LIVING LONGER IN GOOD HEALTH

Also a question of a healthy lifestyle
Netherlands Health-Care Prevention Policy

International Publication Series: Health, Welfare and Sport no. 19

Ministry of Health, Welfare and Sport - NL

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This series provides information on the Netherlands' policies specifically relating to the health, welfare and sports' sectors. In addition, the series reproduces the full text of relevant Acts. The target groups are counterparts of the Ministry of Health, Welfare and Sport (VWS) in other countries, international organizations, embassies of the Kingdom of the Netherlands abroad, foreign embassies in the Netherlands, researchers and other experts.

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SUMMARY

Unhealthy lifestyles: The Netherlands is falling behind internationally

Last year, with the publication of the report, 2002 Public Health Future Exploration (Volksgezondheid Toekomst Verkenning 2002 – VTV), the National Institute for Public Health and the Environment (Het Rijksinstituut voor Volksgezondheid en Milieu - RIVM) presented a probing picture of the health situation in the Netherlands. Although people in the Netherlands are increasingly living longer, healthier lives, unhealthy lifestyles in the Netherlands have pushed the nation towards the middle bracket in Europe. The life expectancy of people in other European Union countries is currently increasing faster than the life expectancy of the Dutch population. Since the early 1990s, the average life expectancy of women in the Netherlands is even lower than that of the European Union (EU). Unhealthy lifestyles among young people are rampant, which is not encouraging for the future. Even more worrying is that poor health, illness and premature death are more prevalent in some population groups than in others. Particularly people with limited education and low incomes are less healthy, including many immigrants.

Several observations about the unhealthy lifestyles of the Dutch population:

- One out of three smokes tobacco
- Nine out of then people eat too much saturated fat
- Three-quarters of the population eat too few fruit and vegetables
- More than half the population gets too little exercise
- Half of the male population and a third of the female population are too heavy
- The incidence of sexually transmissible disorders (STDs) is rising, along with the incidence of abortions among teenagers

Unhealthy lifestyles have serious consequences. Among other things, they lead to increased cardiovascular diseases, cancer, asthma and other pulmonary diseases, diabetes and symptoms of the motor system. That represents a major loss of quality of life. Moreover, these diseases and symptoms cost society between € 2.5 and € 4 billion (thousand million). In the first instance, if these costs are to go down, it is the responsibility of individuals: it is primarily a question of healthy lifestyles.

The benefits of healthy lifestyles

Prevention is better than cure. That certainly applies to health. The RIVM has calculated that 15 percent of disabling illnesses (the aggregate of shorter and poorer quality life through illness) is attributable to smoking, 7 percent to excessive use of alcohol and 6 percent to obesity. The cabinet estimates that at least 20 percent of all disabling illnesses are attributable to unhealthy lifestyles. The RIVM has also calculated that between 5 and 9 percent of total expenses for health care are the result of unhealthy lifestyles, obesity and high blood pressure.

For these reasons, the government – national and local authorities – have invested in prevention for years. Current vaccination programmes against infectious diseases are good examples of preventive measures that reduce (high) health-care costs in the longer term. In 2004, the ministry of Health, Welfare and Sport (Volksgezondheid, Welzijn en Sport – VWS) plans to invest some € 625 million in prevention policy via the Special Medical Expenses Act (Algemene Wet Bijzondere Ziektekosten – AWBZ), particularly in national prevention programmes, youth health care, public health information, health protection and research. In recent years, the cabinet has strengthened youth health care, for example, and introduced a vaccination against meningitis C, including a campaign to help young people in arrears to catch up.

However, the government is not the only source of prevention investment. Health insurers, social organisations (e.g. in sport), social partners and businesses increasingly do so, since they also realise that action is necessary.

Health benefits start by adopting different attitudes in a changing society, in which inactivity stemming from technological developments, organisation of work, leisure time and transport patterns increasingly threatens to become the norm. Prevention policy will only succeed if we hold citizens directly accountable for their behaviours. Health standards deserve greater attention. The changing attitudes towards smoking are a good example of this. Most people are now convinced that non-smoking should be the social norm at work and in public places. Similarly, healthy lifestyles should

again become the norm for everyone – except, perhaps, for people with disabilities or chronic illnesses.

Practical aims in three action plans
The cabinet's policy document treats a large number of subjects in the field of prevention that require action. This will also receive attention in the coming years. They encompass three themes as spearheads. These themes stand out best in a negative sense and are the ones that require the most attention.

These themes are:
- Smoking
- Obesity
- Diabetes

These spearheads concern the major risk factors of poor health, illness and premature death. There will be an action plan with a practical goal for each spearhead. For example, the number of smokers should decline by nearly a fifth; the number of persons who are overweight should not increase; and diabetes among young people must be reduced.

Elaboration of the action plans will include advice from the Public Health Council (2001) (Raad voor de Volksgezondheid en Zorg – RVZ) from Health and Lifestyle (2003) (Gezondheid en Gedrag) and from the 'Obesity' Health Council (2003) (Overgewicht en obesitas).

Working with a package whose effectiveness has generally been demonstrated, smoking policy is now firmly embedded. The aim is to continue this policy forcefully during the coming years. In addition, there will be priority measures to deal with obesity and diabetes, which are closely related. These are relatively 'new' problems that require strong measures to counteract rising trends. The approach to these spearheads will entail knowledge and insights from other aspects of prevention policy. We concur with the actions started to make healthy eating easier and to get people to exercise more, as presented in the cabinet's policy document, 'Sport, Exercise and Health'. Besides the three spearheads, this prevention policy document also focuses considerable attention on psychological symptoms and alcohol addiction.

The action plans cannot be implemented without the co-operation of people in the field. Of course, these parties also have a responsibility for taking action. The cabinet would like to invite these parties in the Netherlands to co-operate actively in implementing the action plans and to develop individual initiatives. Although people are primarily responsible for their healthy (and unhealthy) lifestyles, people's health does not always depend on their own actions. For example, municipalities, companies, manufacturers, schools, health-care services and health insurers also bear responsibility. The relevant parties, including the public at large, must bear their share of the responsibility.

The public must again be more closely involved in prevention policy. Public health is the sum total of the health of individual members of society. The cabinet has therefore decided on an approach that will effectively reach people in practice – at home, at school, at work, at places where people spend their leisure time, in local neighbourhoods and in the doctor's consultation room. It is only in this way, for example, that one can trace and deal with local health arrears or reach specific target groups (youth, immigrants).

This policy document describes the actions that the cabinet plans to employ in achieving the aims of the three spearheads. Here are some examples:
- There will be more emphatic reminders to the public of the dangerous effects of unhealthy lifestyles. In the first instance this will take place through intensive public information, geared towards target groups. In addition, inducements will be necessary to confront people with the consequences of their own behaviours. One such inducement is the increase in tobacco tax on 1 February 2004. There are also others who, besides the government, could offer similar inducements. Health insurers, for example, could offer incentives for healthier lifestyles in their supplementary insurance policies.
- Consultation will take place with municipalities, which have a legal responsibility in the area of prevention, to adapt the spearheads (more fully) to local health policies. The health theme will be part of the 'Metropolitan Areas Policy Framework' (2005-2009) (Beleidskader

grotestedenbeleid). This will enable metropolitan areas to tackle health arrears integrally (lifestyles, living environments, access to health care).
- Businesses will receive reminders of their social responsibility for public health. The cabinet encourages self-regulation (healthy foods, non-smoking catering establishments, public announcements aimed at children) and, if this does not work, will propose suitable legislation.
- There will be incentives for health insurers, both in the preventive and curative sectors (hospitals, general practitioners) to identify health risks in a timely manner that are the consequence of unhealthy lifestyles and to address these issues with their patients. There should be more frequent discussions between doctors and patients about changing lifestyles than is currently the case. Health insurers should monitor more closely the creation of a 'health-care chain' (from the patient's perspective, getting maximum guidance through the care process), including prevention and the application of existing standards and protocols in health care.
- Schools will receive support in further realising the notion of the 'healthy school' – actions relating to school fruit in primary schools and healthy school canteens in secondary education will continue for the time being.

For the most part, these actions are possible by making better use of existing funds, by linking them to the main problem areas and by better practical utilisation of existing opportunities. To do this, the cabinet is deliberately seeking co-operation with other parties. Additionally, in 2004, the cabinet has set aside an extra € 5 million and, from 2005, a structural amount of € 10 million. These moneys will primarily go towards implementing the spearheads, mainly for public information activities and projects, and for activities in the large cities (due to the huge health arrears there). Starting in January 2006, an amount of € 5 million will go to help cover the € 10-million cut in the national sport federation's budget. The federation will use half of this re-investment to stimulate amateur sports, of which Neighbourhood, Education and Sport is the spearhead. The other half will go towards activities designed to promote physical exercise. These activities will dovetail with the spearheads from prevention policy, with particular emphasis on youth and poorly educated workers with low incomes. The cabinet assumes that other parties will also take responsibility for and continue to invest in prevention policies.

Holding on to high-level health protection

Besides the action plans for the three spearheads, simultaneously, there will be a continuation of other aspects of prevention policy that have clearly demonstrated their value in the past. As a densely populated country, the Netherlands has a high level of health protection. This is partly due to vaccination programmes, hygiene measures, the tracking system of youth health care, medical screening of the population and measures relating to health and the environment, product and food safety. The high level of health protection must remain in effect. The policy document therefore describes specific developments in this area.

We have had to confront threats of wanton outbreaks of infection diseases as a consequence of terrorism (smallpox), epidemics of new, unexpected infectious diseases (SARS), along with other incidents and disasters (the fireworks explosion in Enschede, the pub fire in Volendam, fowl pest). These events emphasise the potential need for a rapid, large-scale response and the importance of crisis management and after-care. Under the leadership of the Ministry of the Interior and Kingdom Relations (Binnenlandse Zaken en Koninkrijksrelaties - BZK), the joint government departments are working on the implementation of the 'Crisis Management Policy Plan, 2003-2007'. A crisis involving the risk and spread of infection calls for a separate approach and adjustments in the implementation structure.

Effective research and targeted subsidies

Investment in health care pays off, but it is expensive. The economy is stagnating. We face choices, also in the area of prevention. We can only make these choices if we clearly understand the nature and scale of heath-care risks, the options for dealing with them, the cost and benefits of reducing risks or of measures to improve health and, equally important, matters that the public itself considers important.

Continuing research and transfers of knowledge are essential. Our new subsidy policy places emphasis on three aims: (1) maintaining and sharing fundamental knowledge, (2) (temporary) stimulation of innovation and (3) strengthening the position of vulnerable groups. Research in the field of heath should focus in the coming years on major problems, but also on the opportunities that

prevention offers for health. Much more than is the case at present, research and transfer of knowledge are going to bolster (local) practices. Local partners should be able to take immediate advantage of the knowledge acquired. Simultaneously, this increases the effectiveness of the knowledge infrastructure.

Prevention, a Matter of Patience

Health is a valuable possession. Healthy people feel better, are seldom ill, work more and longer. In short, they are more active. Improved health, reduction of disabling illnesses and premature death benefit the public as well as society. However, health benefits through prevention are also a matter of patience. Naturally, the effects of this policy are closely monitored. The cabinet would like to elevate healthy lifestyles – naturally, within the limits of individual citizens – to the status of a social norm and, together with those who share this responsibility, make good health a permanent feature of the Dutch landscape.

OUTLINE

This booklet consists of four parts. Part I forms the core. It describes the reason for, spearheads and objectives of healthy lifestyles. The other parts deal with developments and plans relating to other aspects of prevention policy.

Part I Health and Healthy Living
Chapter 1 explains the purpose and objectives, focusing on the contribution that prevention could make to health. In chapter 2, there is a brief discussion of the context for prevention and the developments in Dutch society that could affect public health. In an international context, local policy and the lessons of the past provide starting points for the policy described in this chapter. Chapter 3 presents the main findings from the report, Public Health, a Future Exploration (VTV-2002) (www.rivm.nl/bibliotheek/rapporten/270551002.pdf), from the National Institute for Public Health and the Environment (Rijksinstituut voor de Volksgezondheid en Milieu), concerning the status of public health in the Netherlands.
The priorities for prevention are listed in chapter 4. Developments in the area of priority illnesses enable one to follow developments in public health. Chapter 5 identifies three spearheads and objectives for the coming years. We use these objectives to justify the policy conducted. Chapter 6 concerns the aims and treatment of psychological symptoms.

For the most part, implementation of prevention is in the hands of others than the central government. The municipalities play a key role in this. Chapter 7 devotes attention to broadening prevention to local authorities and to other parties in society. The parties will be held accountable for their responsibilities and made aware of how co-operation produces results.

Part II Health and Safety
Chapters 8 and 9 describe developments in prevention in areas that have produced many health benefits in the past. These are the areas in which the government has an inherent task to protect or further public health via facilities, regulations and public information. These form the foundation, as it were, for new health benefits.

Part III Investing in Knowledge and Quality
In chapters 10 and 11, attention focuses on the quality and effectiveness of prevention and public health care. Knowledge, particularly its application, is a strong basis for the quality and effectiveness of actions. The essence of this chapter is better performance through the application of available knowledge.

Part IV Funding
Chapter 12 outlines how implementation will be organised, the costs of the policy plans and the method of funding. There is also a description of how we monitor attainment of the desired effects.

Part I Public Health and Healthy Living

1 Why Prevention Policy?

Good quality health care and prevention could produce many health benefits in the Netherlands.

1.1 Good health is important for the citizens and for society

Ask people what they consider most important for themselves and their loved ones and the overwhelming majority will say, living in good health. The degree of health has a huge impact on the quality of life. General health affects everything one does. This includes schools, education, work, the composition of families, housing, mobility and leisure time, for example.

Health is not only extremely important for people individually, but also for society as a whole. Public health is essential for the vitality and resilience of a society. The healthier people are, the more productive they are at work, with lower costs of absenteeism through illness and disablement. For this reason, health is an important raw material for a country's prosperity.

1.2 Scope of this booklet

Health is the individual ability to function physically, mentally and socially in society. Prevention is the preclusion of illness, complications and exacerbation of diseases, along with the maintenance and improvement of the health of the country's entire population. Not all diseases are preventable. Moreover, it is unavoidable that some chronic diseases will increase with the greying of the population.

Prevention policy is not new. Protecting and promoting health and prevention of certain types of illness have been the subjects of policy for years. This booklet deals with prevention and promotion of healthy lifestyles. We describe what we are currently doing and the new emphasis being given and what we hope to achieve in the short and long terms. This description does not cover all policy in the area of prevention. We have restricted the subject to the most current changes.

1.3 An Urgent Need

The recent report entitled ‘Gezondheid op koers?’ (Health – are we on the right track?) by the National Institute of Public Health and the Environment (RIVM) produced several important findings about public health in the Netherlands:

- we are living longer and healthier lives;
- within the European Union (EU), the Netherlands is losing ground with respect to human longevity, of which unhealthy lifestyles are a main cause;
- there is unequal distribution of good health and these differences seem to be persistent;
- with the growth and ageing of the population, incidence of illness will increase substantially, particularly chronic disorders.

The RIVM concluded that, with prevention – and, especially, with the promotion of healthy lifestyles, there are still considerable health benefits to be gained.

1.4 Objectives for improving health

We would like to see people living longer in good health. One can measure the promotion of public health by the following:

- an increase in the number of healthy years of total life expectancy;
- pushing back avoidable health arrears.

This is not a new goal for prevention policy. The RIVM found that there has not been any essential progress in achieving these goals in recent years. On the contrary, there have been unfavourable changes in lifestyles that, in the longer term, could result in a deterioration of health. The prognoses for 'living longer in good health' are not favourable, judging from the unhealthy lifestyles of adults and young people. Only certain aspects of the lifestyles of older people are progressing favourably.

These findings do not result in changes in goals. However, on the one hand, they give rise to an examination of the effectiveness of current policy and, on the other hand, to transparency about the responsibilities of the central government and that of other parties concerned with prevention.

1.5 Joint Responsibility

People are primarily responsible for their own good (or bad) lifestyles. With a healthy lifestyle, they can contribute greatly to their own good health. However, health is not solely a question of personal actions. Good, accessible education, safe working conditions, proper housing, a healthy and safe environment are indispensable for preserving and promoting good health. These are also the principal conditions for reducing health arrears. Good health also means that people can rely on good, accessible health care. For this reason, there are major efforts, for example, to reduce waiting lists in health care and to improve the quality of services.

Health care is an inherent task of government. The public must rely on the government to identify and, wherever possible, eliminate in a timely fashion health risks over which civil society has little or no influence. No one can expect the government to guarantee safety absolutely. It would not be realistic or affordable. Moreover, it could do far-reaching damage to personal liberties. In short, civil society, care providers, health insurers, social organisations such as schools, social partners and (local) government authorities share joint responsibility for health.

Project Heartbeat
The notion of a 'health counsellor', a qualified nurse, is currently part of *Project Heartbeat,* in the Dutch province of Limburg. This successful collaborative project provides an integral approach to cardio-vascular diseases. The project unites all the parties in prevention and health care. Patients actually receive care throughout the health-care chain.

The health counsellor helps patients to acquire healthy lifestyles. The patients express satisfaction about contacts with the counsellor. A majority have even changed aspects of the way they live. The doctors are also pleased. 'There is a need for more information about healthy lifestyles, but we have no time to do this. That's the way it is. I know that some of my colleagues here think that we should make time for this, but experience shows that it simply does not work. If we devote more time to individual patients, we have to reduce the total number of patients we see – while a qualified nurse can provide information as well as we can'. (Cardiologist, Maastricht Academic Hospital)

1.6 Pointing the Way Towards Prevention

Health benefits start with the acceptance of new attitudes in a changing society, in which inactivity due to technological innovations, the organisation of work, leisure time and transport patterns are increasingly becoming the norm. This means that prevention policy will only succeed if we call individual members of society more directly to account for their own actions. Besides the need for a re-evaluation of social norms, health norms also deserve more attention.

With the prevention policy described in this booklet, the Dutch government lays down the broad outlines of activities for all parties concerned, provides starting points and support for their own actions. This is the fulfilment of the task set forth in the Public Health Collective Prevention Act to establish national priorities every four years in the area of collective prevention. In practice, this means more unity in national and local policy and in broadening action towards other parties, such as schools, social partners, insurers and care providers. Much is already being done to promote good health and protect against illness. However, there is too much social division and fragmentation. There is too little use of opportunities to encourage people in their own social environments to live healthy lives.

A proven, effective way of reducing health arrears consists of a tailored approach for dedicated groups and for active contributions from private citizens. This enables people to assume individual

responsibility. In this way, we move towards more sustainable ways of organising prevention and healthy lifestyles in society, with all parties contributing to the best of their abilities.

Setting New Norms
Since the 1970s there have been many measures designed to reduce the number of traffic victims due to driving under the influence of alcohol: introduction of the 0.5 percent limit, breathanalyzers, public information campaigns, promotion of non-alcoholic alternatives, courses for people convicted of driving under the influence, police checkpoints, tit-for-tat policy. Since mid-1980, the number of victims has fallen by 50 percent. There is general recognition that the norm concerning alcohol and traffic has changed. Whereas many people used to drive with a few drinks under their belts, nowadays it is simply 'not done'.

1.7 Extra Resources

In recent years there have been substantial investments in prevention. For example, extra money has gone towards strengthening youth health care, amateur sports and the promotion of sport, physical exercise and health. Despite the current financial situation in the Netherlands, there are extra funds available for prevention, structurally. Incidentally, the central government is not the only source of investment in prevention: it is also the responsibility of municipalities, care insurers and companies. Total investment is much higher than that of the government.

Realising our aspirations will require considerable effort and creativity on the part of all the parties concerned. More specifically, it will also make it necessary to take what we know to be workable measures, which produce the best results at affordable costs.

2 Public Health and Society

The Netherlands has made global and European commitments in the field of health care. There are also developments and measures in Dutch society that affect public health.

2.1 International agreements

Health-care policy is obligatory. Within the international community there are agreements that the Netherlands must observe. The European Union is developing regulations that make themselves felt directly in the member central governments and directives, which must be incorporated in the national legislation of member central governments. Recent proposals in the area of prevention, for example, concern a community action programme on public health and regulations for creating a general European Nutrition Act, along with the establishment of a European nutrition safety authority and rules for food supplements.

Among the new member central governments of the EU, particularly in central European countries, aspects of the health situation deviate starkly from the situation in the older member central governments. In connection with the free movement of goods, services and persons, one must closely monitor the potential effects of this expansion, especially with regard to food and product safety and the spread of infectious diseases within the EU.

At global level, the World Health Organisation (WHO) focuses on international health issues and public health. A recent initiative from the WHO resulted in the adoption of a worldwide convention on tobacco controls. Another example is the Convention on the Rights of Children from the United Nations. With ratification of this treaty, the Netherlands took on commitments in the area of youth health care.

2.2 National measures

Directly or indirectly, our lifestyles and – for a large part – economic, social and cultural developments in society affect public health. Measures in the areas of housing, schooling, working conditions and social security are extremely important.

One expects the government to be fully familiar with the nature and scope of health risks, to communicate them reliably and to explain clearly how it arrives at certain choices in formulating health norms, with or without taking measures. It is the job of government to identify, inform and make the consequences of choices transparent and, where necessary, to provide alternatives. Government also has a clear responsibility to steer the choices that people make in order to ensure a healthy, safe living environment.

Examples of instruments that the central government can employ are laws and regulations (e.g. the Food and Drugs Act, the Tobacco Act and the Licensing and Catering Act), agreements with the business community about self-regulation, price incentives, national prevention programmes (National Vaccination Programme) and national public information campaigns carried out by Health Promotion Agencies (GezondheidsBevorderende Instituten – GBIs).

2.3 Local elaboration

More traditional forms of promoting good health, such as public information via the mass media, no longer seem to work sufficiently in promoting healthy lifestyles. Communication about health risks, especially with young people and people with limited education (including many immigrants), is often difficult with only public information. In practice, lifestyle intervention works much better when simultaneous attention focuses on the social environment. To reach people, we need to work from within the immediate social environment – the so-called settings: at home, in the schools, during recreation, at work, in health care and in the neighbourhoods. Such an approach affords good opportunities for involving the public in prevention and in tailoring prevention to individual needs.

It is a primary responsibility of municipalities, schools, health-care providers, health insurers and employers to reach out to the public in these 'settings'. Good examples are the themes and programmes that appear in local policy documents, the Sector Report on Prevention and deliberations of large numbers of representatives from municipalities, Community Health Services (gemeentelijke (en regionale) gezondheidsdiensten - GGDs) and other agencies in the Netherlands where this is increasingly taking place. This approach will receive further encouragement and support. The national knowledge and educational institutes and agencies that promote good health have a key role here when it comes to developing and creating access to available knowledge. Intermediary organisations such as the Public Health Care Fund and the Netherlands Institute for Care Research and Medical Sciences (Fonds Openbare Gezondheidszorg en Zorgonderzoek Nederland Medische wetenschappen -ZonMw) fund the practical implementation of innovative local projects.

3 The Current Situation

Although health improved dramatically in the past, it is stagnating today. This chapter explains the causes.

3.1 Strong Improvement in public health

More than a half-century of public hygiene, food safety and health care have brought about unprecedented public-health improvements in the Netherlands. The fact hat infectious diseases are no longer among the main illnesses and disorders is largely due to public sanitation, clean drinking water and improvements in housing. Vaccinations and the use of antibiotics have also contributed to this, along with a substantial increase in prosperity.

3.2 The Netherlands is losing its leading position

The Dutch are living longer. A boy born in 2000 will live on average to age 76; a girl on average to age 81. This is three-and-a-half years longer than in 1980 and around 40 years more than in the mid-19th century. However, the advance of good health in the Netherlands is stagnating. The rate of increase in life expectancy for men is continuing to slow down and, for women, has even stagnated completely. According to the worst-case scenarios, life expectancy in the Netherlands (for men and women) could decline by three years.

We have already lost our leading position in Europe. The gap is widening even further. While increases in life expectancy stagnate in the Netherlands, they are still rising in other European Union countries.

3.2.1 Unhealthy lifestyles

This stagnating health has a clear cause. An increasing number of people are leading unhealthy lives:
- One out of three Dutch people smoke. Although the number of smokers declined over the last 20 years, the figure has now stabilised. As a result of women who started smoking in the 1970s, we are now seeing higher mortality and lung cancer among women.
- Nine out of ten Dutch people consume too much saturated fat.
- Three-quarters of the Dutch eat too few fruit and vegetables.
- More than half of all people in the Netherlands get too little physical exercise.
- Half of all men and more than a third of all women are overweight. The percentage of people with serious weight problems (obesity) has nearly doubled in more than 20 years.

Young people in particular live unhealthy lives:
- Nearly half of all young people between the ages of 15 and 19 smoke.
- Nine out of ten young people do not eat sufficient quantities of fruit and vegetables.
- Half of all young people between the ages of 13 and 17 (and nearly 60 percent of people between the ages of 18 and 34) do not get enough physical exercise.
- Fourteen percent of boys and 7 percent of girls drink too much alcohol.
- Approximately one-third of people between the ages of 15 and 35 without permanent relationships do not always use condoms.

It is difficult to change an unhealthy lifestyle. In the cases of smoking and use of alcohol, they are even addictive. The unhealthy lifestyles of young people represent a long-term investment in poor health.

3.2.2 Consequences

Death and disease are partially due to avoidable health risks. Disabling illnesses refer to the total loss of longevity and quality of life caused by illness in a society. There is a growing body of information available about diseases and disorders. This often concerns a combination of lifestyle, personal characteristics and environmental factors.
The following lifestyles contribute to disabling illnesses:
- smoking 15%

- excessive use of alcohol (excluding accidents) 7%
- too little physical exercise 5%
- too much saturated fat 5%
- too few fruit and vegetables 4%

Registered sexually transmissible diseases have increased since 2000 by around 20 percent per year. The incidence of abortions among teenagers has also risen in recent years. In 2000, more than 3,900 girls between the ages of 15 and 19 received abortions and more than 2,300 girls had babies.

Further, 6 percent of disabling illnesses are attributable to obesity; 6 percent to too high blood pressure and 3 percent to too high cholesterol levels. Another 2 to 5 percent of all disabling illnesses are due to residential and social environments, including air pollution and indoor environments (at home and in the office).

Healthy habits create health benefits. The aforementioned figures suggest that an estimated minimum of 20 percent of disabling illnesses concern unhealthy lifestyles and are theoretically avoidable. The RIVM has calculated the possibilities, compared to surrounding countries. If we in the Netherlands could obtain the most favourable European level for the known risk factors, men could theoretically live 1.4 years longer and women, 1.2 years longer. Such calculations do not represent predictable values, but they are useful for reflecting the Dutch situation and for Dutch policy.

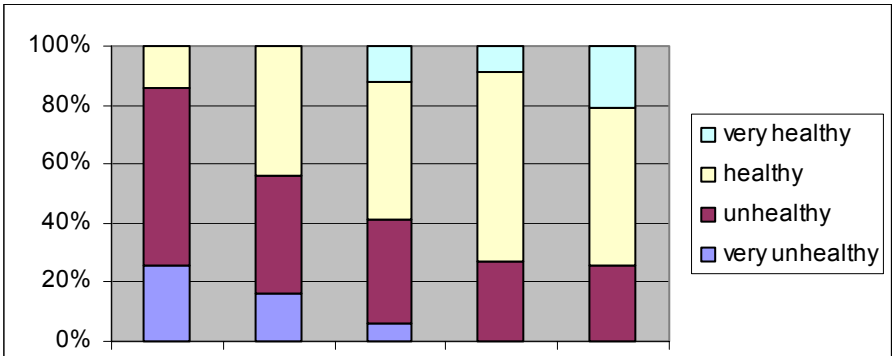
3.3 Persistent Differences

The RIVM report, Public Health Future Exploration (VTV), found that there are continuing major differences in health:

- People live shorter, less healthy lives in the Dutch province of South Limburg, in the north-eastern part of the Netherlands and in the large cities. These regional differences accumulate to nearly ten years of good (perceived) health.
- In the cities there are major differences between good and disadvantaged neighbourhoods (see figure 1).
- Men with primary education live five years shorter than men with higher vocational or university education. For women, this difference is two-and-a-half years.
- People with limited education (primary school) live shorter, less healthy lives. Men and women with little schooling live ten and eight-and-a-half years less, respectively, without health impediments.

These differences in health – also called socio-economic health differences – have apparently not diminished during the last ten years.

Figure 1 Socio-economic status (SES) and health scores (in four categories) in four cities



X^2 =41.1; statistical relation between SES and health ($p<0.001$).
Source: RIVM

There are major differences in lifestyles among various population groups. People with limited education live less healthier lives than those with higher education. Certain aspects of immigrants' lifestyles are unhealthy; and other aspects are healthy. Besides differences in lifestyles, psychological factors and material or structural environmental factors, such as low income and unfavourable working conditions, also contribute to differences in health. This shows that a combined approach, in which individual responsibility plays a central role, will produce the best results.

3.4 Increase in chronic disorders

As the population increases and ages, the incidence of illness in the future will increase dramatically, especially chronic disorders such as diabetes and depression, along with other disorders caused by falls.

The number of persons aged 75 and older will increase in the coming years on average by 15,000 persons per year, to over 1.1 million by 2010. Around one-fourth will be older than 85.

As people age, the chances of chronic illnesses increases. Of all persons aged 75 or older, 59 percent have one or more chronic illnesses. Considering the ageing of society, the number of people with chronic disorders such as heart and pulmonary conditions and diabetes will also increase appreciably. The elderly who have had (and still have) the healthiest lifestyles, the better the chance of avoiding chronic disorders. Living a healthy life should be a life-long activity.

4 Priorities

We establish priorities: we decide focus on specific illnesses. As a basis, we take disorders that cause the most disabling illnesses. However, we also take other arguments into consideration – for example, how we think that illnesses might develop in an increasingly ageing population, the social consequences of illnesses for the provision of medical services, social participation and employability. Moreover, there should be a strong potential for combating diseases and disabling illnesses.

Leading 20 disabling illnesses in the Netherlands
Disabling illnesses are expressed in DALYs (Disability Adjusted Life Years). The number of DALYs is the number of healthy years that a population loses due to illnesses or disorders. It is the total sum of the years of life that someone without these illnesses would have lived (lost years of life) and the years spent with illnesses, making allowances for their seriousness.

Disorders that result in the most disabling illnesses:

1	Coronary heart disease	11	Traffic accidents
2	Anxiety disturbances	12	Breast cancer
3	Stroke	13	Visual impairments
4	COPD	14	Pneumonia and acute bronchitis
5	Alcohol dependency	15	Rheumatism
6	Depression	16	Heart failure
7	Lung cancer	17	Colitis and rectal cancer
8	Arthritis	18	Hearing impairments
9	Diabetes	19	Suicide
10	Dementia	20	Personal accidents

Source: RIVM

4.1 Six priority illnesses

Using the above criteria, the following illnesses (categories) should receive priority (also see table 1):
- Cardiovascular diseases: coronary cardiovascular diseases, heart failure and stroke
- Cancer: lung cancer, breast cancer, colitis and rectal cancer
- Asthma and chronic pulmonary diseases
- Diabetes mellitus
- Psychological disturbances: depression, anxiety disturbances and alcohol addiction
- Motor system disorders: neck or back, arthritis, rheumatoid arthritis.

There has been (and is) much attention given to prevention of cardiovascular diseases, cancer, asthma and chronic pulmonary diseases. In addition, there is also the priority that we give to diabetes, psychological and motor system disorders. These disorders are quite prevalent and are on the rise. They require much care. In particular, psychological and motor system disorders cause considerable absenteeism through illness and disablement.

These six illnesses (categories) occur systematically more often (up to three times as often) among people with limited education, compared to those with higher education. This difference also continues with people older than 55. Treatment of these illnesses therefore has a simultaneous effect on reducing health arrears.

4.2 Other illnesses and disorders

The fact that other illnesses are not given priorities in prevention policy does not mean that they do not get attention. Chapter 6 contains a detailed discussion of illnesses, including infectious diseases. Infectious diseases are extremely important. Because of the risk of infection, infectious diseases not only affect private persons but also public interest. It is a good sign that infectious diseases do not appear among the leading 20 disabling illnesses. Nevertheless, we must remain alert to potential outbreaks, perhaps wilfully caused, and the increase of known or new infectious diseases.

With respect to some illnesses, prevention has already shown its usefulness. Youth health care authorities, for example, have a history of tracing visual and hearing impairments in children in a timely manner, while visual impairments in adults are a point of attention in the treatment of diabetes. Increased safety prevents domestic accidents, traffic accidents and sporting accidents: a combination of measures geared towards the behaviour of consumers and their surroundings.

Personal accidents: is the tide turning?
Following a rise in injuries due to accidents in the first half of the 1990s, developments over the last ten years show a reversal starting in the mid-1990s. The number of people receiving emergency treatment rose by 15 percent during the period between 1991 and 1996; followed by a decline of 8 percent between 1996 and 2001. The number of hospital admissions rose in the first period mentioned by 9 percent but, afterwards, remained at the 1996 level until 2001. These favourable developments occurred mainly in age groups primarily targeted by prevention activities: young children and athletes. For both groups, the number of accidents declined in 2001 by more than 10 percent, compared to 1996.

A worrisome trend in the last five years is the number of injuries to young people (ages 4 to 18) and adults, particularly older adults. An increase of 6 percent during the period 1996-2001 followed a rise of more than 15 percent in the period 1991-1996. Young people were particularly susceptible to sporting accidents, particularly unorganised sports and trendy sports – the reason that the trend did not reverse itself. Among adults, the activities in and around the house (upkeep, odd jobs) and those associated with leisure time (nightlife, pubs, recreation) resulted in higher risks of injury. As we age, these risks increase in and around the house and in care institutions.

Little is known at present about the prevention of some illnesses, including dementia. With the increasing ageing of society, dementia is becoming a major social problem. There are currently some 175,000 people suffering from dementia in the Netherlands. This figure will increase to more than 400,000 by the year 2050. High blood pressure, obesity, high cholesterol levels and smoking contribute to several types of dementia. Science is still at a loss to explain other types of dementia. Prevention of dementia must therefore take place in a 'derivative sense': prevention of priority diseases could also have a positive effect on reducing dementia. At the same time, where possible, we support research into the origins of this illness.

4.3 Prevention is better than cure

Prevention is better than cure. That certainly applies to health. The RIVM has calculated that between 5 and 9 percent of the total spent on health care is due to unhealthy lifestyles, obesity and high blood pressure.

We are gaining increased understanding of the potential for prevention. Research is providing a steady flow of answers to questions about the operation and effectiveness of preventive measures. This also applies to insights in revenues and costs of prevention and care.

New studies by the RIVM have produced data about the cost effectiveness of preventive interventions. They show that preventing illness, promoting good health and increasing measures for safety around the house and in traffic are generally inexpensive. The health benefits per euro are often far less costly than the cost of expensive care later in the illness process.

Studies, projects and experiences abroad show that, by providing good quality care in the Netherlands, we could further reduce disabling illnesses and avoid health risks. We can refer to the timely application of new medical technology that works well, the reduction of variations in treatment by practising physicians, integrated or health-care chain (from the patient's perspective, getting maximum guidance through the care process) and reducing the undesired negative effects of medical treatment. Predictive medicine, new vaccines for various pathogens and new opportunities to use drugs to compensate for the consequences of unhealthy lifestyles could limit health risks.

From the perspective of the illnesses, the approach ensures that there is a clear division of responsibilities among all relevant parties in the health-care chain and that collaboration extends to achieving the health objectives. We would like to establish practical, achievable goals to reduce disabling illnesses among priority diseases. It is realistic to assume that we could dramatically reduce the disabling nature of several diseases and disorders. In the Netherlands, when we take the best European practices as a standard, we could lower incidences of disabling illnesses such as lung cancer, for example, by 25 percent and that of coronary heart disease by 15 percent. A national programme for the prevention of cancer has now started in the Netherlands. It is the initiative of various parties with the support of the Central government. Contiguous to this, we are considering establishing a national cancer-prevention platform, which would serve to stimulate innovation in this area.

Table 1 The gravity and costs associated with the six priority diseases (categories)

	Gravity of the disease	Cost of health care in 1999 (millions of euro)	Changes in number of cases, 2000-2020
Cardiovascular diseases			
- Coronary heart disease	Leading cause of death Most disabling illness Greatest loss of longevity	929	44%
- Stroke	Among top five causes of death Among top five disabling illnesses Among top five loss of longevity	1,029	44%
- Heart failure	Top ten loss of longevity Top ten causes of death	299	43%
Cancer			
- Lung cancer	Among top five causes of death Among top five loss of longevity Steep rise in deaths among women from 1990 to 2000	104	54%
- Breast cancer	Among top five loss of longevity	138	31%
- Colitis and rectal cancer	Among top ten loss of longevity Among top ten causes of death	124	47%
Diabetes mellitus	Steep rise from 1990 to 2000	431	36%
Psychological			
- Depression	Among top five loss of quality of life Steep rise among women	497	15%
- Anxiety disorders	Greatest loss of quality of life Among top five most disabling illnesses Among top five most disabling illnesses	180	12%
- Alcohol dependency	Among top five most disabling illnesses Among top five greatest loss of quality of life	Alcohol and drugs: 285	-/-
Chronic Obstructive pulmonary disease (COPD)	Among top five causes of death Among top five most disabling illnesses Among top five greatest loss of quality of life Steep rise among women from 1990 to 2000	594	COPD: 40% Asthma: 7%
Motor system			
- Neck and back disorders	Most prevalent illness	549	14%
- Arthritis	Knee and hip arthritis: among top five most disabling illnesses	304	38%
- Rheumatoid arthritis	Among top ten loss of quality of life	92	27%

Source: RIVM

5 Three Spearheads

If we are to make gains in health benefits, we must prioritise six diseases. In the coming years, everyone concerned should join forces around three spearheads designed to book results with respect to these six diseases:

- smoking
- obesity
- diabetes

Smoking and obesity are avoidable health risks that cause many disabling illnesses (see table 2). When people stop smoking and lose weight, there are health benefits in the short term. Smoking is recognised as a major public health problem, which has received attention for several years, the effects of which we expect to see in the coming years. Obesity is becoming an equally major public health problem, which now requires extra efforts to reverse the rising trend. Although the approach to be taken is still under development, it could dovetail with existing policy for encouraging healthy nutrition and adequate physical exercise. Diabetes is a chronic illness that is sharply on the rise. On the one hand, this rise has to do with the increasing ageing of society; but, on the other hand, among young people, it is do primarily to unhealthy lifestyles. Effective prevention of diabetes could produce health benefits and a lowering of the rising cost of health care. Diabetes is therefore a model illness, in which the effects of targeted policy interventions of chronic diseases are clear.

With the choice of these spearheads, we are well in line with international and European priorities. That makes it possible to exchange knowledge and experiences and to take co-ordinated measures.

Private persons are primarily responsible for their (healthy or unhealthy) lifestyles. However, municipalities, companies, manufacturers, schools, the health care service and health insurers share this responsibility. In chapter 7 we describe the responsibilities of these parties in a more general sense. We also indicate the measures needed for the (further) involvement of these parties in encouraging healthy lifestyles and social circumstances.

The public must play a more central role in prevention policy. The approach to be taken is one that will actually reach people – at home, at school, at work, at places where people spend their leisure time, in the neighbourhood and in the doctor's consultation room. Municipalities, schools, social partners, care providers, health insurers must elaborate the action programmes for these spearheads.

There are three action programmes designed to provide direction to these activities. The parties in the field will be invited to help implement the action programmes. There will be three recurring target groups in these activities: the youth, people with limited education and the elderly:

- stimulating healthy lifestyles among young people is an investment in the future;
- more targeted attention for lifestyles and the social circumstances of people with limited education will help reduce health arrears;
- establishing attention for the health of older people means an investment in better quality of life.

To achieve an integral approach to reducing heath arrears, central and local government authorities have now joined forces and agreed on two courses of action: 1) endeavouring to include the health issue in the future metropolitan area policy (2005-2009) and 2) dedicating a programme for a targeted social impulse in the (56) districts for special attention in the large cities. In both cases, the spearheads described here are part of the activities to be carried out, along with the performance and results to be agreed.

Table 2 Relationships between several risk factors and the six priority diseases (categories)

Disease	Risk factors for the disease						
	Smoking	Obesity	Nutrition			Exercise	Alcohol
			Saturated fact	Trans fatty acid	Vege-tables and fruit		
Cardiovascular diseases							
- Coronary heart diseases	x	x	x	x	x	x	x
- Stroke	x	x				x	x
- Heart failure	x	x					
Cancer							
- Lung cancer	x				x		
- Breast cancer	x	x			x		x
- Colitis and rectal cancer		x			x	x	
Diabetes mellitus	x	x				x	
Psychological							
- Anxiety disturbances							x
- Alcohol dependency							x
COPD	x						
Motor system							
- Neck and back disorders						x	
- Arthritis		x					

Source: RIVM

5.1 Smoking

If everyone were to stop smoking tomorrow, it would put an end to a major health problem. In the Netherlands we would save nearly 509 million euro annually on the cost of health care. Giving up smoking would reduce pulmonary symptoms and improve physical fitness, reducing dependence on the health-care system immediately. Yet, giving up smoking is easier said than done. Nicotine is a highly addictive substance. Studies show that girls who smoke now and then for a period of three weeks (and boys for an average period of six months) will become addicted.

Young people with limited education smoke twice as often daily as do those with higher education. In other age groups, too, the percentage of smokers among people with limited education is higher than among those with higher or university education. Since people with higher education smoke less, this difference has only increased since the mid-1990s.

Objectives
Not smoking must become the social norm. There has been progress on this point in recent years. While the percentage of smokers in 1994 was still 34 percent, by 2002 it had declined to 31 percent. The aim is to reduce this further to 25 percent by the end of 2007.

International comparison of smoking habits
These figures refer to the adult population during the period 2000-2001.
The data come from the 2003 Country Profiles of the WHO

Greece	38%
Germany	36%
Switzerland	33%
Luxembourg	32%
Poland	32%
Spain	32%

Approach
The passing of the revised Tobacco Act by parliament in 2002 signifies a major step in policy to make not smoking the social norm. The revised Tobacco Act contributes significantly to the protection of non-smokers, but also to discouraging the use of tobacco among young people. Core elements of the Act are the ban on advertising tobacco products, a ban on sales to young people under the age of 16 and prohibition of smoking in public buildings. In terms of enforcement, we are endeavouring to increase monitoring within the available budget for the Food and Drugs Department (VWA) and the Food and Drugs Department (VWA)/Food Inspection Department (KvW) monitor enforcement of the Tobacco Act. The legislation is supplemented with other measures such as public information to promote non-smoking among young people and higher excise duties on tobacco products. In studies, the WHO has clearly demonstrated the effectiveness of the various measures. In countries that have introduced similar measures, the percentage of smokers has declined appreciably. The combination of various measures has proved particularly successful, such as an advertising prohibition, age limits and health warnings printed on packages, in addition to support in giving up smoking, smoking prohibitions and increased excise duties. In short, a broad, coherent package with measures has a clear impact on combating smoking. The support and efforts of local partners, such as the municipalities and Area Health Authorities, schools and sports clubs, health insurers, catering establishments and employers are prerequisites.

Action item 1 Protecting non-smokers
There will be campaigns designed to explain the Tobacco Act to the public at large. This involves subjects such as playing sports in smoke-free areas, smoke-free passenger traffic, smoke-free areas for children and smoke-free places of work. To make the Tobacco Act accessible, at the initiative of the ministry of Health, Welfare and Sport (VWS) and STIVORO (Stichting Volksgezondheid en Roken - The Foundation for Public Health and Smoking), an information centre for 'Smoking and the law' is now open to the public (www.rokenendewet.nl). The ministry has set up working parties in which the social organisations, STIVORO and VWS are represented. Effective 1 January 2004, employers have the legal obligation to provide smoke-free workplaces for their employees. There are approximately seven million employees. Accordingly, smoke-free workplaces are a major step in providing protection from tobacco smoke. The introduction of this regulation receives support in the form of direct information and advice to employers about establishing proper smoking policies and a campaign via the mass media. Besides protection against tobacco smoke in the workplace, this measure will also act as an incentive to encourage many employees to stop smoking.

Action item 2 Preventing young people from starting smoking
For the youth, smoking is often an unconscious means of developing their own identities. However, addiction can occur much quicker than they thought possible. The prohibition on sales to young

people should help them refrain from smoking. A joint marketing experiment, 'non-smoking for young people' by VWS and STIVORO, which took place in the autumn of 2002, showed young people how they can become adults without smoking. STIVORO will introduce this experiment nationally in the coming years, especially for young people in disadvantaged socio-economic groups.

Big Deal?
Several municipalities in northeast North Brabant carried out the Big Deal Project in conjunction with the Trimbos Institute's project, 'Healthy School and Stimulants'. Youth workers talked with young people about the use of stimulants and to find out how the youth, as 'peer group educators', could tackle this problem. In Schijndel, young people decided to ask local bands to write numbers about the use of stimulants. Nearly all amateur bands took part. There was a festival at which each band had an opportunity to perform its song. The young people awarded a prize to the best band. Besides the quality of the music, the judges also focused on the number with the best inherent message for the youth.

Action item 3 Higher excise duties
Effective 1 February 2004, excise duties on rolling tobacco (50 grams) and cigarettes (a pack of 25) rose by 0.46 euro (retail effect: 0.55 euro, including VAT). The price of a pack of (25) cigarettes in the most popular price class was 3.80 euro. The increase in excise duties increased this price by 14 percent. According to figures from the World Bank, a price increase of 1 percent in prosperous Western countries will result in a decline of 0.4 percent in consumption. The Small Business and Research Consultancy (Economisch Instituut Midden- en Kleinbedrijf EIM) also indicates a price elasticity of –0.4. Based on this, the latest price increase of 14 percent should result in a decline of between 5 and 6 percent in consumption. Increases in excise duties particularly affect the smoking habits of young people and people in low-income groups. Some 100,000 young people start smoking every year. Studies by the World Bank show that the number of youth that start smoking declines by around 9,000 when the price per pack goes up by 14 percent. Since one of two smokers dies prematurely on the effects of tobacco use, the decline in consumption and/or the number of smokers will result in fewer premature deaths due to tobacco use.

Action item 4 Local activities
Activities aimed at reducing smoking among young people and people with limited education are part of the further elaboration of agreements with large cities in the context of the Metropolitan Area Policy Framework (health section) and the 'Social Impulse for 56 Neighbourhoods'. They are part of Healthy School Policy (see subsection 7.2).

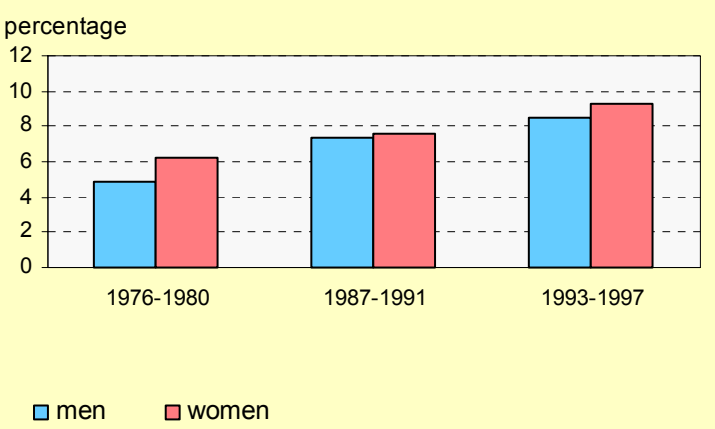
5.2 Obesity

The primary cause of obesity is the imbalance of energy intake from food and energy output through physical exercise – eating too much and exercising too little. In some cases there could also be predisposition.

There has been an alarming increase in obesity in recent years. Obesity is nearly as great a threat to public health as smoking is at present. An increasing number of young people are overweight. In 1997, the percentage of obesity, depending on age, varied between 7 and 16 percent. Whereas people between the ages of two and 20 had serious obesity problems, varying between 0.1 and 1.0 percent in 1980, by 1997 this figure had increased to between 0.5 and 2.7 percent. Recent data show that this increasing trend is continuing. The cost of health care for people who are seriously overweight has already reached 505 million euro per year.

Overweight problems and obesity occur in certain population groups much more frequently. Obesity among women with limited education is five times higher than by those with higher education. The figure is three times higher for men with little schooling. The number of overweight people in this group is also high. A recent study shows that 90 percent of Turkish women in Amsterdam are overweight. The percentage of immigrants that are overweight or obese corresponds to current American percentages, where the situation is even worse than in the Netherlands.

Figure 2 **Percentage of people aged 37 to 43 with serious overweight problems (BMI>=30 kg/m2) during the period 1976-1997, male and female**



Objectives
The number of overweight or obese people must not increase further across the entire line. Considering the expected steep rise, this is an ambitious objective. We hope there will be a reduction, particularly for children. For growing children, timely signalling and proper intervention can easily result in improvements. Healthy weight not only provides long-term health benefits but also, in the short term, better physical fitness and an immediate reduction in the need for health-care services. It is an important aim to get people to take more physical exercise and eat healthier diets.

Considerable Enthusiasm for Health Test
The National Health Test took place this year for the fifth time. In a qualified fitness centre participants take part in a simple physical fitness test. They fill two extensive questionnaires about their lifestyles. Based on this, they receive estimates of their physical fitness and personal fitness advice. During this campaign week some 7,000 people are tested, including around 1,000 employees of the ING Bank. Besides encouraging people to exercise more, the test is designed to generate publicity for physical exercise and for following trends. The Netherlands Heart Foundation commissions the test. The Ministry of Health, Welfare and Sport (VWS) co-finances the event.

The Approach
In the first instance, individuals are primarily responsible for controlling their own weight problems. In addition, a joint approach is necessary, which targets both lifestyles and environmental factors that promote good nutrition and sufficient physical exercise. Manufacturers could produce healthier products. Schools and companies could place greater emphasis on healthy foods available in their canteens. In designing neighbourhoods, municipalities could focus more attention on adequate playgrounds, safe cycling routes to school and accessible sports clubs.

Health at School
It is often possible to enter agreements with schools and sports canteens about offering healthy snacks. Placing healthy foods to the front and not hiding them in a corner would be a good way to start. Also, what about those half-litre bottles of mineral water that everyone brought into the classroom this last year? Drinking more water less sweetened cola promotes health. These kinds of things can be worked out in consultation between schools and suppliers. This is one rage that deserves encouragement.

Practice and research have not yet produced an approach that is totally effective. The 'Conference on Obesity' (2002) organised by the European Union and the Health Council (2003) recommended starting with a 'health and common-sense approach'. By this, they mean plausible activities and

measures or those that could be shown to result in more physical exercise and less energy intake from foods -- two significant pieces of advice in developing a joint plan of action. Both recommendations (RVZ: Health and Lifestyle (2002), the Health Council on Obesity (2003)) call for developing a preventive approach with broad collaboration of the parties concerned. In May 2003, a kick-off meeting took place with 25 social organisations and representatives of the social partners and the business community.

This meeting concluded with the announcement of four themes for elaboration:
- How could local attention for obesity be stimulated and supported?
- How could interventions be set up more effectively at the very beginning, based on the energy balance rather than primarily based on nutrition or physical exercise?
- What kinds of things could manufacturers and suppliers of food and exercise activities additionally do to ensure that it is easier for people to 'make healthy choices'.
- How could (youth health), care services and day nurseries, for example, affect prevention of weight problems in young children?

Action 1 Dovetailing with healthy nutrition activities
We decided to fit the activities of obesity wherever possible into existing policy on all fronts: nutrition, exercise and healthy youth. Public information and other support activities should dovetail as much as possible with existing policy plans from the 1998 Netherlands Proper Nutrition policy document (Nederland Goed Gevoed), which is now being implemented.

Sensible nutrition is a significant factor in weight control and, in a more general sense, in maintaining good health. Given the increase in consumption of ready-to-eat meals, highly-seasoned sauces with fat and other products with a plethora of saturated fats and fatty acids, there are incentives for companies to modify products with the aim of reducing fat content and improving fatty-acid composition.

Accordingly, we will follow a two-track policy in future:
- to encourage trade and industry to make practical modifications in products, via an existing working party on Regular Consultations on the Food and Drugs Act;
- to combine actively and in advance the research and business parties to increase knowledge about trans fatty acids and saturated fats. In this regard, VWS commissioned the Nutrition Centre to establish the 'Project Hidden Fats Plan'.

The Nutrition Centre's campaign, 'Control Your Weight', will continue and develop further.

Action item 2 Making healthy lifestyles the norm, easily and with appeal
The Regular Consultation on the Food and Drugs Act will enter agreements with suppliers of food and exercise activities to facilitate healthier choices. This applies to modifications in products, size of portions, contents of vending machines for sweets and soft drinks at schools, advertising and sales activities for minors and product information.

Action item 3 Dovetailing with exercise activities
The policy document, ‘Sport, Exercise and Health (2001), explains the value of physical exercise for human health, fitness and well being. It also points out that the increase in obesity and lack of physical exercise are closely related. The importance of pairing the approach taken to obesity and efforts to promote physical exercise is abundantly clear. Activities designed to promote physical exercise will dovetail with the spearheads from prevention policy. In particular, they will focus on target groups, young people and adults with limited education and low incomes.

In 2003-2004, the Netherlands Institute for Sports and Exercise will implement ten model projects designed to support healthy and active lifestyles. One purpose of these projects is to get an understanding of whether the approach taken by working with and for people with health arrears is suitable to encourage that target group to engage in more physical exercise and, in this way, prevent obesity.

Action item 4 Early detection and treatment of obesity

We will enter agreements with municipalities on how the youth health-care service will provide children with timely advice about weight problems or their treatment. ZonMw will have a protocol developed. The Youth Health-Care Platform will supervise its introduction. The Nutrition Centre is developing public information material for people who work in the youth health-care service and those in day nurseries.

Action item 5 Activities at school

The School Fruit Project is currently running in seven large cities. Its aim is to encourage children in primary schools to eat more fruit and vegetables. The Nutrition Centre, AGF Netherlands Promotions (agency for public information about potatoes, fruit and vegetables), the Market Gardening Commodity Board and the ministries of Agriculture, Conservation and Cattle Breeding, Education, Culture and Science (OCW) and VWS work together in this project. We will continue these activities with zero and effect measurements until 2005. Introduction of the 'Healthy School Canteens' project took place from 2001 to 2003. The aim here was to advance sensible supply of food and drink in school canteens. Having evaluated the materials developed, the Nutrition Centre has now made it available.

Action item 6 Local, neighbourhood activities

Activities geared towards reducing obesity among people with limited education are part of the further elaboration of agreements with the large cities in the context of the Metropolitan Area Policy Framework (health section) and of the Social Impulse for 56 Neighbourhoods.

Action item 7 Putting research in context

The Obesity Knowledge Centre stimulates coherence between various research projects on obesity and the exchange of knowledge.

Action item 8 International approach to obesity

Obesity is now seen as a global problem. The WHO is developing a global strategy on diet, physical activity and health. The European Commission recently established a network for developing European policy, in which the Netherlands is active.

5.3. Diabetes

With 414,000 ‘official’ diabetes patients in 2000 and 65,000 new cases each year, between 1990 and 2000 diabetes mellitus is among the most rapidly increasing chronic diseases. Diabetes shortens healthy life by several years, affects quality of life and places a burden on curative care. Estimates by the RIVM indicate that a minimum of 160 million euro could be saved annually on medical costs through better, timely care. Encouraging sensible nutrition, healthy exercise and the detection of risk groups contribute to the prevention of diabetes mellitus. Early diagnosis and prevention of complications by proper care could bring about a substantial reduction in disabling illnesses.

The risk factors for type-1 diabetes (also called youth diabetes) are not yet fully known. Risk factors for type-2 diabetes mellitus (also called old-person's diabetes) include obesity, too little physical exercise and wrong diet. Of concern is the increase in type-2 diabetes in children and young people. When treatment is too little, too late or when the diagnosis is wrong, many diabetes patients have to contend with serious complications such as cardiovascular diseases, blindness, abnormalities of the feet (leading to amputation) and kidney disorders.

People with limited education run twice the risk of diabetes than those with higher education. There is also above average occurrence of diabetes among certain population groups, such as Hindustanis and Moroccans. According to various epidemiological studies, the number of undetected incidences of type-2 diabetes is between 100,000 and 400.000.

Good care can prevent complications from diabetes. Studies show that there could be better treatment of diabetes than is now the case. Targeted preventive policy by the care sector could substantially reduce disabling illnesses arising from complications.

Objectives

The aim is to bring about a reduction in the number of people under the age of 55 with diabetes. We hope to achieve this through healthy nutrition, more physical exercise, non smoking and moderate use of alcohol. People with diabetes should live longer, healthier lives by preventing complications and keeping the illness from worsening.

Approach
The approach takes two separate lines:
1 Patients are responsible for their own behaviours.
By assuming responsibility for their behaviours and lifestyles, people can reduce the risk of getting a chronic disease, postponing the onset of illness. Moreover, with healthy lifestyles and by following therapy, one could prevent and postpone complications.
2 Patients, suppliers and insurers join forces, each with their own responsibilities. Together, they agree on the content, outcome and financing of diabetes care.

Diabetes Action Programmes
In consultation with those in the field, there has been an analysis of the diabetes problem Based on the findings, it was decided to develop a national diabetes programme together with the responsible organisations. The aim is for the parties concerned to subscribe to the 2004-2008 diabetes programme in the spring of 2004.

The following strategies form part of the programme to be developed.

Strategy 1 Prevention of diabetes in a healthy population
Reducing unhealthy habits could contribute significantly to the prevention of diabetes. This entails healthy nutrition, exercise, moderate use of alcohol and non-smoking. This chapter and chapter 6 present a clear formulation of the action items. The programme will fit in with these action items.

Strategy 2 Early detection of people with high risk of diabetes
This involves studying the possibilities of establishing a risk profile for individuals, linked to a health-prevention contract. In this way, people will gain greater individual insight in their health status, so that they can take personal responsibility. We also look at whether a risk standard for children could be a uniform part of a basic package for the youth health-care services.

Strategy 3 **Early detection of people with diabetes**
The Health Council has been asked to issue advice concerning the necessity and cost effectiveness of systematic screening of diabetes risk groups.

Strategy 4 Improving current diabetes care.
The aim is to provide a better context for the provision of preventive care, patient treatment and the processing of medical data, to create a logical, balanced chain for made-to-measure care. A necessary condition to this is the establishment of a national care-chain standard to determine who is responsible for implementing the chain. This should not be without obligations, since that would mean that each partner in the chain could act independently without having to make allowances for the way they affect the rest of the chain. In this connection, there will also be a study of task shifting within the total treatment chain, along with an evaluation of the role that area health authorities could play.

6 Psychological Disorders

Annually, one out of four adults has to contend with psychological disorders such as depression, anxiety disorders and alcohol addiction. For the first time in their lives, 125,800 people between the ages of 18 and 65 years experience depressive disorders. In 2000, there were 233,100 suffering from depression. The cost to society of depression is around 1.7 billion euro. In the coming decades, the WHO expects depression in industrialised countries to develop into public illness number one.

Psychological disorders generally spring from a combination of predisposition, environmental factors, stress and lifestyle. Prevention and early detection of psychological disorders could ensure timely treatment of symptoms, keeping them from worsening – with fewer radical consequences for the individual, the surroundings and society. There is a clear connection between physical and mental health. Prevention of psychological problems is therefore extremely important for proper physical health.

People suffering from depression are often seriously restricted in their social functioning. Those with limited education have twice as high a risk of psychological symptoms as people with higher education. For prevention of depression and anxiety disorders, one must look at people's social environments: family situation, work and social networks.

There has been much research concerning alcohol-related problems. Various studies show that, in 2001, around 9 percent of the adult population (over 1.1 million people) were problem drinkers. On an annual basis, 3.7 percent of adults between the ages of 18 and 65 meet the diagnostic criteria of alcohol addiction. Reducing alcohol-related damage to health is therefore a major public health measure.

Psychological symptoms and their potential effects (absenteeism, isolation, behavioural problems, nuisance) are significant problems for local authorities and social partners. The central government cannot solve these problems. However, central government can provide support in tackling the problems more effectively. This particularly entails improving the process of prevention, early detection and care. Enough is known about the bottlenecks in prevention and care of depression and alcohol addiction to take action.

Isolation
A contact centre for elderly people was opened in the Schilderswijk district of The Hague. This contact centre picks up signals at district level about isolated elderly people from social workers, local residents, immigrants' organisations, volunteers, the police, housing associations, churches, etc. The contact centre then calls on social workers or volunteers to work with isolated elderly people. They organise and co-ordinate progress. The contact centre also concentrates on preventing isolation. It stimulates early detection and devotes much attention to the social infrastructure around the elderly.

6.1 Objectives

For alcohol addiction, the aim is to reduce the percentage of problem drinkers aged 16 or older from 9 to 8 percent in 2004. This would represent a decline of 11 percent, compared to 2001.

Psychological symptoms constitute an extensive public health problem. The problems are complex but, according to current knowledge, only partially susceptible to prevention. The nature of the problem, available knowledge and insights demands a step-by-step approach with some long-term objectives. A first step for depressive disorders is to focus more attention on prevention and care, where prevention often takes the form of early detection and early treatment.

There are effective measures available for prevention and treatment of depression. Although the mental health authorities provide by far the most help, they reach too few people, particularly the youth. Since we would like to see a greater range of preventive measures, we have asked the mental health authorities (geestelijke gezondheidszorg - GGZ) to assign priorities within current budgets to

prevention and early detection of depressive disorders. Additionally, there are still many potential benefits through the timely employment of minimum intervention measures via the area health authorities, the schools, home care, industrial health care and primary health care. When someone suffers from depression, it is important to make sure that it does not get worse, that related disorders do not arise and that, after recovery or improvement, the situation does not worsen.

6.2 Approach to Alcohol Addiction

The scope and seriousness of alcohol-related problems call for action in the area of prevention and care. It is especially important to prevent young people from drinking far too much, along with timely recognition and treatment of alcohol problems. To reduce the problem of excessive alcohol use, the government is further expanding the Alcohol Policy Document and the Alcohol Care plan. Below is a description of the main developments.

The National Institute for the Promotion of Health and Prevention of Illness (Het Nationaal Instituut voor Gezondheidsbevordering en Ziektepreventie - NIGZ) will continue to provide information to young people via large-scale summer campaigns at beach campsites. These campaigns are unique in that the public information not only aims at young people, but is also presented by young people. Youth volunteers receive training to approach holidaying young people with a message about moderate drinking. Initial studies show that this has a favourable effect. When approached personally, young people appear to be better informed about alcohol, are conscious of their own drinking habits and are willing to drink less on regular nights out.

There are ongoing consultations with the alcohol sector in an effort to persuade advertisers not to target young people with alcohol advertisements and marketing. The intent of these consultations is to arrive at a new, practical, easy-to-understand, formal commitments to protect young people. If unsuccessful, then the minister of VWS will issue a ministerial advertising decision pursuant to the provisions of the Licensing and Catering Act.

In collaboration with the Trimbos Institute, the NIGZ is continuing tailored public information via the Internet for heavy drinkers. These are people who not only drink heavily, but often do not have any alcohol-related symptoms or problems, or do not identify them as such. This is followed immediately and anonymously by personal advice for coping with alcohol.

The drinking habits of parents, the way in which they bring up their children and discuss the drinking habits of and with their children affect the way their children use alcohol. We consider whether the use of alcohol could also be part of upbringing information to parents.

Medical assistance (family doctors and care and treatment of addiction) only extends to a small percentage of problem drinkers. For this reason, we are looking to see whether the Internet would afford opportunities to detect people who already have drinking-related problems and offer early treatment. Several institutions for care and treatment of addiction, including De Brijder en Jellinek, have started initial interventions via the Internet. These are pilot projects. In collaboration with the Amsterdam Institute for Addiction Research, the Trimbos Institute is studying the effectiveness of a self-help module on the Internet for problem drinkers.

Family doctors must do more to combat alcohol abuse

Doctors tend to see alcohol abuse as a social problem, even though it entails serious health risks. It is therefore not right for some doctors to question whether it is their duty to help patients reduce alcohol consumption. That is the position of Dr P. Anderson, who recently received his PhD based on research into the role that family doctors could play in the prevention of alcohol abuse. His dissertation shows that family doctors could detect and help high-risk drinkers using fairly simply methods. There are already successful programmes for this in the UK and Russia. Family doctors could limit the injurious effects of excessive alcohol use by some 10 to 16 percent. Anderson thinks it would be desirable for family doctors

Family doctor practices have an estimated 200 problem drinkers on average (per 2,350 patients).

In practice, these doctors only detect one in seven of these problem drinkers. There is therefore much to be gained. Studies show that screening and minimal intervention of alcohol-related problems in family doctor practices is effective. According to family doctor guidelines, this should effective. However, it still does not work well in practice. This is also the case in other countries.

In 2002, the Netherlands GGZ launched the three-year 'Alcohol Care Action Plan' in the Netherlands. The plan initiated many new, low-threshold types of assistance. These often entail targeted information to specific groups, a primary approach to problematic use of alcohol and training of primary care workers, for example. The Netherlands GGZ has incorporated the most successful projects in a catalogue of innovative care projects for alcohol assistance. At the conclusion of the Alcohol Care Action Plan, the extra funds will go towards low-threshold alcohol care. Successful projects can therefore continue. In addition, in consultation with field organisations, there may leeway to shift the emphasis to prevention in the second instance. In this regard, there could be preventive courses developed for young people with (early) alcohol-related problems, for example, young people who get into trouble with the police or the courts due to alcohol-related offences, or those who go to first-aid stations under the influence following accidents.

6.3 Approach to Depressive Disorders

The approach taken will dovetail as much as possible with current or previously proposed policy measures. The RIVM and the Trimbos Institute was asked to write a document with a sound scientific basis for the further policy development of prevention of psychological symptoms, including depression.

Improving the Quality of Care
In the context of strengthening primary mental health care, there have been several years of thematic work on improving the expertise and skills of family doctors in the area of psychological problems. Co-operation will also be encouraged among partners in primary care and between primary mental health care and specialised GGZ institutions (secondary care), assisted by projects. Via consultations on prevention and treatment, secondary care will contribute to the expertise of family doctors. It is clear that these projects are useful.

Violence is a significant risk factor for depression and anxiety disorders. Based on the policy document, 'Private Violence, A Public Concern', under the direction of the ministry of Justice until 2007, an interdepartmental plan of action is being prepared to deal with and, where possible, prevent domestic violence.

This plan will advance the expertise of care professionals and social workers in this field. The assistance methodology for early prevention of violence requires further development and testing for its effectiveness. A protocol for Child Abuse is currently under preparation for persons who work in the youth health-care service. This will be available during 2004.

Course helps combat depression
The course, 'In the Doldrums, Out of the Doldrums' is structured intervention based on behavioural therapy, geared towards the approach to depression. The aim of the course is to teach skills to break through the negative spiral of depressive symptoms and thereby avoid any worsening of these symptoms. This takes place by means of relaxation exercises, cognitive skills (recognising and breaking through negative ways of thinking) and social skills. Studies show that the depressive symptoms of the subjects diminished faster and more fully than people in a control group. There are numerous variants of the course: for people aged 55 and older, for people with chronic physical illnesses, for young people, young adults and for Turkish and Moroccan immigrants. The course for adults and those 55 years or older is currently being introduced in more than 90

Work-Related Psychological Problems
Dutch employers seem more active than ever in their approach to and prevention of work-related psychological problems. Nevertheless, there are still more arrears in this area, compared to the approach taken by employers, for example, to physical risks. The ministry of Social Affairs and Science (Sociale Zaken en Wetenschap - SZW) enters covenants with social partners in many sectors. These entail clear commitments about reducing work pressures and other factors that contribute to psycho-social work burdens. At the request of The Working Perspective Committee (2003-2007), TNO Work (department of the Dutch Organisation for Applied Scientific Research) developed a tool to help employers incorporate prevention activities in their operational management.

Reporting ill due to psychological problems carries a relatively high risk of protracted and total absence from the job. It is therefore important to identify and intervene in a timely fashion when there are work-related psychological problems. Causes of a non-medical nature, such as conflicts at work, require a timely approach to prevent resulting psychological problems. In many cases there are depressive and anxiety disorders. Disorders stemming from the use of narcotics and addiction problems also affect the work situation. Of all employees who are absent for psychological reasons, approximately 42 percent visit their family doctors two months prior to reporting ill. TNO Work is therefore preparing recommendations for the prevention task of family doctors prior to employees reporting ill. ZonMw is working on effective intervention (via family or company doctors) to inform employees about psychological problems. In practice, family and company doctors do not always make the same diagnosis about nervous exhaustion, depression and anxiety disorders. There is a need for joint guidelines for company and family doctors in diagnosing, counselling and treatment of employees with psychological symptoms. This is included in the programme of the Netherlands Organisation for Research (Nederlandse organisatie voor wetenschappelijk onderzoek - NWO), 'Psychological Fatigue in the Workplace', which will run until early 2004.

The national Prevention Support Centre (a collaboration between the Netherlands Mental Health Authority and the Trimbos Institute) and the Netherlands Work and Psyche Knowledge Centre would like to incorporate prevention protocols in the Work Assistance Protocols series for psychological symptoms developed this year. Further, the Guidelines Office of the Netherlands Association for Work and Industrial Medicine (Nederlandse Vereniging voor Arbeids- en Bedrijfsgeneeskunde - NVAB) would like to develop a guideline for prevention of psychological symptoms.

Organising a Coherent Approach
Although psychological symptoms such as depression are a national problem, they are difficult to tackle with national measures. Nor is prevention of depression only a matter of specialised GGZ institutions. As with improving healthy lifestyles, prevention of depression must take place where people live: at home, at school, at work and in the neighbourhoods.

Municipalities devote considerable attention to psychological symptoms, especially now with socialisation of care, and people who used to live in institutions are increasingly returning to society. Municipalities need greater opportunities to be able to steer towards collective GGZ prevention. There is therefore a proposal to give responsibility for collective GGZ prevention to the municipalities and to transfer the moneys concerned from the Special Medical Costs Act (AWBZ) to the municipalities. There will then be consultations with the parties concerned, including the Association of Netherlands Municipalities (Vereniging van Nederlandse Gemeenten – VNG), the Netherlands GGD, the Netherlands GGZ and the Trimbos Institute, about whether or how this can be realised. In 2004, in

consultation with the association of municipalities, the Trimbos Institute and the Netherlands GGD can draw up an action plan to support local processes.

The Trimbos Institute will further elaborate the above approach in the field, in consultation with the relevant parties. The parties must indicate the special risk groups for which they have proven knowledge they have to undertake specific action and to bring these parties together in a depression-prevention platform.

Because of the drastic consequences of psychological symptoms, early recognition (of the problem) and early intervention in children and young people are priorities. With their long reach, the youth health-care service and the schools play key roles here. In non-urgent cases, the youth health-care service can offer types of individual and collective upbringing support. If there is a need for specialised help, there are referrals to social work, youth care or specialised mental health care. Upbringing support could help prevent depression, behavioural problems and parental problems with upbringing. There is encouragement of low-threshold upbringing support as part of the current basic package on offer by the youth health-care service. Therefore, in close consultation with the VNG, the Netherlands GGD, the National Association for Home Care (Landelijke Vereniging voor Thuiszorg – LVT), the Youth Health-Care Platform and the health-promotion agencies, forms of assistance for this low-threshold upbringing support will be developed and introduced. This action is part of the aspiration to arrive at a balanced chain of care for you people: Operation JONG, in which the government departments most concerned work closely together.

7 Widening and Embedding Activities

The government cannot realise prevention policy on its own. It is therefore desirable to distribute responsibilities and to implement preconditions that enable local approaches. The distribution of responsibility in the area of prevention is complex, often less demarcated than is the case in care, for example. It is necessary to look closely at who is responsible for what – in short, to widen and embed activities.

7.1 Municipalities

From 1990, the Public Health Collective Prevention Act (De Wet collectieve preventie volksgezondheid – Wcpv) delegated several important tasks to the municipalities. The starting point was that policy and implementation of activities to promote health and protection should take place locally, based on a good knowledge of the local health situation. A second starting point was that health-care policy should not only be a matter for the health-care sector, but health care should form an integral part of policy development and decision-making in other sectors. Local health-care policy documents, along with new-style administrative agreements, form the link between the local situation and the national priorities. In this way, 135 of the 489 municipalities have adopted a local policy document. The remaining municipalities are busy and will probably adopt the policy document in 2004.

Municipalities and municipal (and regional) health authorities (GGDs) must therefore develop and implement health policy. For this purpose, the money needed has gone to the Municipal Fund. Yet, there is a certain lack of attention locally for health policy. Reports by the Health-care Inspectorate (Inspectie voor de Gezondheidszorg – IGZ), a recent study into municipal health policy, the VTV-2002 report and recent soundings in the field of prevention and public health care also confirm this. There is sympathy for the problems of municipalities in implementing local health policy. We take the signals from municipalities seriously that this is much more 'unruly' in practice than it is 'on paper'. They deserve a helping hand in smoothing out the implementation of local health policy. Wherever possible, the expertise of the national knowledge and training institutes and the health-promotion agencies in the area of national objectives and priorities should be in tune with local needs. This expertise should be made available for municipalities and local partners. There are agreements with health-care funds, such as the Netherlands Heart Association, concerning their efforts to encourage and support local activities. By supporting the Municipal Health Network, they contribute to the exchange of experiences and knowledge among municipalities. The National Institute for the Promotion of Health and Prevention of Illness website now offers municipalities immediate access to knowledge in the area of disadvantaged groups.

Municipalities occupy an important place in local co-ordinating prevention, curative health care, nursing and care. They must stimulate and enable accessibility of care and the co-operation of the parties. They can do this by conducting active distribution and business-licensing policies for facilities and by reminding health insurers of their care obligations for specific local needs.

The Wcpv obligates municipalities to approach health care inter-sectorally. They can establish the necessary ties locally between health, residential living and well being. After all, the municipalities are responsible for matters such as spatial planning, public education, employment, social security benefits, welfare, youth policy and general social work. These provide common ground for municipalities to tackle health arrears. Particularly in the large cities, the health status of inhabitants in disadvantaged districts lags behind that of other residents.

7.2 Schools

In the classroom, schools devote attention to the importance of health. Teaching goals in primary education expect pupils to show how they can contribute to maintaining and promoting their own health and knowing what they can do if they or others become ill or receive minor injuries. This includes attention for things such as physical hygiene, the risks of addictive habits such as smoking and the use of alcohol and dealing wisely with potentially dangerous situations in and around school. In addition, schools ensure that teaching takes place in a safe, healthy environment.

Besides all this, schools conduct more or fewer explicit health-care policies. In developing and implementing school health-care policies, schools can ask for support from GGDs, the youth care and GGZ agencies. Schools that make use of this are usually quite satisfied. Individually, schools already utilise materials developed by national health-promotion institutes.

Schools are free to devote greater attention to health and health policy at school, with the goal of becoming a 'healthy school'. The 'healthy school' is a broad concept that pertains to the health of pupils and teachers. Besides health, this notion also encompasses individual care and the school environment. Realisation of this is no simple matter, not only because of the complexity of the issue but also due to current teacher shortages, the enormous pressure on implementing core objectives and outside pressures for the schools to deal with countless social issues.

Schools will participate in the national network of 'Healthy Schools'. With the health-promotion agencies, they will add further interpretation to the notion of the healthy school. Support for realising healthy schools will come in the form of research and development of school models of types of regional co-operation. Such regional co-operation, for example, means that agencies such as youth care, regional agencies for ambulatory mental health care, consultation agencies for alcohol and drugs and local welfare agencies in the region co-operate to provide demand-driven support to schools. The GGDs can play key roles in this.

Support also takes place by developing quality instruments for teaching materials about health. Schools will of course be free to choose the support they want and to apply the models and instruments offered.

Due to the growing incidence of unwanted pregnancies and sexually transmissible diseases, these activities will incorporate the theme of healthy sexual habits.

7.3 Work

Employers should give greater priority to health policy. Health is a primary raw material for employability and productivity. Employers are increasing aware of this. An increasing number of large companies in the Netherlands recognise the need to make health part of their operational management. Policy developments in the area of social security have provided a clear impulse for industrial health policies. Moreover, the continuing ageing of the population compels companies to establish age-related and health-related personnel policies. In many sectors, the ministry of SZW has entered covenants with social partners about the prevention of work risks and about fast, effective ways of job reintegration.

Talks with employers and employees should stimulate integral health policies, so that specific attention focuses on the spearheads described here. GGDs and municipalities must improve co-operation with regional and local employers to implement this preventive health policy. Employers can utilise the services of the agencies such as the NIGZ and TNO Work institutes. In this regard, initial attention will go to sectors where there are many people with limited schooling. Company doctors can also support employers. The NVAB encourages this professional group to play an active role in prevention.

The outcome of the 'Social Security and Care' project has been published. They present the policy agenda for the coming period and the actions to be taken together with other parties. The aim of the project is to accelerate removal of the 'firewall' between social security and health care. Good co-operation among the parties concerned with prevention, absenteeism and integration are essential to enable people to integrate or reintegrate successfully in the labour market.

7.4 Care

Attention for prevention is an essential aspect of offering reliable care. This means that prevention is a partial responsibility of care providers. Care providers can link activities aimed at lifestyles (giving up smoking, physical fitness) to treatment, by addressing patient responsibilities for healthy lifestyles.

Changing one's own lifestyle can and should be a more frequent subject of discussion between care providers and patients, than is the case at present. Until now, individual health care has devoted too little attention to prevention of illness and reducing health risks.

Still, there are several very effective prevention methods available, such as Minimal Intervention Strategy, whereby family doctors during brief consultations could have success in getting patients to stop smoking. These methods, which only receive sparse attention now, could be implemented throughout the country and should be seen as a norm for good-quality health care.

Health insurers also have an important task in stimulating healthy lifestyles among their policyholders. Various insurers are already moving into this market. Physical exercise, giving up smoking and health tests are already standard tools that some insurers use for supplemental insurance. Prevention could contribute to the positive images of insurers. It could be a successful, appealing product for which there is increasing demand. However, prevention also directly affects health and medical consumption by insured persons. Fewer pulmonary symptoms and better physical fitness reduce medical consumption immediately, offering short-term benefits for insurers. We invite insurers to devote more attention to prevention, among other things, by keeping them informed of the cost effectiveness of preventive measures.

There are expectations that the health-care chain, an effective integral approach to illness and diseases, will produce many health benefits. This is particularly important in care for chronic diseases and disorders. Pilot projects have shown that targeted attention greatly reduces specific health risks in care, such as bedsores and infections from injuries. Also, consistent application of standards and protocols could prevent unnecessary complications from illness.

Health insurers should oversee realisation of a good health-care chain and the application of current standards and protocols. The development and implementation of performance comparisons (benchmarking) in the various core sectors (family doctor care, acute care and hospital care) stimulates working according to standards and protocols.

There are several significant impediments to investing in prevention by health insurers and care providers. The cost of preventive care exceeds the proceeds; the health effectives are not always clear, probably only occurring in the longer term. There is an unintentional benefit for insurers' competitors: the insured persons are free to choose their own insurers. Family doctors have high workloads and sometimes assume that unsolicited advice and guidance could harm confidential relationships with their patients.

Part II Health and Safety

8 Health and Prevention of Illness

Past successes are no guarantee for the future. In this chapter we reveal our approach to new risks and how we intend to take advantage of new developments, including areas where there were health benefits in the past.

8.1 Combating infectious diseases

The Netherlands is densely populated. With increasing global passenger traffic and the expansion of the European Union, there is greater risk of new infectious diseases. The introduction of many measures, including vaccination programmes (the State Vaccination Programme) and hygiene measures, has proved quite successful in combating infectious diseases. With the current implementation structure, we are in an excellent position to tackle new infectious diseases. This was clear from the approach taken to the outbreak of meningitis C in 2002.

The aim is to reach 95 percent of the targeted population in the State Vaccination Programme and 80 percent in the National Influenza Prevention Programme. There must be a reduction in the risk and scope of infection from infectious diseases such as sexually transmissible disorders (STDs), meningitis and multiple-resistant hospital bacteria. For STDs, the aim is to stabilise the percentage of young people having safe sex with changing partners at 69.

Recent developments suggest that new organisational impulses are necessary to improve anticipation of new, unknown infectious diseases and large-scale threats. It is extremely important to prepare effectively and efficiently for any potential occurrence of new, sometimes unknown, diseases. This affects the way in which central government and local authorities should implement protective tasks.

8.2 The youth health-care service

The aim is to achieve a balanced offer of high-quality facilities in the youth health-care service accessible to all young people. Introduced on 1 January 2003, the Public Health Collective Prevention Act provides a basic package of tasks for youth health care. This preventive care focuses on the active, timely detection of illnesses and health risks that disrupt normal physical, mental and social development. There will be further improvement of the scientific basis of the basic package. In the framework of the prevention programme at ZonMw, standards and protocols will be developed to implement the basic package. The Youth Health Care Platform, which started in the spring of 2003, is responsible for assessing, monitoring and advancing the quality of the basis task package.

The basic package has a uniform and a made-to-measure section. For the uniform section, Municipalities are in charge of organising implementation. In implementing the made-to-measure section, municipalities must ensure that policy and implementation are in concert with the local situation. Youth health will receive an extra impulse from additional co-operation among the various persons or authorities that exercise influence on the children or their environments – e.g. parents, guardians, schools, youth care, youth health care, welfare and other facilities.

The municipalities must ensure that the authorities concerned work together, ensuring proper organisation of facilities for the youth and inter-sectoral coherence. Socio-cultural circumstances, the home and living environments and the socio-economic position of the families have a major effect on the development and health of children. The youth health-care service and youth care devote increasingly more attention to individual and collective upbringing support. In this regard, we cannot always wait until there is a demand for care. In the interests of the parents and their children, the assistance will have to be increasingly outreaching.

We need to keep a close watch on the health of Dutch children and young people. To do so, we need to collect and record information uniformly during contact moments. There must be uniform terms. It is therefore important to stimulate the youth health-care service to adopt and introduce 'uniformity of

language'. Further, the sector receives support in the collective development of the electronic dossier by involving the care sector's national institute for ICT in the process.

The health-care chain for children and young people requires further strengthening. The aim is to bring about an aligned offer of signals, referrals, care and assistance, with a 'social net' for vulnerable young people.

There are signs that there is a shortage of doctors occurring in the youth health-care service. We will investigate whether a proper distribution of tasks between doctors and nurses could help solve this problem. We are also studying the possibility of a referral function for youth-care doctors.

8.3 Population Screening

Preventive care starts with early detection of illness and timely intervention. We pursue effective implementation of population screenings for specific illnesses, such as breast and cervical cancer and prenatal screenings. For breast cancer, the aim is to achieve a screening level of 80 percent and, for cervical cancer, 75 percent. The scope of the PKU test for newborn babies will remain at 99 percent.

There are an increasing number of syndromes where early detection (screening) is possible, sometimes even long before an illness manifests itself. We expect this trend to develop further through advances in science and technology. In particular, diagnostic methods for hereditary and congenital disorders, including predictable genetic diagnosis and the possibility of genetic screening, are fast-moving developments. We must be on guard for any negative consequences. Aspects such as the feasibility of treating disorders, insurability, ethical dilemmas, solidarity and increasing demand for care require a well-considered vision in the application of large-scale screening in the future.

The pending proposed changes to the Population Screening Act will include a further vision of the application of large-scale population screenings.

A broad social debate about the goals and basic assumptions of screening newborn babies is necessary. However, based on the indicative report of the Health Council, it was decided in consultation with this Council to expand the request for advice about screening for cystic fibrosis (CF) to include advice about neonatal screening. This advice will encompass the entire spectrum of screening of newborn infants, including screening of congenital metabolism disorders and CF. The Health Council is expected to issue its advice late in 2004.

In 2004, the Health Council will also issue recommendations about the feasibility of treatment issue. Pursuant to the Population Screening Act, a license is necessary to do research if the illness in question is not treatable. In practice, the feasibility of treatment is a difficult notion to employ.

9 Health Protection

The prevention and anticipation of health risks over which people have little or no control is an important government task. New developments demand that the government remain vigilant.

9.1 Safe products and prevention of injury

Accidents in and around the house form a significant part of safety and health problems. Children and older people are the main risk groups, although no age group is exempt from the risk of having accidents. In most cases, accidents involve products or other physical objects in the environment (house, public space, playground and the like). Besides standards established by the government, suppliers should be aware of their primary responsibilities for making safe products or services. Consumers are responsible for using the products and services safely. Not only is product safety important for preventing accidents, it also focuses attention on potential, long-term health effects.

The aim is to bring about a decline in the number of domestic accidents by 10 percent between 2001 and 2008. By 2006, the aim is to reduce the number of accidents to the level of the early 1990s, when 700,000 emergency cases were treated. In 2001, there were still 750,000 incidences. We want to accomplish this through:

- Fewer accidents involving young children (from birth to four years of age); a decline of 5 percent in 2006, compared to 2001. In 2001, of the 100,000 children, 6,200 received emergency treatment.
- By further reducing the total incidence of sports-related injuries by 10 percent.

Another major point of interest are injuries due to fire. Fires are responsible annually for 1,700 domestic accidents. The number of people with serious wounds was approximately 800 in 2001, with a 30-percent increase occurring during the last five years. The aim is to reduce the number of deaths and domestic injuries due to fire by 10 percent in 2006, compared to 2001.

To achieve these aims, it was decided to take an approach designed to provide public information about the risks of accidents and about preventive measures that people can take themselves. This will take place via campaigns in the mass media, but also via schools, the youth health-care service, sports clubs or via the care sector. The central government and the business community will jointly ensure safe consumer products.

Besides injuries, products can damage health in various other ways. Policy focuses on barring consumer products that entail chemical, microbiological or radiation risks for health or safety. The aim for the coming years is to conduct more preventive substance policy, whereby business must actively communicate ways of controlling and safeguarding the chemical safety of consumer products.

In 2004, the new European General Product Safety Directive will also be incorporated in the Netherlands Food and Drugs Act. This directive prohibits trading of unsafe products intended or suited for human consumption. It is a powerful instrument for taking action against unsafe products for which there are no specific safety regulations. It will introduce a type of simplified standard by means of European standards. Businesses must report unsafe products and the government will have the authority to remove consumer products from the shop. We are specifically working to establish European standards for products with injury records showing that they are frequently associated with accidents. For the directive, the government and the business community must still develop clear methods for evaluating the risks of products.

With respect to safety in the service sector, the Netherlands supports the observations of the European Commission to develop a system of rules for this complex area. Experiences in the Netherlands with self-regulation, such as those developed for safety in swimming pools, riding schools, sports that are all the rage and primary schools play an important role here. With business and the service providers, this policy will apply to both the public and private sectors.

Favourable experiences in the area of public-private partnerships for child safety (making available low-threshold safety methods and facilitating their application) will be used for other policy aspects,

namely safety and maintenance of houses, unorganised sporting activities and safety relating to doing odd jobs at home. The Consumer Safety Association serves an independent knowledge centre for this. Among the partners are municipalities project developers, housing associations, the DIY sector, gas and energy companies, installation firms, odd-job services, manufacturers/importers, as well as providers of new sporting and recreational activities.

Risk communication is a basic condition for gaining consumer understanding for both the legal measures and realising changes in lifestyles. There must be a continuation of the positive results from a systematic public-information approach to child safety. Along with the aforementioned partners, the mass-media campaigns should contribute significantly to the implementation.

The National Fire Safety Plan will start in 2004. This represents a collaboration of the ministries of the Interior and Kingdom Relations, Housing, Physical Planning and the Environment, Education, Culture and Science, Social Affairs, Health, Welfare and Sport and Justice. Implementation will have the support of the Insurers Association and the Netherlands Association for Fire Brigade Care and Contingencies.

9.2 Nutrition and Food Safety

Nutrition is an important factor in maintaining good health. Only a small number of persons in the Netherlands satisfy the Good Nutrition Guideline (Goede Voeding - RGV) and the nutrition standards. The aim is, by 2010, to ensure that more people satisfy the RGV and the nutrition standards for saturated fat, trans fatty acids and fruit and vegetables. In 1995, trans fatty acids still comprised 2 percent of total energy intake. The aim is to see this figure drop to 1 percent by 2010. In 1997/1998, energy intake of saturated fats was 14 percent; the aim is to see this drop to 10 percent by 2010. People will be encouraged to eat more fruit and vegetables.

The government would like to prevent consumers from consuming food with excess or too few important vitamins or minerals. An example of this is folic acid, a profylactics to prevent babies being from being born with spina bifida. Further, prevention should apply to foodstuffs with too high concentrations of agricultural, industrial, environmental and process pollutants. There must be assurances that foodstuffs from genetically modified organisms and new nutritional ingredients are safe.

Breast-feeding is important for protecting mothers from breast cancer and, possibly, from ovary cancer and from fractures. Infants that receive breast-feeding run fewer risks of acute inflammation of the middle ear (otitis media), lags in knowledge development and certain types of allergies. In 2000/2001, 18.5 percent of children in the Netherlands received only breast-feeding for six months. The aim is to increase this figure to 25 percent by 2010. An increase in the percentage of breast-fed babies will result in fewer health-care expenditures.

Commissioned by the ministry of VWS, the Nutrition Centre started the five-year campaign, 'Give Breast-Feeding A Chance' in 2002. The campaign encourages breast-feeding from different perspectives (that of the mother, social environment, health care, policy) and encourages certification of institutions according to the WHO initiative, Baby Friendly Hospital.

Annually, dozens of children are born with spina bifida, with accompanying loss of health and quality of life. Consumption of extra folic acid by women around the time of conception could contribute significantly to immediate prevention of neural tube defects. Following a public information campaign in the autumn of 1995, consumption of folic acid rose gradually. However, it appears that a large group ignored or largely ignored this advice. Among immigrant women and women with limited education, the percentage of folic acid consumption is much too low and is no longer on the rise.

To increase the percentage of women that take folic acid supplements during the recommended period from 35 to 70 percent, the Nutrition Centre and the ERFO Centre (hereditary factors) will continue the public-information campaign about folic acid. The Health Council has been asked to weight the health benefits and risks with simultaneous enrichment of products with folic acid, combined with taking folic acid supplements.

Some 53,000 people in the Netherlands are infected with Salmonella and 80,000 with Campylobacter Infection annually. Besides acute gastroenteritis symptoms, this latter infection results in around 60 cases of Guillain Barré disease, several thousand cases of reactive arthritis, greater risks of death and approximately 25 deaths annually. The minimum estimated cost of this is 30 million euro per year. Around 40 percent of the Campylobacter and/or Salmonella infections come from eating contaminated poultry. A national decision has made it clear that the supply or sale of poultry with Campylobacter or Salmonella to consumers for consumption will no longer be tolerated in the medium-long-term (four to five years).

A recent study by the VWA/Food and Drugs Inspection Authority (Monitoring Pathogens in Chickens and Chicken Products, 2002) shows that 40 percent of poultry meat sold to consumers is still contaminated with Salmonella or Campylobacter. It is therefore now essential to introduce the previously announced, potential ban on the sale of contaminated poultry meat to consumers. The aim is to prohibit the presence of Salmonella and Campylobacter bacteria on raw poultry meat for consumers in 2007. This is conditional to inclusion in legislation coming from Brussels relating to hygiene. Pathogens cannot be totally avoided in meat. It is therefore important to translate this goal into 'a low-level of presence (zero+)' or 'virtually pathogen free'.

Allergies and food intolerance is on the rise. Medically-demonstrated instances of preventing food allergy in Europe are around 2 percent for adults and between 5 and 8 percent for children. Moreover, there is a relationship between food allergies and food intolerance at a young age and other allergic phenomena, such as asthma, at an older age.

The Health Council was asked for advice concerning food allergies and intolerances. Also, in the spring of 2004, the Food and Drugs Inspection Authority (VWA/Keuringsdienst van Waren) will issue recommendations about how to employ new EU rules so that they offer better information to consumers with food allergies or intolerances. Based on these recommendations, the ministry of VWS will soon start preparing an integral plan of action (with a nutritional, medical and VWA orientation).

9.3 Health and the Environment

The RIVM estimates that between 2 and 5 percent of loss of health stems from (known and unknown) environmental factors, such as large-scale air pollution caused by fine dust and ozone, noise pollution from traffic and from mites and fungi in houses. Among others, it is particularly important to improve the quality of the living environment and reduce health risks in disadvantaged, metropolitan neighbourhoods where environmental risks are accumulating.

In the policy document, ‘Health and the Environment', the authors examined whether it was still possible to derive health benefits in the interface between the environment and health. Reducing noise pollution, air pollution caused by fine dust and ozone and improving the quality of indoor environments could still produce substantial health benefits. The action programme that is being put into effect between 2002 and 2006 particularly focuses on the quality of the indoor environment and reinforcing local environmental-health policy.

National campaigns draw attention to the quality of indoor environments. In addition, there is support and incentives for local pilot projects concerning the use of sensors, which could improve the quality of indoor environments in homes and schools.

Municipalities are devoting increasingly attention to the relationship between the health of the population and the quality of the living environment. To support municipalities in this, the Netherlands GGD and the VNG plan to reinforce the quality of medical environmental studies in the coming years. The action programme will make national knowledge and expertise available to municipalities. Also, in the context of preparing a new covenant period for metropolitan area policy, a link will be made between health and the living environment.
Health and the environment is a pre-eminent subject for making agreements at European and global levels. The Netherlands is contributing to uniformity in policy reports about health and the environment. The Dutch support the proposal for better conversion of monitoring data into policy. The

European Union has adopted a European strategy for health and the environment. The European Union and WHO work together closely.

9.4 Crisis management and after-care

In recent years, the Netherlands has faced an increasing number of crises and disasters: the plane crash at the Bijlmer Housing Estate, the pub fire at Volendam, the fireworks explosion at Enschede and the accident involving a Hercules military aircraft at Eindhoven. Such incidents, which often result in many deaths and injuries, are seen as disasters – shocking events that impact people physically, mentally and materially.

Additionally, there are new threats to public health that increasingly require more attention. These are crises relating to infections or animal diseases such as BSE, MKZ, fowl pest and threats from new diseases such as SARS. A crisis that entails risks of infection or epidemics demands a totally unique approach. The threat of a crisis could also come from bio-terrorist attacks, for example, the consequences of which could be similar in nature and range.

There is increasing attention being given to crisis management. Crisis management aims to control and limit the harmful effects of acute emergency situations, through prevention, preparation, response and after-care. The combined government departments under the direction of the ministry of BZK are investing more time and money in crisis management. Important projects in this area are 'Quality Assurance Crisis Management' and 'The 2003-2007 Crisis Management Policy Plan'.

The medical services during accidents and disasters are a joint responsibility of the ministers of VWS and BZK and the municipalities. The further embedding of emergency medical assistance in public health care demands attention. In the context of further strengthening preparations for crises and disasters related to infectious diseases, the recently developed scenarios will undergo evaluation and revision in co-operation with the GGDs. VWS also concentrates on psychosocial help for victims and relatives and on after-care. As a result of increased attention for after-care, a plan of action is being drawn up to improve direction by insurers for the disaster-related cost of care, regardless of the type of disaster. Financing of after-care for disasters now principally comes from budgeted funds.

ZonMw has started preparations for a research programme to study alignment between traumatological and medical assistance at accidents and disasters during the initial phase of a crisis.

Following (large-scale) incidents and crises, there are frequent debates about the relationship between potential exposure to dangerous substances, for example, and their health consequences. Victims often attribute their health symptoms to such exposure.

VWS is responsible for health-care research, in which the ministry can take action or share responsibility with third parties. It is therefore important to do health research quickly. This will enable us to make sure that fewer people get or continue to suffer from permanent health symptoms. Moreover, health research contributes to the recognition and acknowledgment of the victims' problems. To achieve better deployment of knowledge and manpower in health research relating to disasters, VWS established the Centre for Disaster-Related Health Research (Centrum voor Gezondheidsonderzoek bij Rampen – CGOR) at the RIVM. The CGOR works closely with the Impact Foundation, which is a national knowledge centre for psychosocial care following disasters. The GGD and regional medical officers can consult this institute for advice about preventive care, including secondary prevention methods.

There are various ongoing studies during the period from 2004 to 2007, which were set up following the Enschede, Volendam and Bijlmer disasters. The objectives are to prevent permanent injuries to victims and unexplained physical symptoms resulting from disasters and to help them resume their normal lives as soon as possible.

Part III Investing in Knowledge and Quality

10 Investing in Knowledge and Quality

Knowledge forms the basis for policy and practice, if it is useful and properly applied. The proper application of knowledge is the motor that drives innovation and quality improvement.

10.1 From knowledge to implementation

There is an ongoing need in policy and practice to modernise and improve, based on insights in the medical-biological, psychological and social processes that affect prevention. The knowledge extends from more fundamental research to research geared towards success and failure factors in implementing new insights in prevention practice. This involves various knowledge developed and exchanged at various levels – in science, by intermediary organisations, in practice and internationally).

A recent recommendation from the Council for Health Research (Raad voor Gezondheidsonderzoek – GGO) show that, although there are sufficient efforts being made to augment knowledge, the knowledge itself is not always put to optimum use. This has to do with organisational, co-operational, co-ordinating and funding methods. The process of knowledge production and application needs to stay the course and ensure that knowledge yields benefits.

10.2 Keeping pace with developments in health

The RIVM's 'Public Health Future Exploration' report (VTV) is a good instrument for monitoring developments in the field of public health. Besides a four-year summary report, there are annual thematic reports. Research data from the RIVM are also available via the ‘National Public Health Atlas’ and the ‘National Public Health Compass' (www.rivm.nl/vtv/data/site_compass/introduction.htm). Along with other research data, these data form the basis for developing and evaluating policy.

Over the years, the VTV report has devoted increasing attention to (the effects of) prevention and care. By linking these effects to the status of public health and by making geographic comparisons, the VTV report is of greater use in making and justifying policy. It was agreed with the RIVM how a future Public Health Future Exploration report could better support policy options in preparing new policy.

The RIVM is collecting and analysing data from 2004 about developments in health differences in the so-called monitor of socio-economic health differences.

Local health policy should result from insights in local health problems. A recent study by the IGZ shows that more than half of the GGDs have a clear understanding of health problems in their own regions. The other half is not in a good position to outline policy based on local data. The project by the Netherlands GGD, together with the RIVM, 'Local and National Health Monitor' (whereby the area health authorities enter agreements about the collection of certain core data (base data) could help in this regard. Based on regional data, the RIVM outlines a national picture and then makes the regional and national data available in digital form.

10.3 Reinforcing research and development

The Council for Health Research (Raad voor Gezondheidsonderzoek, RGO) advice indicates that there is a need for developing cost-effective preventive measures and programmes, evaluation of current measures, programmes and knowledge about the effect on policy instruments. Research and development activities should focus on this. The RGO sketches a comparable need in its Labour and Industrial Medicine recommendations. The European Union's policy programmes are also relevant in this context. The Public Health Action Programme, the Sixth Environmental Action Programme (2002-2012) and the Sixth Framework Programme (a study covering the period 2002-2006) are examples. Dutch organisations and government authorities could benefit (more than is currently the case) from the European Union's incentive programmes.

Making Choices in Research and Development Activities
Priorities from policy, along with practical problems and issues, should influence the agendas of knowledge institutes much more than they currently do. New knowledge should be useful and applicable to policy and practice. This means that choices have to be made in research and development activities. Priority illnesses and spearheads require the development, application and evaluation of national, effective preventive activities. Programmes such as 'Prevention Programme' and 'Healthy Living' from ZonMw enable new approaches to prevention.

ZonMw plays a key role in programming research and development activities funded by VWS. In the instructions given to ZonMw, the priorities described here are key focal points. The activities implemented should transparently contribute to achieving the goals of prevention policy.

To gain more insight into effective types of prevention, the stages of life in which people are more open to healthy lifestyles and the role of the government in prevention, the Social and Cultural Planning Agency (Sociaal en Cultureel Planbureau – SCP) was asked to indicate the opportunities and potential or lack thereof for prevention from a sociological viewpoint. The planning agency was also asked expressly to include health and healthy lifestyles in its course-of-life research.

Reinforcing Knowledge Infrastructure
The RGO has found that there is poor co-ordination between various university and private research groups. The scarce funds available are therefore not being used effectively. Interaction between practice and science is also still too restricted, resulting in too little use of knowledge developed in the sector.

The preference is for reinforcing interaction between science, education, professional groups and practice. Astute collaborative constructions between science and practice should encourage mutual influence. Examples already exist, such as successful co-operation among area health authorities and universities, including the Limbrug Heartbeat Project (see subsection 1.5).

There must be a good overview of available knowledge in the area of prevention and public health. This not only entails knowledge with a sound scientific basis but also knowledge accumulated through best practices. This forms the basis for the resulting practical guidelines. Further, a good overview of the research field contributes to better direction of the research efforts of universities and private institutes, such as the RIVM. Such direction requires joint efforts in the fields of policy, education and prevention.

VWS commissioned ZonMw, with NWO, to use integral programming to develop relevant knowledge and stimulate its application. ZonMw functions as an intermediary organisation in the network of research, policy and public health care.

ZonMw will further stimulate and organise interaction between research and practice. In doing so, it will work in concert with initiatives from the field, guided by the RGO advice.

10.4 Converting knowledge into practice

The use of standards, protocols and instruments in several prevention areas is still too optional. As a result, the sector's efficiency lags unnecessarily behind. There is a need for a culture with a natural understanding of the need for guidelines and standards, which would stimulate their wide application.

Developing Standards and Protocols
The RGO found that insufficient efforts have been made to develop standards and protocols of prevention. It added that this is not possible due to a lack of good, systematic overviews and evaluations of preventive measures and programmes.
Some positive developments:
- Standards and protocols are being developed for combating infectious diseases, industrial health care and youth health care.

- In the field of medical environmental studies and technical hygiene, national centres are being (or recently have been) established to develop standards and protocols.
- The Centre for Review and Implementation (Centrum voor Review en Implementatie – CRI) – part of the National Institute for the Promotion of Health and Prevention of Illness (NIGZ) – collects knowledge and insights about health promotion and circulates them on a broad scale.
- The Preffi quality instrument, an instrument for the systematic development and implementation of (new) interventions developed by the National Institute for the Promotion of Health and Prevention of Illness, uses available knowledge and insights as starting points.

Ways of improving co-ordination, management of guidelines and standards for prevention are currently being studied. The preference is for a formalised working relationship between the organisations that undertake activities in this area. The contributions made by education, refresher courses and continuing education must be expressly included.

Based on the advice of the Social and Economic Council about new, work-related health risks, a study will be undertaken of the most relevant knowledge suppliers in this area. The emphasis will be on the question of how best to combine knowledge and insights about such disorders, to make them accessible and transfer them to employers, occupational health & safety services and other parties responsible for taking measures to combat new work-related risks.

With the parties concerned – employers, employees, occupational health and safety services, scientists and insurers – the ministry of SZW is exploring the possibilities for supplementary measures to further reduce the effects of repetitive strain injuries (RSI) and work pressures. As a follow-up to the recommendations about RSI by the Health Council, the ministries of SZW and VWS have commissioned TNO Work to draw up a list of effective measures.

Implementation and Innovation
There should be better use of current knowledge and new insights. Innovation can come through development and implementation of new interventions and intervention methodologies. In recent years there have been countless successful projects carried out and effective interventions developed in the area of prevention. In general, these projects are not well known and have received insufficient follow up.

There should be wider application of available knowledge. The context and concerted action are not yet optimal. The ZonMw, the Netherlands GGD, the Public Health Care Fund, the VNG, the RIVM, the NVAB, the Netherlands School of Public and Occupational Health (NSPOH) and the health-promotion institutes do useful work in this area. They need to have expertise to support the policies implemented. They provide a link between knowledge and implementation. The basic conditions are client-orientated attitudes, focusing on the problems in the sector, and the expertise to convert knowledge into practical support. Good co-operation among these institutes is a condition for properly 'serving' the practical field.

Improved co-ordination of implementation encouraging greater demand, planning and achievement orientated work procedures will entail making several necessary changes to the management relationship between the ministry of VWS, the knowledge institutes and the health-promotion institutes (GBIs).

11 Quality and Efficiency

Preventive care should be at a good level. It should be effective, client-orientated, have a sound scientific basis, be safe and geared towards co-operation.

11.1 Quality policy

Effective 1 January 2003, all public health collective prevention tasks were covered by the Care Institutions Quality Act. This means that the institutions that carry out these tasks – the GGDs and consultation bureaus – must supply demonstrably reliable care. This gives assurances to the public about the quality of preventive care supplied.

From the various reports by the IGZ about implementation of Wcpv tasks and from the evaluation of the Care Institutions Quality Act, it appears that quality policy at the GGDs is still not running normally. There are virtually no standards and criteria for measuring quality. The IGZ also found that the GGDs were undergoing many changes as organisations. Increases in scale are happening everywhere in the country through mergers of smaller services. The cabinet shares the opinion of IGZ that increases in scale are unavoidable as a means of bringing the quality of work to an acceptable level. The GGDs are expected to share their expertise with the municipalities, advise them about policies to be implemented and firmly support the implementation of legal tasks and assignments they receive from the local authorities.

Based on the model of the Harmonisation of Quality Assessment in the Care Sector Foundation (Sichting Harmonisatie Kwaliteitsbeoordeling in de Zorgsector - HKZ), the VNG, the Netherlands GGD and LVT, the VNG, plan to further advance and streamline quality policy. This is made possible by a state subsidy for the HKZ Foundation and by starting a programme at the Public Health Care Fund Foundation, which will improve the quality of collective prevention. As with all other institutions covered by the Care Institutions Quality Act, based on public health collective prevention (Wcpv), providers of preventive care must quality systems embedded in their own organisations by the end of 2005. The health care inspectorate (IGZ) ensures that all area health authorities comply with quality policy. The health care inspectorate would like set a date with the Netherlands Area Health Authority by which all area health authorities have integral quality systems.

The GGD should be more active in some areas. These authorities should be self-evident sources for upbringing support, a professional force in implementing school health-care policy, the motor behind district-driven approaches and an equal partner in the chain of prevention, care and nursing. Implementation of parts of area health authority tasks above the regional level would be a good step forward.

11.2 Training

Expertise of workers in the field is a condition for the quality of prevention and public health care. The training of these people is therefore extremely important. The NSPOH and TNO Prevention and Health are major training institutes in public health care. The NSPOH trains socio-medical personnel to doctors specialising in 'society and health' and to doctors specialising in 'work and health'. In addition, the NSPOH offers refresher courses and continued education for public health-care professionals and managers, including educational modules for those responsible for local health-care policy. The NSPOH and the NIGZ have agreed to co-ordinate course activities.

The two-year programme for youth doctor offered by TNO Prevention and Health will end. In its place, TNO Prevention and Health will offer a new one-year programme for doctors that primarily work in youth health care. This course lines up with the programme for doctors that specialise in society and health.

The minister of VWS will create a steering committee for training and occupations in public health care, intended to ensure that initial training in medicine dovetails as closely as possible with advanced training, including advanced training in social medicine. Also, the initial medical training should devote sufficient attention to social medicine. To achieve this, the final year of the six-year study of medicine

will be a bridging year to prepare for advanced training. Various faculties are already preparing for these changes.

11.3 Comparing performance

Achievement of the national goals will depend partially on the performance of prevention agencies. Performance comparisons (benchmarking) will be encouraged to assess and improve performance. Besides area health authorities and home-care agencies, municipalities and schools should compare their performance as 'health municipalities' or as 'health schools' (where such comparisons have already existed for a time). The initiative for this lies with the schools and municipalities.

Based on the action plan, Modernising Government, the minister of Administrative Innovation and Kingdom Relations favours unequivocal performance comparisons in the public sector. In the further development of prevention benchmarks, the parties will be encouraged to seek common ground in the current activities of the association of municipalities, in the framework of metropolitan area policy and of sector organisations in the field of education.

Internationally, too, benchmarking is increasingly common, referred to as Health System Performance Assessments. Various studies have compared performance in the Dutch health and care systems, including one by the WHO and another by the Organisation for Economic Cooperation and Development (OECD). The OECD is conducting a three-year performance study of health care systems, the OECD Health Project. The subproject, Health Care Quality Indicators, develops indicators to be able to assess the quality of health care in various countries. This also includes examining the effects of care on health. The Netherlands participates in the OECD Health Project.

Part IV Funding, Implementation, Assessment and Monitoring

12 Implementation, Assessment and Monitoring

This chapter describes the organisation and funding of implementation and how we intend to monitor whether desired effects are achieved.

12.1 National Health Platform

To realise the social task of prevention in public health, the central government will work with other parties that (should) see themselves as stakeholders in the established goals. This collaboration is essential and is difficult to get off the ground. To bring about targeted agreements about the tasks and responsibilities, we are considering the temporary establishment of a national health platform. This platform would be responsible for reaching agreement about social assignments surrounding prevention and about the mutual stakeholder positions of the parties concerned. There must be clear definitions of the tasks and responsibilities of all parties concerned, including the derivative activities. The platform would call attention to the parties' contributions to dealing with the detected health risks and to realising the aims formulated. In this way, we can ensure a better collective approach to dealing with current and future health-care problems.

12.2 Funding

In 2004, the Netherlands will spend a total of 45 billion euro on public health and care. Of this amount, 625 million euro will go towards health promotion and protection. This amount does not include prevention activities, which are integrated in care and in social, youth and sport policies.

A significant part of this (over 210 million euro) will go towards national prevention programmes such as the National Vaccination Programme, the National Influenza Prevention Programme, population screening for breast and cervical cancer and research for PKU/CHT/AGS, familiar hypercholesterolaemia, hepatitis B in pregnant women. Since 1 January 2003, the municipalities are responsible for total youth health care for young people – from infants to 19-year-olds. Via the scheme for specific payments to the youth health-care service, the municipalities will make an amount of more than 176 million euro available.

The central government funds the health-promotion institutes, such as the National Institute for the NIGZ, the Trimbos Institute, STIVORO, the Nutrition Centre, the Consumer and Safety Foundation, the Aids Fund and the Anti-STD Foundation.

The central government invests in research and development by funding the programmes and activities of ZonMw and the Public Health Care Fund. Most of the data for policy information and monitoring comes from the Public Health Future Exploration report published every four years, the annual sector reports, the thematic reports, the *National Health Atlas* and the National Health Compass of the RIVM. This latter institute receives a structural subsidy from the ministry of Health's budget. The health-promotion agencies also conduct monitoring activities; they fund the institutes concerned from institutional subsidies.

12.3 Intensifying policy

We have described the areas that will receive priority in the coming years. In the past, there has been investment in prevention. Extra funds went towards reinforcing youth health care, amateur sports and the advancement of sports, physical exercise and health. Despite the current financial situation, in the 2004 health budget the cabinet has reserved an extra amount of 5 million euro for prevention; structurally, for the years that follow, this amount will increase to 10 million euro. This money is intended for implementing activities, including lifestyle campaigns, especially in areas with more acute health problems – centred around spearheads and the achievement of the established objectives. It is expected that, in their policies, the parties working both at national and local levels will do everything possible to focus attention on the illnesses and spearheads and will invest in ways of achieving the

established objectives. This will make total investments much higher than those of the central government alone.

For urban health performance in the framework of the new covenant period for the 2005-2009 metropolitan area policy, the cabinet will make 5 million euro available annually, starting in 2005. This relates to two subjects, youth and education and health in cities. In this way, the cities and the central government will combine forces. With an intensification of the partnership – i.e. greater commitment from government departments – there will be ample opportunity to better align national and local policy. During discussions of the alcohol bill in the Lower House, it was indicated that there would have to be extensive support for schools by prevention consultants and activities on the part of area health authorities.

12.4 Monitoring and Assessment Policy

The prevention policy described here covers the period from 2004 to 2007. We will pay close attention to whether this policy achieves the desired effect. This entails the following questions:

- Has the government achieved what it wants to achieve?
- Has the government done what it wanted to do?
- Did it cost what it was supposed to cost?
- Were the policy choices made the right ones?

The policy described partially concerns qualitative and partially quantitative aims. This includes combating priority illnesses and preservation of the current level of protection. These goals will be accurately described in consultation with relevant parties from the prevention field, the care sector, companies and social organisations. The development and clear description of the goals is designed to give everyone clear, measurable goals with broad support. Based on these aims, the relevant parties can then determine their own activities. We will develop performance indicators in close consultation with these parties, which should show whether these goals have been attained.

List of Abbreviations

Arbo	=	Occupational Health & Safety (working conditions)
AWBZ	=	Algemene Wet Bijzondere Ziektekosten (Special Medical Expenses Act)
CARA	=	Chronisch aspecifieke respiratoire aandoeningen (Chronic Non-specific Pulmonary Disorders) (Eng.: CNSLD (Chronic Non-Specific Lung Disease)
COPD	=	Chronic Obstructive Pulmonary Disease
CRI	=	Centrum voor Review en Implementatie (The Centre for Review and Implementation)
EIM	=	Economisch Instituut Midden- en Kleinbedrijf (Small Business and Research Consultancy)
GBI	=	GezondheidsBevorderende Instituten (Health Promotion Agencies)
GGD	=	Gemeentelijke (en regionale) Gezondheidsdiensten (Community Health Services)
HKZ	=	Sichting Harmonisatie Kwaliteitsbeoordeling in de Zorgsector (Foundation for Harmonisation of Quality Assessment in the Care Sector)
ICT	=	Information and Communication Technology
IGZ	=	Inspectie voor de Gezondheidszorg (Health Care Inspectorate)
KvW	=	Keuringsdienst van Waren (Food Inspection Department)
LVT	=	Landelijke Vereniging voor Thuiszorg (National Association for Home Care)
NIGZ	=	Het Nationaal Instituut voor Gezondheidsbevordering en Ziektepreventie (National Institute for the Promotion of Health and prevention of Illness)
NSPOH	=	Netherlands School of Public Occupational Health
NVAB	=	Nederlandse Vereniging voor Arbeids- en Bedrijfsgeneeskunde (Netherlands Association for Work and Industrial Medicine)
NWO	=	Nederlandse organisatie voor wetenschappelijk onderzoek (Netherlands Organisation for Scientific Research)
PKU/CHT/AGS	=	fenylketonury/ congenital hypothyreoid/ androgenital syndrome (Phenylketonuria Congenital Hypothyroid/Androgenital Syndrome)
RGO	=	Raad voor Gezondheidsonderzoek (Council for Health Research)
RGV	=	Goede Voeding (Good Nutrition Guidelines)
RIVM	=	Rijksinstituut voor Volksgezondheid en Milieu (National Institute for Public Health and the Environment)
SCP	=	Sociaal en Cultureel Planbureau (Social and Cultural Planning Agency)
STIVORO	=	Stichting volksgezondheid en Roken (The Foundation for Public Health and Smoking)
TNO	=	Nederlands onderzoeksinstituut voor Toegepast Natuurwetenschappelijk Onderzoek (Dutch Organisation for Applied Scientific Research)
VNG	=	Vereniging van Nederlandse Gemeenten (Netherlands Association of Municipalities)
VTV	=	Volksgezondheid Toekomst Verkenning 2002 (Public Health Future Exploration Report)
VWA	=	Voedsel en Warenautoriteit (Food and Drugs Department)
VWS	=	Ministerie van Volksgezondheid, Welzijn en Sport (Ministry of Health, Welfare and Sport)
Wcpv	=	De Wet collectieve preventie volksgezondheid (Public Health Collective Prevention Act)
ZonMw	=	Fonds Openbare Gezondheidszorg en Zorgonderzoek Nederland medische Wetenschappen (Netherlands Institute for Care Research and Medical Sciences)

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Dutch life expectancy continues to increase: we are living longer. Still, the Netherlands is not healthy enough. As a result, people are living less longer than possible and are ill more often than is necessary. Unhealthy lifestyles among young people are increasing dramatically. In particular, the health of people with limited schooling and low incomes is lagging behind. With these unhealthy lifestyles, the Netherlands has slipped into the middle bracket of European countries. Poor health costs society a great deal of money – the costs of health care, absenteeism through illness and disablement. Only a targeted approach to the chief 'health culprits' – smoking, excess use of alcohol, too little exercise, unhealthy fats – can reverse this development. That will only happen if everyone joins us, starting with the public at large and including the central government, the municipalities, health insurers, business, social organisations and research institutes. This is the heart of the message in this booklet: an adaptation of the cabinet's policy document:

Living longer in good health – also a question of a healthy lifestyle.

The Ministry of Health, Welfare and Sport - NL