent or incidental activities are not the end of the line. This is the warning that management experts give. The prevailing view is that the greatest benefit is to be obtained by systematically addressing fundamental production factors. Whereas in the past labour was often the central economic factor, knowledge plays a more decisive role in a highly industrialised society such as ours.\* This became apparent first in the private sector. Companies nowadays seek to recruit the best-trained and best-educated people they can, thus increasing the intensity of competition. Any business that, having reached a certain level of performance, becomes complacent will soon find itself overtaken by others that have found cleverer working methods or developed better products. In order to keep pace with the field, a business needs to create an internal dynamism that will enable it to adapt quickly to change as it occurs. Non-profit organisations are not insensitive to the forces that drive the commercial sector. Depending on its exact role, a public sector organisation may be regulated by, for example, legal security, legal equality and democratic control, but its clients nevertheless make ever higher demands regarding operational and service quality, just as private-sector clients do.

In management science literature, knowledge is usually defined quite loosely and includes both explicit and implicit forms, i.e. codified knowledge (knowing that) and experience-based skills (knowing how). Distinction is made between individual and collective knowledge. At the primary level, knowledge entails a

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\* C Sprenger (ed), C van Eijnsden, S ten Have, F Ossel. Vier competenties van de lerende organisatie (Four Competencies of the Learning Organisation). The Hague: DELWEL, 1995; H van Duivenboden, M Lips, P Frissen (ed). Kennismanagement in de publieke sector (Knowledge Management in the Public Sector). The Hague: Elsevier, 1999; M Weggeman. Kennismanagement: de praktijk (Knowledge Management in Practice). Schiedam: Paper, 2000.

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person's ability to attach significance to information and to perform tasks. However, such abilities are reflected at the group level. Some authors reserve the term 'competence' for these abilities. A competence that meets certain criteria (such as being difficult to copy) is termed a 'core competence'.\*\* Every organisation, whether subject to market disciplines or budget disciplines, needs to possess a core competence.

An organisation's core competence is the product of interaction between its personnel. The greater the personal knowledge of an organisation's personnel, the more efficiently such knowledge is exchanged and the more readily it is put to collective use, the greater the organisation's ability to meet the requirements placed upon it. A good knowledge flow increases the likelihood of the organisation learning. The task of the management does not, as it once did, consist of planning and control, but of facilitating processes of knowledge creation, knowledge sharing, knowledge application and knowledge evaluation. In most cases there are barriers and resistance to overcome. Knowledge workers, or professionals, are inclined to regard their knowledge as a personal possession, rather than as part of the intellectual capital of the organisation. Furthermore, in situations where they enjoy a significant degree of autonomy, they are apt to be led in their decision-making by the standards and values of professional colleagues than by the collective ambition of the group. Another problem that often arises is that the collective ambition of the group is not adequately articulated, making individualism more likely and reducing the flexibility and responsiveness of the organisation.

What tools enable managers to remove such obstacles or, put more positively, to capitalise most effectively on knowledge as a production factor? Weggeman, regarded by many as the first champion of knowledge management in the Netherlands, distinguishes three complementary fields of management. The first involves the explicit or 'explicitable' and therefore objectively communicable component of knowledge. Where the management of such knowledge is concerned, information and communication technology (ICT) – in the form of tools such as databases and electronic networks – can be particularly useful. The second field of knowledge management is human talent development, which in this context is in essence the management of professionals. Numerous techniques have been shown to be effective in this field, including the mentoring of junior personnel, the use of personal commitment statements that include learning objectives, and the provision of sabbaticals for experienced personnel. Third, there is orientation to the aims and culture of the organisation. In this regard,

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\* C Prahalad, G Hamel. The core-competence of the corporation. Harvard Business Review, May-June 1990.

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Weggeman refers to the creation of a knowledge-friendly organisation, which in effect involves the application of organisational science principles to a knowledge-intensive organisation. In this field, it is important to find work forms that discourage territory drift and allow the development of a culture of cooperation, as expressed in a collective ambition. Appropriate initiatives need to be encouraged, rewarded and anchored within the fabric of the organisation, the experts say.

In recent times, there has been a growing conviction that introspective analysis and internal adaptations are not sufficient. While increasing the efficiency of business processes and maximising the return on knowledge are important, focusing exclusively on these matters is like perfecting mass production methods when there is a growing demand for bespoke products. If anything is obvious in the modern world, it is the desire that clients have to influence elements of the production system. No matter how efficiently products and services are produced, clients are likely to value the efficiency of production less than providers might expect, if the offering lacks differentiation. Hence, organisational consultants constantly stress that added value must be gauged not in terms of product characteristics, but in terms of consumer perception. For an organisation, what this amounts to is managing perceptions and experiences.<sup>9</sup> The modern term for this process is co-creation: involving customers as partners at various points in the production chain. Sharing responsibility to a degree is integral to this. It is also necessary to accept uncertainties in the production process, which consumers tend to find easier if they have a role that process. However, it is also imperative that an organisation is open about its capabilities and limitations when entering into an agreement. In other words, it is essential to manage the expectations that (potential) clients have. You have to be able to ‘sell’ a conditional ‘Yes’ and ‘No’.

This *tour d’horizon* brings our analysis to its conclusion. The demand for rationalisation of the advisory system was born out of political dissatisfaction at the system’s opacity and the intermingling of the advisory and consultative processes. In response, the Framework Act was framed to disentangle the two. And it may be deemed to have succeeded. However, separation – certainly separation of the consumers and providers of advice – can go too far, and consequently fail to have the desired effect. The art is finding an appropriate balance between independence and collaboration. To this end, structured knowledge factor-oriented

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\* C Prahalad, V Ramaswamy. The co-creation connection. *Strategy + Business*, 2002; 27(2).

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internal and external consultation is indispensable. If an advisory body succeeds in establishing such consultation, its image will be greatly enhanced.

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A The departmental discussion partners

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B The Presidium Committee

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## **Annexes**





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## **The departmental discussion partners**

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Separate discussions were held with each of the following ministerial representatives:

- N.C. Oudendijk, Deputy Director General for Public Health, VWS (also present: J Hulleman, VWS)
- Dr. P.A.H. van Lieshout, Director General for Care, VWS
- H.A.P.M. Pont, former Director General for Environmental Management, VROM; Director General of the RIVM
- A.B. Holtkamp, Director for Chemicals, Waste and Radiation, VROM (also present: J. van der Kolk, VROM)
- Dr. P.C. Noordam, Head of the Occupational Environment Department, SZW
- G.A. Koopstra, Director for Food, Veterinary and Environmental Affairs, LNV

The text of chapter 2 of this report has been cleared with the parties concerned.



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## The Presidium Committee

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- Professor J.A. Knottnerus, President of the Health Council, The Hague, Chairman
  - Professor H.R. Büller, professor of internal medicine, University Medical Centre, Amsterdam
  - Professor H.J.P. Eijsackers, Director of Alterra, Wageningen
  - Professor J.K.M. Gevers, professor of health law, University Medical Centre, Amsterdam
  - Professor J.G.A.J. Hautvast, Vice-President of the Health Council, The Hague
  - Dr. M. van Leeuwen, General Secretary to the Health Council, The Hague, Secretary
  - Professor N.J. Leschot, professor of clinical genetics, University Medical Centre, Amsterdam
  - Professor J.W.M. van der Meer, professor of internal medicine, St Radboud University Medical Centre, Nijmegen
  - Professor D. van Norren, Director of TNO Technical Human Biology, Soesterberg
  - Dr. W.R.F. Notten, Director of TNO Prevention and Health, Leiden
  - Professor W.F. Passchier, Deputy General Secretary to the Health Council, The Hague, adviser
  - Professor W.H.M. Saris, professor of human nutrition, University of Maastricht
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- Professor H.K.A. Visser, former professor of paediatric medicine, Erasmus University Rotterdam (until June 2002)
- A. Wijbenga, Head of the Air Quality and Safety Bureau, Province of South Holland, The Hague