Positive Health: from niche-discourse to government jargon

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Abstract
In Dutch healthcare a shift in discourse is taking place where the focus is shifting from ‘disease and care’ to ‘health and behaviour’. If this change in language (thinking) is combined with changes in structure (organising) and dailty practices (doing) in healthcare it constitutes a societal transition. Using a discourse analysis combined with a transition perspective, we analyse this shift through the development and diffusion of the concept of Positive Health. Positive Health has developed from niche discourse to an important part of the national health policy. This article reflects on this successful integration in government policy and the applied (discursive) strategies to achieve legitimacy for Positive Health. Additionally, the question is posed if discursive change (strategies) can serve as a motor for transformative change.

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1. Introduction

In the discussions about Dutch health care, a shift in discourse or used language and way of thinking is becoming increasingly clear. This pertains to the shift from a focus on illness and eliminating its cause, to a focus on health and well-being and maintaining and improving health (e.g., Taskforce JZJP, 2018; RVZ, 2010). When the emphasis is on illness, the main focus is on what makes someone sick and how this can be 'repaired' (pathogenesis); an emphasis on health focuses on what makes and keeps someone healthy (salutogenesis), and how we can learn to better deal with the challenges that come with life (Nelissen & Degryse, 2015; Vaandrager & Koelen, 2011).

In the current organisation of Dutch health care, the diagnosis and treatment of disease is the starting point for structure and financing, for example recognisable in medical specialisation for various syndromes, medication as an important treatment method and financing based on diagnosis and treatment (Broerse & Grin, 2017; Commissie Werken in de Zorg, 2019; Rotmans, 2012; Schuitmaker, 2010; Van Raak, 2016; Walg, 2014). On the other hand, designing health care from a perspective on what makes and keeps us healthy, may mean paying more attention to lifestyle and prevention, the influence of living environment and socio-economic status, social relationships and the extent to which someone feels part of society (RVZ, 2010; Walg, 2014, 2019; De Gruijter, Nederland & Stavenuiter, 2014).

In 2010, the Council for Public Health and Care (RVZ) kicked off this change of perspective with the report Care for your health!. This report proposed 'health and behaviour' as a new order instead of 'disease and care'. This change of perspective was proposed by the RVZ as a possible answer to the increasing number of chronic conditions in relation to the expected limitation of human and financial resources. However, an actual shift in the structure and financing of health care on the basis of 'health and behaviour' has not yet been realized and this new perspective was only partially visible in the years after 2010 in the way of thinking about, working in and organising health care. This seems to be slowly changing.

The increasing attention for the new perspective of 'health and behaviour' coincides with the use of the concept of Positive Health[1] (see box below). Positive Health has become a commonly used term in policy-related language in the Dutch health care sector in ten years' time and can be found in government policy documents such as the National Health Policy Memorandum 2020-2024 (VWS, 2020), and also in vision documents and policy documents of influential actors in health care, such as representative organisations of health care professionals (including Commissie Werken in de Zorg, 2019; Federatie Medisch Specialisten, 2017; NFU, 2020; Stuurgroep Kwaliteitskader Wijkverpleging, 2018). This is a remarkably fast diffusion process from a new concept to a regularly used and widely known reference in public policy.

[1] Positive Health is deliberately written with capital letters. The term is not new and appears in literature with different meanings. The use of capital letters distinguishes the (Dutch) version with six life domains.

Positive Health
Positive Health emerged from the introduction of a new concept of health (Huber et al., 2011) in which health is seen as people's ability to cope with the physical, emotional and social challenges of life. And to be able to self-manage this as much as possible. Positive Health was introduced as an elaboration of this broader view of health (Huber et al., 2013), translated into six dimensions: bodily functions, mental well-being, meaningfulness, quality of life, participation and daily functioning. Positive Health is both a vision of health that reflects how thinking about health and disease is changing, and a method for people to map health (using a spider web diagram with six dimensions), thereby forming a basis for an 'alternative dialogue' building on one's perceived health and well-being and looking at the whole person in the context of their circumstances.

In order to interpret this rapid diffusion process of the Positive Health concept in health care, this study uses a transition perspective. Transition research looks at the patterns and mechanisms of structural changes in societal (sub)systems. Transitions arise from the 'path dependence' of dominant ways of thinking, working and organising in a societal subsystem (Broerse & Bunders, 2010; Loorbach, Frantzeskaki & Avelino, 2017). This is also referred to as the 'regime' and describes the way in which actors have become accustomed to shaping a certain social function together, which translates into rules, agreements, technologies, knowledge and training, and organisational structures. Such regimes emerge gradually, often in response to historical problems, but at the same time develop inertia because they are so institutionalised and optimised. If society and societal needs change at the same time, actors within such a regime can come under increasing pressure and persistent problems can arise that can no longer be solved by the regime itself (Loorbach et al., 2017).

Transition research in (Dutch) healthcare (collected in Broerse & Bunders, 2010; Broerse & Grin, 2017, among others) unravels some of these complex and persistent problems and makes visible how they arise from the dominant characteristics of the way of thinking, working and organising in health care, partly following the success of specialised, curative care (Van Raak, 2016). Berkers (in Broerse & Grin, 2017) illustrates how the systemic changes of the past decades (e.g., basic health insurance, market forces, decentralisation) do not yet offer a future-proof answer to persistent problems in the field of financial sustainability (affordability), decreasing personnel capacity and declining solidarity in the light of an ageing society and an increasing demand for care. From the perspective of transition research, these are indications that a regime is 'unsustainable' and will come under increasing pressure, eventually becoming unbalanced and moving towards a new equilibrium. This goes hand in hand with increasing crises and problems and ultimately political intervention, but also with an increasingly active search for alternatives or 'niches' (Loorbach, 2014; Loorbach et al., 2017).

This search for a future-proof design for health care is recognisable in the titles of reports that have been published in the past few years: *The right care in the right place* (Taskforce JZJP, 2018), *Towards a future-proof healthcare system* (Rijksoverheid, 2020), *Collaborating on appropriate care: the future is now* (Dutch Healthcare Authority & Healthcare Institute, 2020), *Discussion paper Care for the Future* (VWS, 2021), *Choosing tenable healthcare* (WRR, 2021). These reports and

titles make it clear that the Dutch health care system is under pressure and is looking for alternatives. The shift in discourse (from illness to health) illustrates a different way of thinking and possibly also a different way of working and organising, which is now becoming visible at the level of the regime itself.

The Positive Health concept refers to the general idea that health is becoming more important than illness and care and that focusing on health is a way to increase social well-being and reduce the societal costs for care. The direction as outlined in the aforementioned report by the RVZ (2010), among others. The alternative offered by Positive Health can be described in transition terminology as a transformative innovation (Loorbach et al., 2020): a different way of thinking, working and organising that challenges, changes or replaces the regime. This now seems to be the case, given the inclusion of the concept and the involvement of all kinds of typical regime actors such as the Ministry of Health, Welfare and Sport (VWS), advisory councils and science.

In this article we try to trace the development and rapid spread of Positive Health as an alternative perspective for the future of health care and to understand which strategies contributed to this diffusion process. The main question for this study is formulated as follows: *How can we understand the discursive shift within Dutch healthcare, using the example of Positive Health, from a transition perspective?* In the next section, we first elaborate on the theoretical perspectives of discourse and transition before explaining our method and main data sources. Based on this, we then describe the diffusion process of Positive Health and analyse how this came about and which strategies have been applied. Finally, with the transition lens we reflect on the inclusion of Positive Health in government policy and the implications for the future course of the transition in healthcare.

2. Theoretical perspectives

2.1 Discourse

The introduction signals a shift in the way in which the role of care is perceived and discussed: from disease to health. This possible paradigm shift can have far-reaching consequences for the entire health care system, but so far it has mainly been reflected in the language used. Within the social sciences, language is seen as a social act and language thus forms its own reality (Van den Berg, 2004). Language can therefore be interpreted in this context in the broadest sense of the word and includes all forms of expression of meaning. Language and language behaviour can be investigated with a discourse analysis. Discourse analysis is research into the way in which opinions and realities are constructed discursively – that is, in language – (Van den Berg, 2004). Discourse can then be seen as a specific way of talking about and understanding the world (or an aspect of the world) (Jørgensen & Phillips, 2002). Behaviour can also be modified by influencing a certain view of reality. Language is therefore not only descriptive, but also has a performative effect by influencing behaviour (Austin, 1962): it has an effect on reality through action. Here, a discourse analysis is used to investigate to what extent the dominant discourse in Dutch health care is subject to change, with a specific focus on thinking and talking about illness and health.

Discourse analysis has a large number of approaches and levels of abstraction, in which language use is studied in its own right or linked to social practices to a greater or lesser extent. This study was inspired in its execution by the critical discourse analysis of Fairclough (2005) and the argumentative discourse analysis of Hajer (2006). The focus here is on tracing the development in the way of thinking and talking about illness and health. A closer look at the use of the concepts 'disease' and 'health' is relevant, because the concept interpretation also determines health policy and thus has a potential performative effect on how health care is implemented.

2.2 Transition

A transition is defined as a shock wise radical change in the dominant way of thinking, doing and organising (regime) in a societal (sub)domain (Grin, Rotmans & Schot, 2010). The change is radical in the sense that it is fundamental (not necessarily big or fast) and takes place in culture as well as structure and practices (Frantzeskaki & De Haan, 2009; Rotmans & Loorbach, 2009) i.e.: a fundamental change of thinking, organising and doing within a societal subsystem (such as health care). Research into historical transitions has revealed the patterns whereby dominant culture, structure and practices (regime), as a result of societal changes and an inability to adapt, gradually come under increasing pressure to change (Loorbach et al., 2017). A transition is the process in which a regime becomes unbalanced due to external pressures, internal tensions and emerging alternatives, after which space is created to arrive at new and more fundamental solutions than would have been the case with optimisation and improvement (Rotmans & Lorbach, 2009).

Persistent problems are tenacious problems that are (re)produced by existing structures and actors in a system (Loorbach, 2007). This (re)production is influenced by interests, dependencies, lack of perseverance (or need to cooperate) and the lack of a common perspective. These problems are therefore complex and systemic in nature and cannot be solved through optimisation and efficiency because they arise from the characteristics of the system (Broerse & Bunders, 2010; Broerse & Grin, 2017; Schuitmaker, 2010). These system characteristics originated historically as a reaction to the problems of the time and have led to a variety of routines, structures and dependencies that make it difficult to do something completely different. Schuitmaker (2010) has identified some characteristics of the health care system that contribute to the (re)production of persistent problems. Characteristics such as standardisation, use of (evidence-based) protocols and guidelines and specialisation contribute to maintaining a system that is based on the perspective of 'disease and care'.

The concepts of niche and regime in transition studies have their origins in the Multi-Level Perspective (MLP) (Geels, 2002; Rip & Kemp, 1998; Schot, 1998). This MLP outlines how developments at the macrolevel (e.g., demographic developments, political shifts, digitization, individualization, globalization, climate change) provide a changing context that makes the dominant way of thinking, working and organising (the regime) less able to deal with persistent problems. When the existing regime comes under pressure, space is created for alternatives (niches) that oppose the dominant way of thinking, working and organising (Broerse & Grin, 2017; Loorbach

et al., 2017). These niches can take different forms, such as new organisational models, new technologies or social innovations.

In health care, the regime is strongly focused on technological innovation, diagnosis and treatment, and close public-private partnerships (Rotmans, 2012, 2014; Walg 2014). The financing structure, protocols, structure of professions, drug- and technological treatment solutions are based on this regimen. This regime was built up in the post-war decades and replaced a much more decentralised regime in which district nursing and the general practitioner played a much more important role (Van Raak, 2016). Population growth, diseases of affluence and technological progress gave rise to a movement towards the current regime, which has been increasingly liberalised in recent decades under the pressure of rising costs (Rotmans, 2012; Walg, 2014). But this regime is proving less and less an adequate response to the societal change resulting in health inequalities and ageing with more chronic, multiple disorders. An alternative adequate response may harbour solutions to be found in other domains, such as lifestyle, living environment, social participation or poverty reduction (Dutch Healthcare Authority & Healthcare Institute, 2020; National Government, 2020; RVS, 2020; RVZ, 2010; VWS, 2020, 2021; WRR, 2021).

These societal developments lead to persistent problems in the health care system and increase the pressure to investigate alternatives. This creates new niches such as Positive Health. Positive Health offers an alternative language with a focus on behaviour, health and resilience, and thus an alternative interpretation of the way of thinking, working and organising in health care.

In transition theory, such an alternative way of thinking, working and organising that challenges the regime is referred to as “transformative innovation” (Avelino et al., 2019). Unlike technological innovation, this is primarily about social innovation that develops in a different way. In this context, therefore, we speak of the 'diffusion of transformative social innovation': the process and methods through which new ways of thinking, working and organising are created, spread and gradually become institutionalised. Transition researchers have developed several typologies that represent the development of innovation in the context of transformative change. Loorbach et al. (2020) name five development mechanisms of transformative innovation that summarise the core of different typologies: growing, replicating, partnering, instrumentalising and embedding. These development mechanisms will be explored in the case of Positive Health.

With the transition perspective, we highlight both the societal factors and circumstances as well as the process of diffusion (in the sense of dissemination) of the new discourse and the strategies that contribute to the infiltration[2] of new language at regime level, for example in the form of policy. This analysis also takes a look at existing system barriers and the resistances and lock-in that arise from path dependency. In recent years, more attention has been paid in transition research to the role of existing (regime) actors and institutions (Turnheim & Sovacool, 2020) that actively contribute to system change and the development of a new way of thinking, working and organising. Transformative innovation is supported by existing actors

[2] Infiltration is used here in the neutral meaning of the process of filtering into or through.

and institutions and not opposed (Berggren, Magnusson & Sushandoyo, 2015) as the original MLP model indicates. In the discussion section we look at the development of Positive Health with this transition lens.

3. Method

This research focuses on tracing the adoption of Positive Health at regime level in the National Health Policy Memorandum 2020-2024. We follow the trail of the development and dissemination of the language of Positive Health (as a niche). Discourse analysis fits well with transition analysis because it allows the investigation of problem definitions and proposed solutions for social problems, but also because it offers the possibility to reconstruct and follow the emergence of an alternative way of thinking in relation to the dominant one. Especially when the focus is not on technological innovation but on social or transformative innovation, discourse analysis seems to be the most suitable method. The research is firstly based on an analysis of the discourse in collected documents. In addition to documents from the Institute for Positive Health (iPH), such as policy plans and annual reports, a set of related documents has been identified, such as national advisory reports and (scientific) publications on Positive Health. For the publications on Positive Health, we made use of the materials that iPH makes available via its own website and searches were made in both scientific and popular search engines with the command “Positive Health”. This search term was also used on the website of the Ministry of Health, Welfare and Sport. In a next step, various other relevant sources were found using the snowball method and added to the study. This mainly concerns core documents from the various healthcare domains.

In addition to the document analysis, a context analysis was carried out in which websites, news items and visual material in which Positive Health was the subject were also studied. A detailed look was taken at the discussion surrounding Positive Health in the form of critical articles and responses to this from Machteld Huber as the founder of the concept and iPH. The analyses were supplemented with two interviews with iPH representatives, in which the findings from the document and context analysis were checked. Using a timeline, the origin and development of Positive Health in the Netherlands have been mapped. The analysis of the discourse in the documents took place in two rounds. Initially inductive on the basis of four questions that are derived from the research questions: which problems and solutions are presented, which arguments and counter-arguments can be identified, which actors are involved or are assigned a role, and which care domains does this cover? In the second instance, a deductive search was made for the applied (discursive) strategies (Johansen & Van den Bosch, 2017; Loorbach, 2007) to gain position for Positive Health and to spread the ideas.

The present analysis has come about in an iterative process in which general understanding and main points are alternated with in-depth textual analysis.

4. Development and growing attention for Positive Health

Positive Health was introduced by Machteld Huber as a new broad approach to health. In her research, the current definition of health formulated by the World Health Organization (WHO) in 1948, turned out to be insufficiently useful, as it assumes a state of complete physical, mental and social well-being. In the present time, in which people are living longer and there is a high prevalence of chronic

diseases, the group of people who are completely healthy according to this definition is very small. Huber was given the opportunity to organise an international conference in 2009 with the Health Council and ZonMw[3] to explore a new definition of health. With a group of international scientists, a new, more dynamic definition of health was proposed: health as the ability to adapt and self-manage in the face of social, physical and emotional challenges (Huber et al., 2011). ZonMw then commissioned Huber to further develop this concept and to work on operationalisation. The Positive Health concept with the six domains and the spider web diagram is the result of this (see box and figure 1).

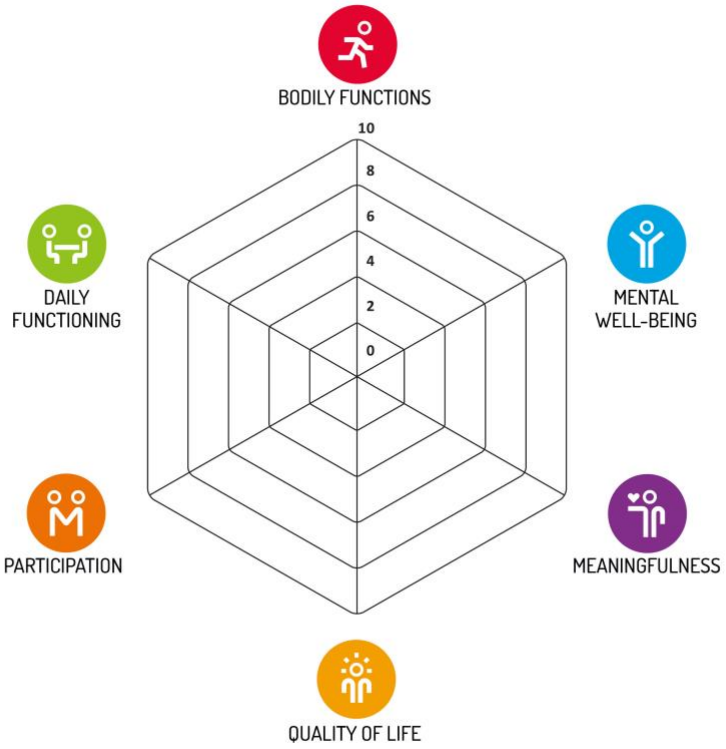

Figure 1. Spider web diagram. Source: www.iph.nl/en & www.positivehealth-international.com

An interview with Machteld Huber in the Dutch newspaper NRC, after completing her PhD in 2014, introduced Positive Health to the general public and interest increased exponentially. With a first testing ground in the Northern Maas valley (Boers & Huber, 2015), practical experiences were gathered in a network of healthcare professionals, welfare organisations, health care insurers and municipalities with the development of a common frame of reference and action perspectives arising from the spider web diagram. The interest in Positive Health was such that a separate institute was founded in 2015: the Institute for Positive Health (iPH). From iPH, the dissemination of knowledge about the Positive Health concept has been further shaped through lectures, supervision of more living labs and conducting of dialogues with stakeholders such as the Ministry of VWS and health insurers.

[3] ZonMw is the Dutch organisation for health research and healthcare innovation. ZonMw finances health research and stimulates the use of the developed knowledge – in order to improve health care and health.

As Positive Health became more widely known, criticism also increased. In 2016 and 2017 in particular, several critical publications were published (Kingma, 2017; Poiesz, Caris & Lapré, 2016; Van der Stel, 2016; Van Staa, Cardol and Van Dam, 2017; Vosman, 2017). The criticism focuses on the breadth of the concept and how everything is identified as health with use of the six dimensions. As a result, the field of expertise and the practice of the health care profession are unlimited and medicalisation is encouraged instead of decreased. Another point of criticism raised is that Positive Health focuses on behaviour rather than health, that this is confusing and leaves out objective bio-psychosocial conditions. Patients may feel that they are not being taken seriously. A third point of criticism concerns the point of self-management. Critics indicate that not everyone is able to self-manage and be self-reliant, for example as a result of life stage, incapacity or vulnerability, and are these people then unhealthy? In line with this, it is also noted that adaptability, as a core concept within Positive Health, is not always positive or healthy; for example, in situations of domestic violence, adaptation is not the most advisable behaviour. In addition, there is criticism with regard to the quality of the research conducted and the scientific substantiation of Positive Health, and the question is asked to what extent Positive Health brings something new to long-standing and broadly oriented professional groups such as general practitioners and occupational therapists (Van Boven & Versteegde, 2019; Scheijmans & Stoopendaal, 2018). A large number of these points of criticism have been mentioned in the article by Poiesz et al. (2016) in the Dutch Journal of Health Sciences[4]. In this same journal, Machteld Huber formulated a response in which the choices made are substantiated (Huber, 2016).

From 2017, Positive Health starts to appear in national reports and sector-related core documents, for example Vision Document Medical Specialist 2025 (Federatie Medisch Specialisten, 2017), Quality Framework District Nursing (Stuurgroep Kwaliteitskader Wijkverpleging, 2018), Report Committee Working in the Healthcare (Commissie Werken in de Zorg, 2019) and Raamplan Artsopleiding 2020 (NFU, 2020). The report of the Taskforce JZJP[5] (2018) is an important prelude to embedding Positive Health in the policy of the Ministry of Health, Welfare and Sport (VWS). This report was commissioned by the Ministry of Health, Welfare and Sport and gives reasons why the organisation of health care must (and can) change, based on a shift from illness and care to health and behaviour. Positive Health is mentioned as part and example of the movement. The content of this report was then used for the main agreements between the Ministry of VWS and the various health care domains, which means that Positive Health is also mentioned in some of these agreements. The breakthrough of Positive Health in government policy came with the publication of the National Health Policy Memorandum 2020-2024 (VWS, 2020), in which Positive Health is presented as an important pillar in the vision. More recent reports, such as an advice from the Dutch Care Institute and the Dutch Healthcare Authority (2020) and a discussion paper from VWS (2020), both about the future of health care, also refer to the philosophy of Positive Health as a building block for the future of health care and government policy. The Positive Health concept has been included in many policy documents and is becoming better known among a wider public, and is therefore also spreading further.

[4] In Dutch: Tijdschrift voor gezondheidswetenschappen.
[5] JZJP stands for Juiste Zorg op de Juiste Plek and translates to Right Care in the Right Place.

5. Diffusion process

Transition researchers have developed several typologies that reflect the development of innovation in the context of transformative change (Loorbach et al., 2020). In essence, all typologies involve different mechanisms (in different terms) that stimulate growth, development, reinforcement and embedding. Loorbach et al. (2020) identify five development mechanisms in this context: growing, replicating, partnering, instrumentalising and embedding. We can view the development and diffusion of Positive Health in the light of these developmental mechanisms of transformative innovation.

Growth, in this context, is quantitative in nature. In this study, no quantitative analysis was performed of the increased brand awareness, the number of training courses taken or the number of actual users. However, at first glance, growth can be said to exist if one looks at the increasing demand for training or the increasing number of publications (including visual material) about Positive Health or in which this is referred to. Growth in terms of sustainable (structural) financing is still developing.

Replicating refers to the translation of Positive Health ideas and practices into a different context. We can identify various developments in this area, for example adapting the dialogue tool 'My Positive Health' for specific target groups and expanding it to other domains such as work. In addition, iPH also translates Positive Health to be applicable on multiple levels: individual, organisation, district/municipality and regional/national.

Partnering is about pooling resources, competences and capacities, for example with other innovators. The iPH Foundation explicitly seeks cooperation with others, for example in the field of training, research and implementation processes. The starting point is to seek synergy and commonality, co-creation and cooperation with intrinsically motivated people or partner organizations, who then fulfil the role of ambassador. IPH works with a 'coalition of the willing' and from the start a lot has been invested in finding and stimulating these intrinsically motivated ambassadors within established health care institutions and practices and in organisations at regime level (e.g., Ministry of VWS, health insurers, representative organisations). In any case, these contacts have yielded broad support for iPH and offered plenty of room for sharing about Positive Health, and institutes such as ZonMw and Vilans[6] also explicitly contribute to this.

Instrumentalising i.e., strengthening an innovation by exploiting opportunities in the governance context, is perhaps the most invisible factor in the ongoing diffusion of Positive Health. Chance encounters that open doors, meeting influential ambassadors, being able to inspire people in relevant positions; utilising the opportunities that these encounters bring, and continuing to seek out these encounters, has made an important contribution to the awareness and diffusion of Positive Health.

The last development mechanism is embedding, with institutionalisation resulting from mainstreaming and structural anchoring and an innovation has become part of

[6] Vilans is the national knowledge organisation for long-term care. Like ZonMw, Vilans works on projects commissioned by the Ministry of VWS.

a social structure, for example through regulation or financing. Both in expressions of iPH (such as mission, vision, policy plans, objectives, annual reports and publications) in the years 2015-2021 and in the various memorandums and policy documents of the Ministry of VWS and advisory reports to the government in the same period, a very similar description of context and problem formulation can be found that outline the need to do things differently and how Positive Health can contribute to this (see table 1). The prominent positioning of Positive Health in the National Health Policy Memorandum 2020-2024 (hereinafter referred to as NHPM) of the Ministry of VWS implies embedding through institutionalisation and acquired legitimacy of the concept.

Table 1: Overlapping discourses used by niche and regime actors in the years 2015-2021

	iPH	**Ministry of VWS and related institutes** **NHPM**
Outlined context	– Ageing and increase in the chronically ill, increased life expectancy. – Affordability of health care is under pressure.	– The current health care system is financially unsustainable due to ever-increasing costs. – Increase in the number of elderly people with chronic conditions and multimorbidity, social problems such as loneliness. – Technological developments.
Problem formulation	– Concept of health by WHO too static and ambitious. – Citizens/ patients are insufficiently self-reliant with regard to their health. – Insufficient cooperation/ coherence between care and social domain/ partitions. – Patient-centred care is insufficiently implemented in practice. – Focus on condition/ complaints/ problems and medicalisation.	– Medicalisation and hospitalisation because of emphasis on disorders and treatment. – Increase in medical treatment options. – As a result of the above two points, there is an increasing demand for available care and resources. – Lack of cohesion and coordination. – Proportion of people unable to get their lives back on track and to maintain control over the support and care they receive. – Waste of money and manpower due to unnecessary care (claimed by the citizen) or wrong choices for the use of care (expensive if it is not necessary, on location if it can also be done at home/digitally, too little prevention/lifestyle/healthier environment). NHPM – A shared and cross-domain vision and approach to health issues is needed. – Being healthy and feeling healthy are influenced by underlying problems such as (physical or social) living environment, education or income/debt. – Pressure on daily life in youth and young adults. – Vitality of the elderly must be maintained as much as possible.

Table 1 (Continued)

	iPH	**Ministry of VWS and related institutes** **NHPM**
Contribution of Positive Health	– Appeals to society to look, think and organise differently together. – Focus on self-reliance, resilience, strengthening self-management. – From need to want. – Building a bridge between care and the social domain through a common language. – People are really central. – Tapping into intrinsic motivation in patients and professionals. – Giving more meaningful substance to policy and organisation of care and welfare. – Looking for solutions in prevention or domains other than the medical.	Positive Health *as part of* organising care more efficiently: – Tailoring supply more to actual demand. – Investing in prevention, lifestyle, early detection and broad assessment of what is really needed. – Professionals feel they add value. – Increasing the self-reliance of people and their network/ environment. – Care is more coherent, well-being really central and care integrated around people and organised as close as possible. – Person-oriented care that meets people's need to be able to organise their lives as well as possible with an illness or disorder. – Early approach to social problems. NHPM – Health issues are not only about the physical aspects of health, but also about the ability to adapt, your well-being, self-management, resilience, participation and sense of purpose. Health is therefore more than 'not being sick'. – Positive Health as a cross-domain binding factor through a broad view of health, stimulates cooperation.

In the development and dissemination of Positive Health, various actions can be distinguished that have supported this diffusion process (see table 2). These actions and strategies have not been deployed only by iPH and have partly not been developed strategically, but have arisen unconsciously. However, the sum of these various activities has contributed to the spread of Positive Health and can be seen in retrospect as a transition strategy to allow this discourse to contribute to transition. Based on the framework of transition management, we also distinguish here between three levels of influence: discursive/culture (strategic), networks/structure (tactical) and routines/practices (operational) (Loorbach, 2007).

Strategic: discursive and culture	• Presentation of Positive Health as (contributing to) the solution to problems within the health care system, for example 'the key in the turnaround of health care'. • Use of positive words: of course, Positive Health, but also, for example, inspiration, growth, co-creation, self-direction. • Joining the movement from disease to health. Comparison with other related concepts and where they can reinforce each other. • Publications, including response to criticism and willingness to engage in dialogue. • Machteld Huber's personal story (and with this also having a figurehead) reinforces the message.
Tactical: networks and structure	• Coalition of the willing: focusing on people with intrinsic motivation to use this concept. • Involvement of experts (e.g. international conference). • Subsidies by and cooperation agreements with regime players (VWS, health insurers, Vilans). • Bringing expertise into an institute. • Scientific research (published). • Press attention by winning prizes or scoring well in rankings. • Strong digital presence. • Lobbying.
Operational: routines and practices	• Transparency, for example sharing experiences and practical aids via the website. • Testimonials by users in practice (e.g. via YouTube). • Accredited training (general practitioners, medical specialists, nurses, physiotherapists). • Publishing Positive Health handbook (for general practitioners). • Broadening to other domains, for example work (vitality).

Table 2. Actions that supported the diffusion of. Positive Health

In addition to the rise of Positive Health, a number of related movements can also be identified. The concept of Positive Health refers to positive psychology (Seligman, 2008; Walburg, 2010). Positive psychology focuses on promoting people's mental resilience as opposed to the problem-oriented focus of classical psychology. The inaugural address *The road from follow-up care to prevention: off the beaten track* (De weg van nazorg naar voorzorg, buiten de gepaande paden, Ruwaard, 2012) also deserves to be mentioned here. A movement that strongly overlaps with Positive Health is 'positive healthcare with the model for solution-oriented working' (Bannink & Jansen, 2017), where the starting points are the same, but the practice model uses a different approach. There appears to be a lot of overlap in the problem formulation used by these parties. Where possible, the iPH Foundation collaborates with representatives of these other movements that are similar to Positive Health and

form competing discourses, as it were. The perspective of a common denominator is also used to investigate how different concepts and ideas can reinforce each other.

6. Discussion

It is sometimes said about the Positive Health concept that it offers something for everyone (usually as a criticism), but it is possible that this is exactly where the strength and connecting factor lies. When the concept is simultaneously sufficiently clearly framed and knows little difference in interpretation, the concept shows flexibility and offers a shared identity. From the criticisms described in an earlier section, the argument has regularly been put forward that Positive Health does not offer anything new: the general practitioner naturally has a broad view, the occupational therapist always looks for possibilities in everyday life, the connection between domains has been known since prevention medicine. So nothing new? Perhaps not, but a single professional group or a single care domain, in the past, has not had the perseverance (and possibly also not the aspiration) to let their ideas become commonplace within the entire care system. The how and why of this falls outside the scope of this study, but a possible explanation is that specific professional groups or care domains derive their identity too much from their own profession or domain (and operate within that structure) to spread their ideas across domains. In addition to the criticism of 'brings nothing new', there are also professionals, researchers and policymakers who actually look for and confirm that Positive Health can have a reinforcing effect with their own domain. Scheijmans and Stoopendaal (2018) compare Positive Health with occupational therapy and conclude that both can fulfil the role of intermediary between the care and welfare sectors. Here again, the common language is highlighted as an instrument to improve cooperation between professionals and domains.

In the previous section, the diffusion process was analysed on the basis of five development mechanisms of transformative innovation (Loorbach et al., 2020). The use of these development mechanisms has proven to be a useful lens to interpret the applied diffusion strategies. Although the development mechanism growth is probably more a result of applied strategies such as replication, partnering and instrumentalising. In addition to the researched development mechanisms mentioned by Loorbach et al. (2020), another strategy can be discovered on the basis of this analysis: strengthening the concept. The analysis shows that many actions are aimed at strengthening the basis of the ideas. Specific actions in this context are evaluation research and research into measurability and operationalisation (Van Vliet et al., 2021) of the Positive Health concept. Additionally, efforts are being made to strengthen the concept by entering into a public dialogue with critics. A final action that supports this strategy is to examine related concepts and see them as reinforcing and not competing. This strategy of 'strengthening the concept' is reminiscent of the (discursive) strategies of deepening and broadening as described by Johansen and Van den Bosch (2017).

In the context of Positive Health, little explicit mention is made of cost control in healthcare, but the description of intended results (for example fewer referrals to secondary care, solutions outside the medical domain) can be viewed in that light. In that sense, these expressions of Positive Health support the government discourse and there are overlapping problem definitions with regard to the unsustainability of the health care system, the development of citizens' self-reliance and the approach

to medicalisation. This connection, in combination with the broader movement in shifting thinking from disease to health, may in itself have been sufficient for the Ministry of Health, Welfare and Sport to use Positive Health more often in policy. However, it is also important to realise that VWS and its related institutes and programs have been involved in iPH from the first development of Positive Health. Financial support was given and input from VWS was also provided in the development of Positive Health. This applies to multiple stakeholders, including insurers and various health care professionals.

With the growing application of Positive Health in practice, the influence of existing structures and interests is also becoming visible (path dependency; Loorbach et al., 2017). For example, restrictive financing mechanisms can frustrate the effective design of Positive Health. This emerged in a pilot with a general practice in which the prescribed time for a consultation was extended from ten minutes to fifteen minutes and an alternative dialogue based on Positive Health was conducted. This led to a 25 percent reduction in referrals and a decrease in the number of medication prescriptions (Jung et al., 2018). But the pilot was not expanded by the commissioning/paying health insurer, despite the significant drop in the number of referrals to the regional hospital (which was in dire financial straits). The (financial) interests of the hospital, certainly relevant to guaranteeing the regional care infrastructure for citizens, was reason to erect a barrier to the expansion of the successful project. This while the results of the project were in line with the goals of both the health insurer (sensible care) and the Ministry of VWS (the right care in the right place/ appropriate care).

This case, which is clearly referred to in the advisory report Collaborating on appropriate care; the future is now by Dutch Healthcare Institute and the Dutch Healthcare Authority (*Samenwerken aan passende zorg; de toekomst is nú, ZIN/NZa,* 2020) shows that more thought needs to be given to the possible impact of thinking, working and organising from Positive Health for the existing health care system and the financial structures: a turnaround will deeply intervene in the distribution of resources. Phasing out obstructive elements in the desired movement from illness to health is a crucial but as yet barely explored challenge. The diffusion strategies that emerge in this analysis emphasise the importance of language and thus the influence of dominant culture and practices (Frantzeskaki & De Haan, 2009), but also directly mark the impact of (lagging) structural changes such as financing or echelons. The reports (from VWS and other regime players) that embrace Positive Health often use words such as 'integral' and 'cross-domain', which also immediately poses an important challenge with regard to how we interpret and translate concepts such as health and health care into a workable system. The research agenda for sustainable transitions (Köhler et al., 2019) explicitly focuses on the role of existing organisations and regime players (Turnheim & Sovacool, 2020) and the reinforcing role (Berggren et al., 2015) that they can play in realising lasting fundamental change, comparable to iPH's strategy of working closely with VWS and health insurers at an early stage.

7. Conclusion

This article outlines how the health care system is under pressure, creating room for alternatives. It appears there is now a fundamental search for other values in order to redesign the health care system. The government uses concepts such as

'appropriate care', 'the right care in the right place' and 'integrated care', but Positive Health is also often mentioned. This article attempts to understand how and why the philosophy of Positive Health has managed to occupy a prominent place in the changing policy discourse in Dutch health care.

Positive Health substantiates the proposed paradigm shift from 'disease' to 'health', introduced to policy makers via the Council for Public Health and Care (RVZ) in 2010. The concept development was supported by the Health Council and ZonMw. This enabled an easy introduction in policy terms for Positive Health. A second explanation for the warm reception of Positive Health is the early and continuous involvement of system players such as the Ministry of VWS and the health insurers in the development of the concept. From the early development of Positive Health, parties have been invited to provide input and therefore system players also recognise the concept. The iPH Foundation is reaping the benefits of a proactive network strategy here. A final explanation for the emergence of Positive Health lies in the language itself. The discourse surrounding the paradigm shift from illness to health includes concepts such as resilience, self-management, self-reliance, lifestyle and prevention and is in line with the broader government discourse on phasing out the welfare state. The focus on health (instead of disease) fits in well with the prevention and lifestyle concept and the possibility of saving costs because people grow old in a healthier way and rely less on the health care system.

From a transition perspective, you can ask the question whether the diffusion of the Positive Health concept has made the transition from care to health irreversible or whether this mainly concerns the mainstreaming of an idea and concept, but included in the existing regime without too many structural changes. This question can only be answered by historians in the future: it is too early to determine whether the change in thinking will also lead to profound changes in the structure and work of health care. Although it is undeniable that our way of thinking about health and care is fundamentally shifting, it has also become apparent that the underlying system barriers and interests are still very stable. The question is therefore to what extent the parties are also able to gradually internalise another way of thinking and to accompany it with step-by-step changes in the rules, procedures, routines, agreements, partnerships, investments and training. The transition thesis is that if they fail to do so, the currently dominant regime will remain intact, but will inevitably face future crises due to its persistent problems. To then perhaps still move into transition.

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