



A healthier Netherlands

A healthier Netherlands

*Key findings from the Dutch 2014
Public Health Status and Foresight Report*

Colofon

Editors of the Key Findings

N. Hoeymans, A.J.M. van Loon, M. van den Berg, M.M. Harbers, H.B.M. Hilderink,
J.A.M. van Oers, C.G. Schoemaker

Design

Irene van Kuik, VijfKeerBlauw

Photography

Hollandse Hoogte

Infographics

Frédérïk Ruys

Translation

Michael Dallas

Contact

vtv2014@rivm.nl

Author's rights reserved

© 2014, National Institute for Public Health and the Environment (RIVM),
Bilthoven, Netherlands

Parts of this publication may be reproduced, provided that the source, National Institute for Public Health and the Environment (RIVM), as well as the title and the year of publication are cited.

A healthier Netherlands: Key findings from the Dutch 2014 Public Health Status and Foresight Report
ISBN/EAN 978-90-6960-275-2

Original Dutch title:

Een gezonder Nederland: Kernboodschappen van de Volksgezondheid Toekomst
Verkenning 2014.

Dutch Uniform Subject Classification: 860

A publication by:

National Institute for Public Health and the Environment (RIVM)
PO Box 1
3720 BA Bilthoven
The Netherlands

Foreword

The sixth edition of the Public Health Status and Foresight Report contains a wealth of information on trends and outlooks in public health and health care in the Netherlands.

Fortunately, the situation is positive in many respects. Thanks to steady improvements in the health care system, Dutch people are living increasingly longer. This is due both to the timely detection of health risks and to the enhancements achieved in terms of treatment, medical equipment and medicines. We could improve things even further by living healthier lives.

At the same time, more people are living with long-term illnesses. That is a partial result of the health care improvements, as people who live longer are more likely to develop health problems. Diseases that used to be fatal at younger ages, such as diabetes and cardiovascular conditions, can now be managed in ways that allow people to get older and older.

It is also worth noting that more and more people who are living with long-term illnesses, be they old or young, are now able to participate fully in the community. Older people stay longer in their own homes. Those who are able to work keep working. People are well informed about their health conditions, thanks to the Internet, and they are keen to adopt the latest technologies that help them remain as independent as possible.

Society is changing, and so are people's preferences. Since costs are also rising too steeply, it is clear that we need to organise health care differently. Care ought to be delivered in or near the home, with a full range of online services and the use of smart technologies. If we can transform health care in ways like these, we will both further improve it and make it more affordable. Upcoming threats must also be addressed, such as growing antibiotic resistance. To face these challenges, we need the commitment of all. Only together we can achieve a better public health in the Netherlands.

The Minister of Health, Welfare and Sport,



Edith Schippers



About the Dutch 2014 Public Health Status and Foresight Report (PHSF-2014)

This summary of key findings is part of the comprehensive PHSF-2014 report. The full version of the PHSF-2014 can be consulted in Dutch at www.eengezondernederland.nl. The PHSF-2014 provides a broad overview of public health in the Netherlands. The information is drawn in part from other RIVM websites, including the National Public Health Compass (www.nationaalkompas.nl).

Four theme reports have also been published as part of the current PHSF. They deal with health and social participation, prevention in the health care system,

health and citizenry, and the use of a social cost-benefit analysis for prevention and health care (see the list of earlier PHSF-2014 Dutch publications on page 51). The findings of the theme reports have been integrated into the full version of the PHSF-2014 and into this summary of its key findings.

Our work in creating the PHSF-2014 has been supported by a Scientific Advisory Committee, a Policy Advisory Group and an RIVM Feedback Group (see page 48). Many other people have also contributed. In the run-up to the full publication of the PHSF-2014, intermediate products were presented and discussed with stakeholders.

A healthier Netherlands

Key findings from the Dutch 2014 Public Health Status and Foresight Report

A Healthier Netherlands, the sixth edition of the Dutch Public Health Status and Foresight Report (PHSF), has once again compiled a large body of up-to-date information on the state of public health and the health care system in the Netherlands. The full version of PHSF-2014 can be consulted in Dutch at www.eengezondnederland.nl.

Previous PHSFs, the first of which appeared in 1993, were published during a period of gradual changes in public health policy in the Netherlands. The primary emphasis was on continuity, and the central principles of policy were to keep people healthy as long as possible, to cure the ill as rapidly as possible, to support people with disabilities and to promote social participation. Since that time, changes in the field of public health have gained quite some momentum. Vocal citizens now make their demands known in public debate, in doctors' surgeries and via social media; commercial firms have discovered health as a growth market; and economic recession has put paid to the belief in unlimited growth. A number of health system reforms are currently in progress. Many public health functions and responsibilities are being transferred from national to local authorities.

The research findings summarised here are intended not only for the Ministry of Health, Welfare and Sport, but also for other ministries, local-level authorities, business enterprises, civil society organisations, health professionals and ordinary citizens. Our view extends far into the future. The purpose is to support and elucidate strategic discussions.

Our explorations have come to centre on four primary societal challenges in the field of public health in the future:

1. To keep people healthy as long as possible and to cure illness promptly
2. To support vulnerable people and enable social participation
3. To promote individual autonomy and freedom of choice
4. To keep health care affordable.

In part A of this overview of key findings, we describe the quantitative trends relating to each of these four challenges and examine some developments that underlie them.

In part B, we focus in more detail on these societal challenges, and we examine ways in which they are interconnected, since addressing one challenge could make it either easier or more difficult to deal with another. We describe strategic opportunities and options for the future.



Part A

Trends in public health

Part A Trends in public health

Part A summarises the current state of public health in the Netherlands and highlights past and future trends. Our projections of future trends are based on analysis of historical trends and on modelling, supplemented by findings from literature studies and assessments by experts. This is our ‘business-as-usual’ or trend scenario, in which we extrapolate current societal developments, assuming there will be no new or additional policy measures. The future trends we describe extend to 2030, and where possible we expand the time horizon to 2040.

Life expectancy, morbidity and determinants

Life expectancy still rising, but less swiftly than in the past decade

The life expectancy of Dutch men now stands at 79 years and it rates amongst the highest in the European Union. The average life expectancy of women is 83 years, which is in the middle range in the EU due to relatively high rates of smoking by Dutch women in the past. Dutch life expectancy increased sharply by more than 3 years in the past decade. According to our trend scenario, it will continue to rise, but less strongly than over the past decade; from 2012 to 2030, Dutch men will gain about 3 years of additional life expectancy, and women slightly more than 2 years. Compared to other EU countries, the Netherlands will then retain about 6th place.

Dementia: most important cause of death by 2030

Lung cancer and coronary heart disease were the leading causes of death in 2011. For the future, we anticipate a continued decline in mortality from coronary heart disease and stroke. Our projection indicates that a growing number of people, predominantly elderly people, will be dying from dementia or accidental falls. By 2030, dementia will be the major cause of death. Mortality as a result of infectious diseases is low at present, despite periodic outbreaks of larger or smaller epidemics. The future is uncertain in this respect, as new infectious diseases may arise at any moment. More and more bacteria are showing increasing resistance to antibiotics, whilst few new antibiotic drugs are being developed.

Steep rise in life expectancy largely due to disease prevention and health care

The relatively rapid increases seen in life expectancy in the past decade are attributable mainly to the availability and uptake of improved health care services. In important respects, health care has become more effective. This becomes apparent in many areas of health care, and particularly in the management of diabetes mellitus, pregnancy, cardiovascular disease and cancer. An estimated 40% of the total drop in mortality from coronary heart disease is accounted for by improved treatment options. A host of preventative measures formed another contributing factor in the rising life expectancy. Of particular benefit were anti-smoking measures, the increased use of drugs to reduce blood pressure and cholesterol levels, population screening, the elimination of trans fatty acids from foods and improved road safety. If current policies are sustained, we expect prevention and treatment opportunities to further improve, with a consequent additional rise in life expectancy.

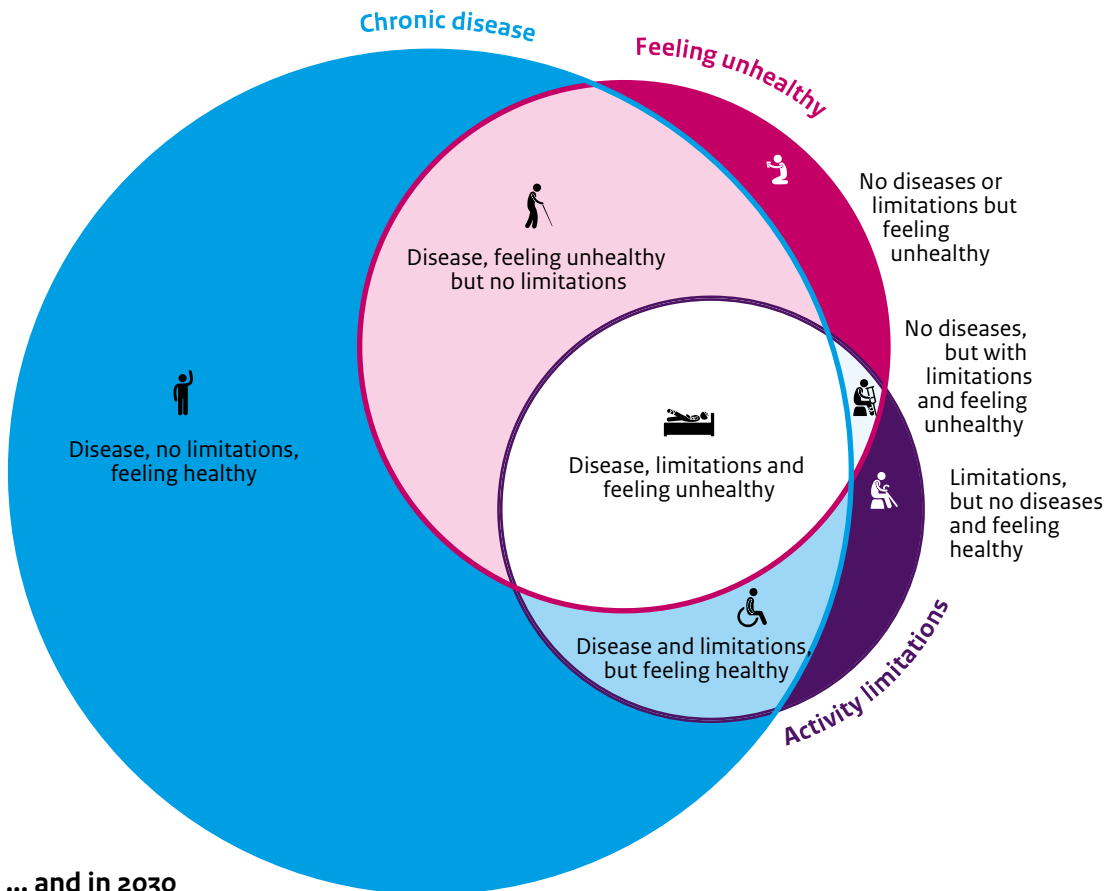
More people with chronic diseases, steady numbers with activity limitations

Partly because of health care improvements and the ageing population, the prevalence rates of most types of chronic illnesses increased in the past decade. That growth is expected to continue. Early detection and improved treatment of diseases imply that people live longer with their illnesses. The number of people with diabetes mellitus, for instance, rose from 0.4 million in 2000 to 0.8 million in 2011, and it is expected to reach 1.2 million by 2030. Similarly, the numbers with arthrosis, hearing impairments and coronary heart disease will each rise to one million or more. We anticipate that the total number of people with chronic illnesses will grow from 5.3 million in 2011 (32% of the population) to 7 million (40%) by 2030, including increasing numbers with two or more long-term conditions (multimorbidity). The figures refer to people with doctors' diagnoses, and do not include overweight, hypertension or the use of eyeglasses or hearing aids. In its rates of chronic diseases, the Netherlands does not differ markedly from other European countries. The growth in the numbers of people with long-term illnesses in the Dutch population has not increased the numbers with activity limitations (see figure on page 11). Despite the ageing of the population, the number of people with activity limitations will remain stable in the future. Only a minority of the adults with self-reported chronic illnesses say they feel unhealthy (35%) or that they experience limitations (21%; see figure on page 11). We shall return to this issue later in part A.

Greatest burden of disease is from mental disorders, cardiovascular disease and cancer

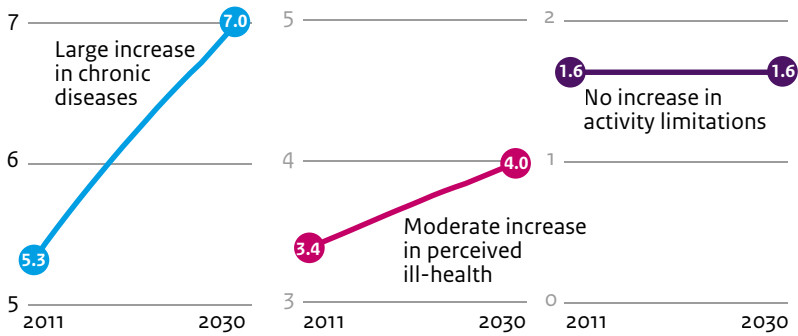
Chronic diseases such as mental disorders, cardiovascular disease and cancer were to blame for the heaviest burdens of disease in the Netherlands in 2011 (see figure on page 12-13). Within these main disease groups, coronary heart disease caused the highest disease burden, followed by diabetes mellitus, stroke, anxiety disorders, COPD (chronic obstructive pulmonary disease), lung cancer, mood disorders, and neck and back problems. The diseases shown in the figure are responsible for approximately 70% of the total burden of disease. A disease burden is considered high if a disease is widely prevalent, long in duration, relatively severe or frequently fatal. Our projections suggest that coronary heart disease and diabetes will still be the conditions with the highest disease burdens in 2030.

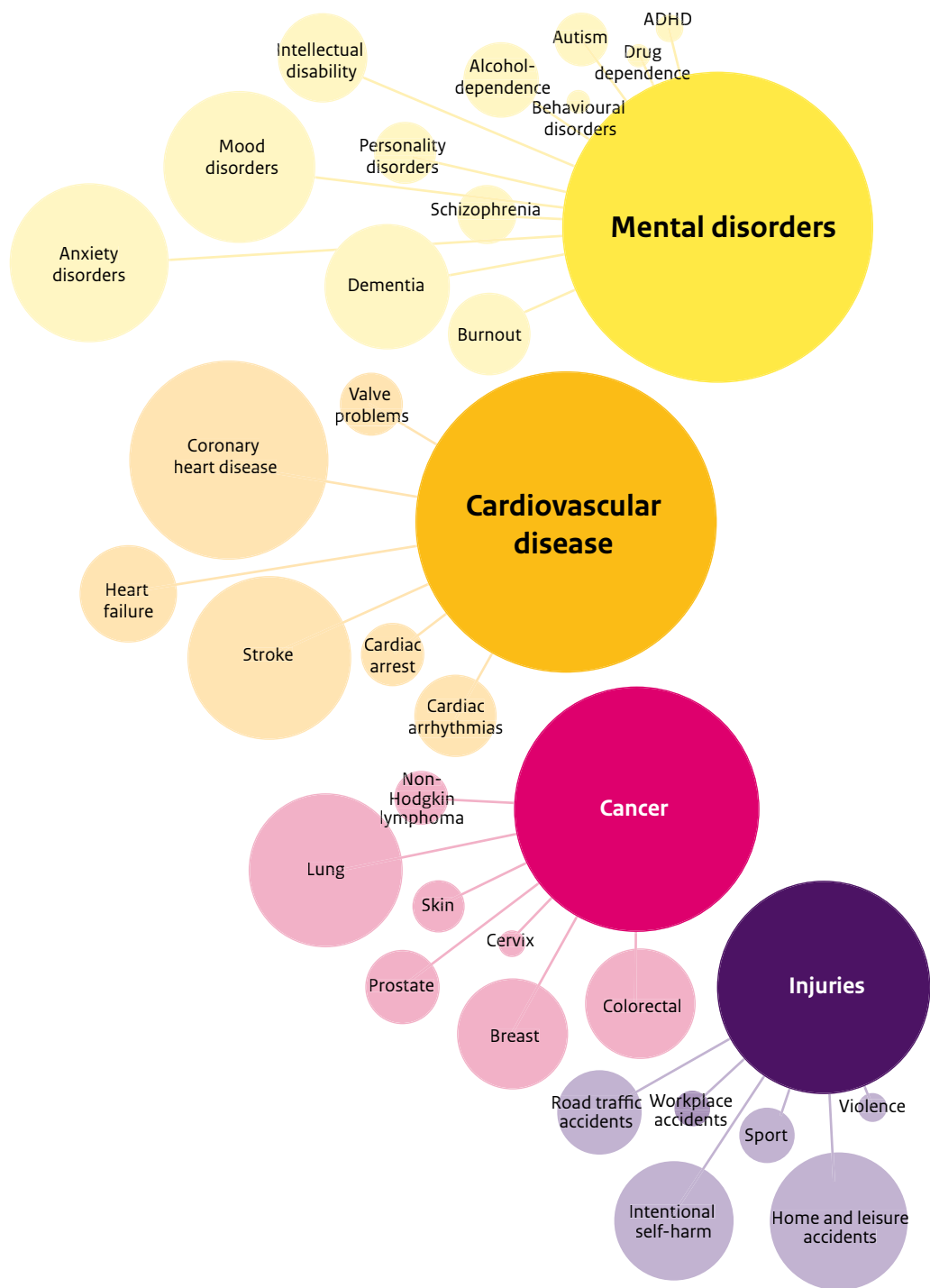
Chronic diseases, self-perceived health and activity limitations today...



... and in 2030

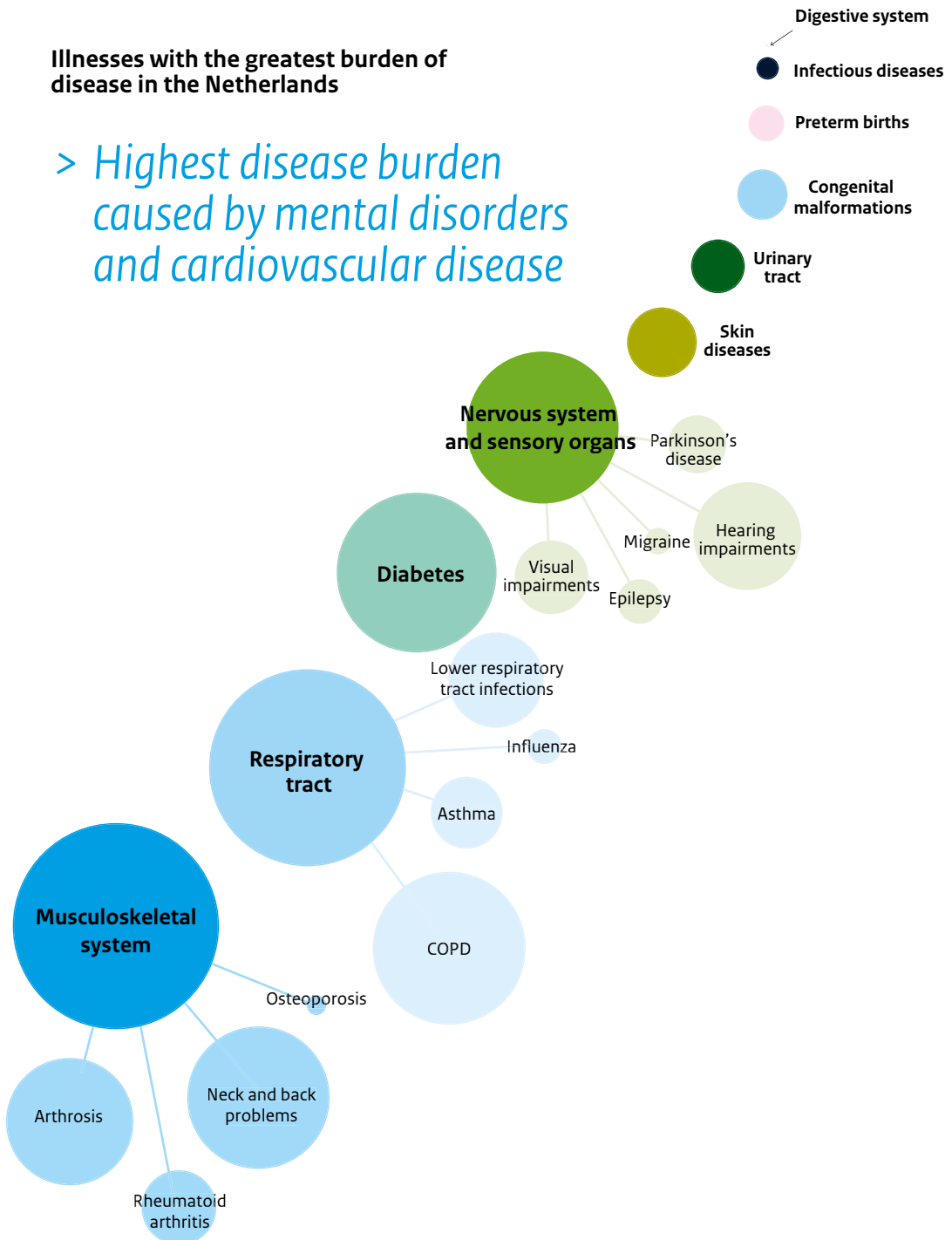
Continued increase in numbers with chronic diseases up to 2030





Illnesses with the greatest burden of disease in the Netherlands

> Highest disease burden caused by mental disorders and cardiovascular disease



Halt to unfavourable lifestyle trends

Smoking remains the major cause of death and illness by far (causing 13% of the disease burden). It is followed by overweight and little exercise (see figure). For many years now, the percentage of smokers has been declining. The percentage of Dutch male smokers is now slightly lower as compared to other EU countries, and the percentage of female smokers is about average. Extrapolating from past trends, we project that the Dutch rate of smoking will continue to decline in the future, from 23% in 2012 to 19% in 2030. People with low education have a 1.5 times higher rate of smoking than those with high education, a disparity that slightly widened from 1990 to 2012. For overweight and obesity, the persistently negative trend seems to have come to an end. Although the percentage of overweight people is not projected to further increase in our trend scenario, it will remain stubbornly high at 48%. One in three Dutch people get little exercise and that will still be the case in 2030. The percentage of heavy drinkers will remain at 10%, as in 2012. Developments in specific groups such as the lesser educated may be less favourable, and not all trends amongst the youth are favourable either. Although young people are now smoking and drinking less, the number drinking extremely high amounts remains unabatedly high. Dutch youth also drink more often than other European young people.

Contributions of various determinants to the total Dutch disease burden

Percentages not to be added together

Smoking:
heaviest
impact
on disease
burden

>

Smoking

Overweight

Little physical
exercise

Excessive
alcohol use

Too much
salt

13.1%
of total disease
burden is due
to smoking

5.2%

3.5%

2.8%

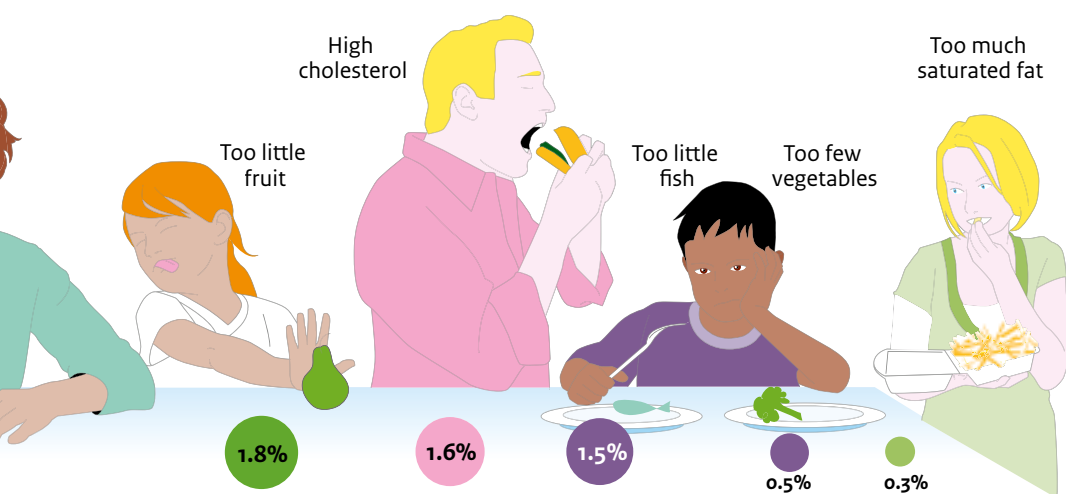
1.9%

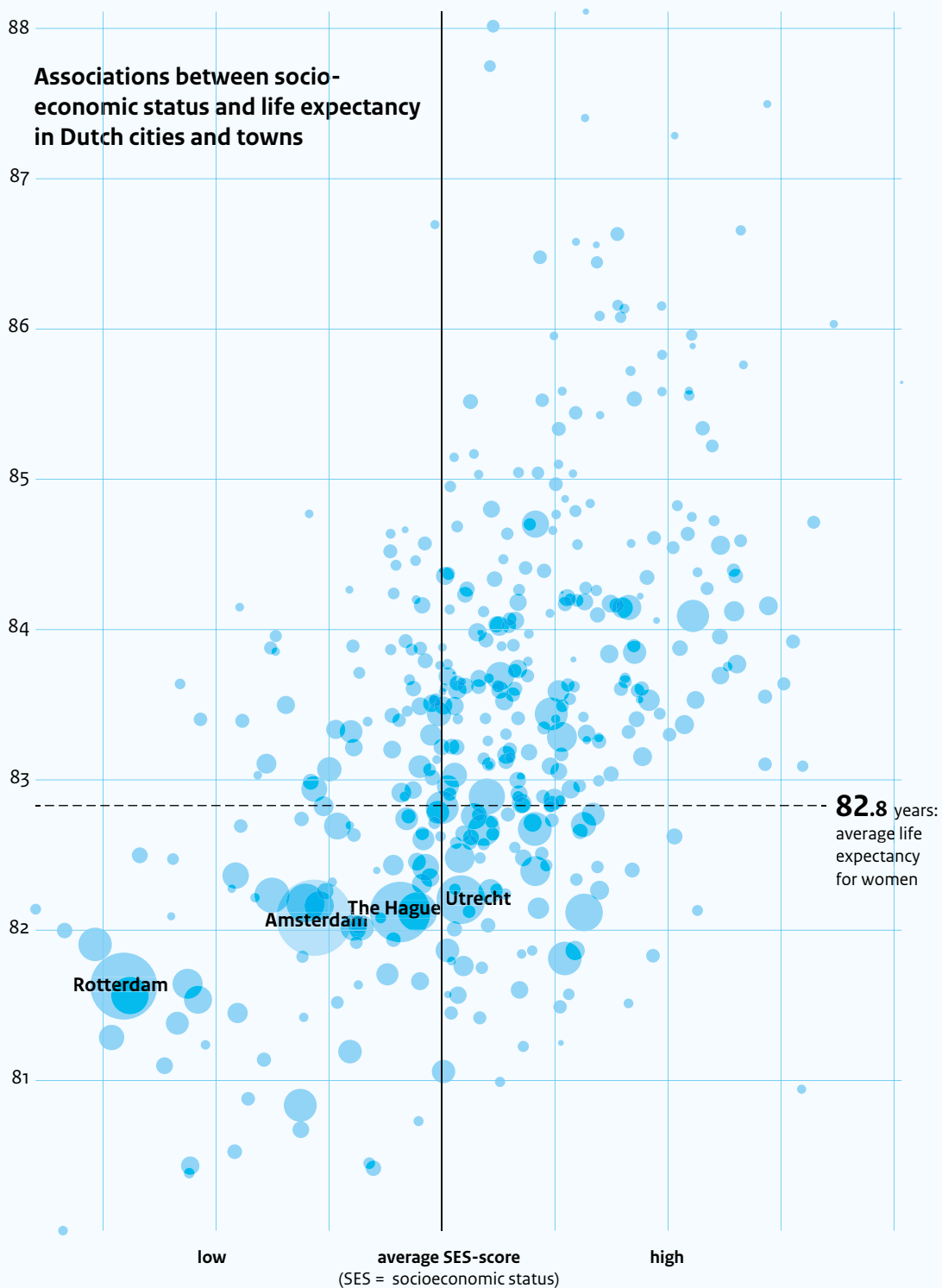
Unfavourable social or physical environments add to disease burden

Beyond lifestyle factors, the social and physical environments in which people live also contribute to the aetiology of diseases. Unfavourable working conditions and physical environment factors are two examples that can each be blamed for 5% to 6% of the burden of disease. Health protection measures have made the physical environment cleaner and safer; exposure to particulate matter has diminished, and we expect a further reduction in the years to come. This applies to a far lesser extent, though, to other environmental factors such as exposure to road traffic noise, ozone and radon. The most harmful working conditions derive from exposure to hazardous substances, psychosocial workload and physical strains on the job.

Environmental factors can also help to improve health

In recent years, spatial planning of physical environments has focused increasingly on health promotion. Efforts to make public spaces more conducive to cycling, sporting activities and outside play, and to create more greenery and outdoor areas where people can meet one another, have had positive impacts on both social cohesion and health. The use of such public venues may be encouraged explicitly, but the planning of the surroundings may also include 'nudges' to influence behaviour more subtly. Nudging 'propels' people in certain directions without financial incentives or prohibitions; an example can be seen in the layout and decor of staff canteens.





Vulnerable groups and social participation

Wide socioeconomic variations in health status

For people with low levels of education, life expectancy averages 6 years shorter than for people with high levels. In terms of life expectancy in good self-perceived health, the difference is 19 years. Differences in health status also exist between ethnic Dutch and ethnic minority populations. Health disparities show strong associations with work and income. And those social determinants are closely connected, for their part, with physical and social living conditions, lifestyle, access to health care and, by extension, with health status. In the comparisons we make here, the extremely vulnerable groups, including homeless people, asylum seekers and undocumented immigrants, have been left out of the analysis. There are approximately 27,000 homeless people in the Netherlands, an increase of 9,000 since 2009.

Large differences in life expectancy between various towns and regions

Differences in life expectancy are also apparent between different cities, towns and regions of the Netherlands. Residents of large cities, for example, have lower average life expectancies (see figure on page 16). Part of the variance is explained by socioeconomic status, but there are many other factors as well. In towns with declining populations, for instance, it is often the healthier people that are moving out.

> *City dwellers live shorter lives*

Possibly widening health inequalities in terms of education levels

Life expectancy amongst the lesser educated likewise sharply increased over the past decade, and the gap with respect to people with more education remained roughly stable. The same was observed in healthy life expectancy. For the near future, however, the gaps may possibly widen. Many effects of the recent economic recession, such as unemployment, are only just emerging, and the lesser educated and other vulnerable groups have been hardest hit. Whether and how that trend will continue into the longer term is uncertain.

Most adults with chronic disease are in paid employment

Over two thirds of people aged 20 to 65 with self-reported long-term illnesses work 12 or more hours per week. That is a lower rate of employment than for people without chronic illnesses, 80% of whom hold paid jobs. But the underemployment applies predominantly to those who report activity limitations in addition to their illness (of whom 40% are working) or who feel less healthy (of whom 49% are working; see figure on page 19). Two thirds of those aged 20 to 65 who have long-term illnesses report no activity limitations and rate their own health as good. In this group, the percentage in paid employment (77%) almost matches that in the group without chronic illness. It is therefore not so much the disease diagnosis that governs the rate of work participation, but the activity limitations and perceived state of health. A similar conclusion applies to people who participate in voluntary work.

Most people with chronic diseases have similar rates of employment to those without disease



Social participation usually promotes better health

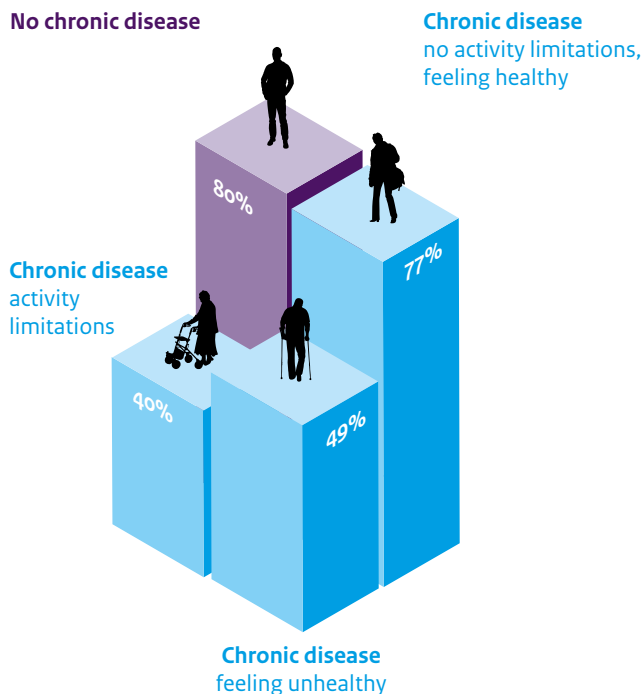
Social and community participation in the form of educational, work or voluntary activities is conducive to good health. Reductions in absenteeism and early school leaving result in higher average levels of education, which in turn lead to higher socioeconomic status and greater opportunities in future life – including a greater likelihood of good health. Participation in employment or voluntary work also generally has beneficial health effects, except when under exposure to unfavourable working conditions.

Informal care can have adverse health effects

Informal care is another form of social participation, but its effects on health are not always entirely positive. One in five older informal carers report that their health has deteriorated as a consequence of their care activities. That mainly applies to those who are providing intensive or complex care or who are caring for people with behavioural problems. A possible further complication is that increasing labour participation, particularly in the group aged 55 to 65, may heighten the pressure on many informal carers. And this comes at a time of generally growing societal pressure on people to do voluntary work and provide care to those around them.

Percentages of people aged 20 to 65 in paid employment

12 hours or more per week



Autonomy and freedom of choice

Changing meanings of health, increased emphasis on self-direction

The observed trends show that more and more people have chronic illnesses, but that many of them are living longer, are feeling healthy, do not experience activity limitations, and are taking part in the community. This means that the group of people with chronic diseases is highly diverse. At the same time, a debate is underway about a new conception of health. It would place less emphasis on people's illnesses or state of health as such, and would focus more on how individuals can learn to live with any health problems they may have. The ability to adapt and to manage one's own life may be more important to health than a medical diagnosis.

More freedom of choice and self-direction in health care and in communities

Local authorities are increasingly engaging community residents in shaping health policies. Individuals with health problems are also increasingly being engaged in managing their own care, often with the support of technological and e-health resources. For those individuals, that means more personally tailored care, more self-management and more self-direction; for health care providers it means allowing clients more latitude and adopting a more supporting role. The new Patients' Rights (Care Sector) Act gives patients, clients and their representatives a stronger voice. Simultaneously with this strengthening of the legal position of individuals, authorities are making more pressing appeals to them to practise self-reliance and arrange care within their own personal networks. Virtually all people express willingness to provide help to parents, friends or relatives on occasion. About half of the population are even willing to do so frequently. But the other side of the coin is that only a fraction of the population (25% in the over-65 age group) want to receive help from family members in their personal care.

Not all people are equally self-reliant

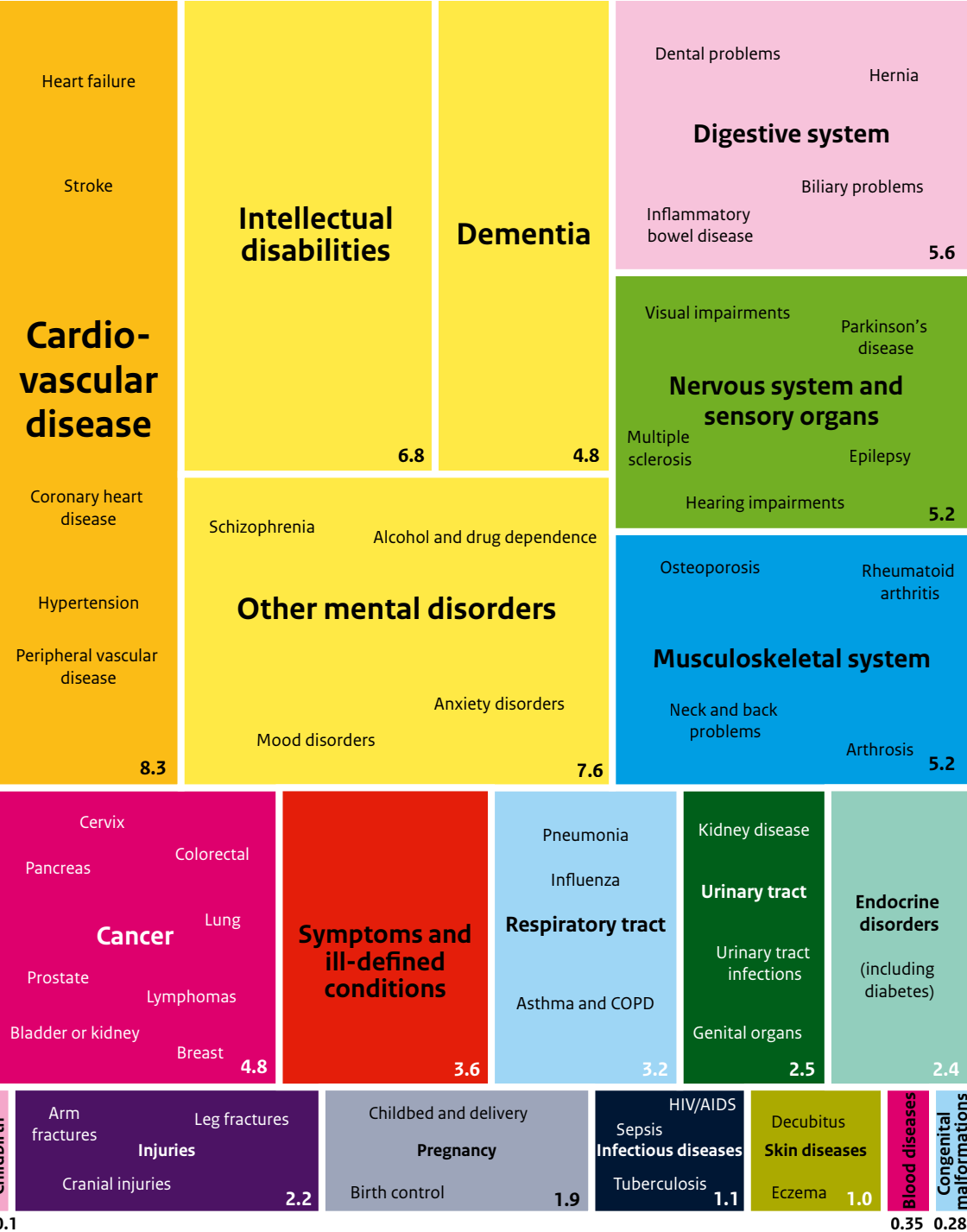
Self-direction and freedom of choice presuppose self-reliance on the part of individual people. Not all individuals, however, possess equal degrees of self-reliance. There are social groups, such as the lesser educated and the vulnerable elderly, that lack the potentials and capabilities to exercise self-direction. About 10% of the Dutch population are low-literate and 29% have limited health literacy. The latter percentage is the lowest in Europe. People with low health literacy do not have the skills to obtain, understand and evaluate information about good health or to apply it in making decisions that affect their health. Vulnerable people therefore need support that is tailored to their capabilities and preferences.

The future: expanding options for self-direction

Opportunities for self-direction are expected to increase across the board in the future, not only because technological and societal trends will continue, but also because the level and content of education will change, making future younger generations more capable of self-direction. Future generations of patients will therefore prefer and demand more shared decision-making. In recent years, health care training programmes have devoted increased attention to the need for patient input. In some sectors, this is already widely accepted, but in others it will require substantial transformations.

Health care expenditures by disease category in billions of euros in 2011

€ 67 billion
 
 € 13 billion
 About 16% of costs are not attributable to diseases



Health care expenditures

Highest expenditures for cardiovascular disease and mental illness

In the Netherlands, the largest sums are spent on the treatment and care of patients with cardiovascular disease, mental illnesses in the category Other Mental Disorders (which includes conditions such as schizophrenia, mood disorders and alcohol dependence; see figure on page 22) and intellectual disabilities. Relatively rapid increases in expenditure have occurred for cancer, diseases of the nervous system and sensory organs, and metabolic diseases. These are conditions that occur predominantly in older people, indicating a relatively strong effect of population ageing on future health expenditures. Moreover, these are categories for which new, relatively expensive medicines have become available in recent years.

Rise in health care expenditures from 9.5% to almost 14% of GDP

In 2012, Dutch health care expenditures came to 83 billion euros under the definition used in the analyses of CPB Netherlands Bureau for Economic Policy Analysis. That amounts to nearly 5,000 euros per capita. That is a similar level to those in France and Germany, but higher than in other EU countries. From 2000 to 2012, expenditures increased by 4% to 5% per year on average (at constant prices), although the increment over the most recent years was more moderate. Expressed as a percentage of the gross domestic product, health care expenditures grew from 9.5% to nearly 14% of GDP in the 2000–2012 period.

< *Highest costs were for the categories cardiovascular disease, other mental disorders and intellectual disabilities*

Expenditures continue to rise, but at an uncertain rate

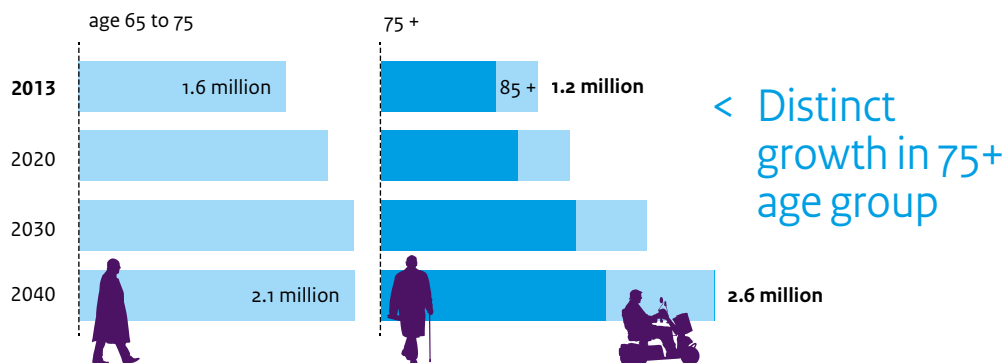
Were this trend to continue, the per capita health care expenditures in the Netherlands would reach around 8,500 euros per capita by 2030. That would come to 150 billion euros, or 19% of GDP. Recent policy measures in the curative care sector and the planned modifications to the organisation and funding of long-term care are intended in part to alter this upward spending trend. If the measures achieve the anticipated effects, then a substantial easing of the trend should be evident by 2018. The exact scale of the savings will become clearer in the years to come, and the effects the measures have on other public health challenges should also become more apparent.

Developments in the background

Older people to make up one quarter of the population by 2030

The developments in public health described above are influenced by other, broader trends. Demographic developments, for example, are among the most powerful forces driving public health trends. The Dutch population is to grow from 16.7 million in 2012 to 17.6 million by 2030. The population age structure, in particular, will alter substantially. The percentage of people aged 65 or older grew from 14% in 2000 to 16% in 2012, and it will increase to 24% in 2030, after which it should more or less stabilise at around 26%. Shifts are also expected within this older age group (see figure). There will be more and more people 75 or older, and the 80-year-olds of 2030 should be healthier than those of today.

Anticipated trends in the older Dutch population, 2013-2040



Educational and labour participation levels increase

The percentage of Dutch school leavers without basic qualifications has been cut in half. In 2012, 7.3% of the 15-to-25 age group were no longer in training and had attained no basic educational qualification. That was lower than the 15% in 2001. The expectation is that educational participation will continue to grow and that the numbers without qualifications will further decline. The average educational attainment level should rise further until 2020 and then stabilise. Rising average levels of education are associated with higher personal levels of health literacy, knowledge and opportunities. Not only educational participation, but also labour participation rates have increased, especially in older workforce segments. Especially the curtailment of early retirement options has pushed up the average retirement age from 61 in 2006 to 64 in 2012.

Economic recession appears over, but limited growth expected

Economic developments can take an erratic course. In the 1991–2000 period, Dutch economic growth averaged 3.2% per year, as compared to only 1.4% in the first decade of the current century. From 2008 to 2012 it came to a mere 0.1%. The aftermath of the economic recession is still discernible in indicators such as unemployment rates, but in early 2014 the economy appeared to be improving hesitantly. The open nature of the Dutch economy and its consequent dependency on an array of unpredictable external factors makes any longer-term projection highly uncertain. CPB expects an average growth rate of 1.25% for the coming 4 years. For the longer term, it projects an average GDP growth of 1.7% per year. If economic growth were to exceed the growth in health care expenditure, the percentage of GDP spent on health care would diminish.

Technology is entwined with everyday life and with care

Technology has nestled into daily life at a rapid pace. Computers have changed from desktops into laptops into tablets. More and more people are shopping online, sharing information via social media and working independently of location. Technological applications are also increasingly seen in prevention, treatment and care. Their benefits range from improved diagnostic skills to regenerative medicine to facilitation of independent living. Research on genetic profiles, for example, enables more targeted prescription of medicines; sensor technology enables instruments that monitor health status (quantified-self apps) and home automation devices. Technology also holds risks, and it raises ethical issues. Ethical dilemmas may arise in particular surrounding the beginning and the end of life.

Summary

Part A of the Key Findings reviews the most important trends in Dutch public health. Due in part to improvements in prevention and health care, Dutch life expectancy has increased by more than 3 years in the past decade. The disparity in life expectancy between people with low and high levels of education remained approximately 6 years. More than 5 million people are now living with a chronic disease. Cardiovascular disease, cancer and mental illness are responsible for the heaviest burdens of disease; smoking and overweight are major determining factors. The rate of smoking is decreasing, and trends in other lifestyle factors are no longer unfavourable. Many people with chronic diseases feel healthy, do not feel limited in their activities, and take part in the community. Increasing emphasis is now put on the ability to adapt and manage one's own life. Vulnerable social groups need support in doing so, and that support should be responsive to their capabilities and preferences. Dutch health care expenditures rose from 9.5% to nearly 14% of GDP in the 2000-2012 period.

For the future, we can project a number of long-term trends with a relative degree of certainty. By 2030, Dutch life expectancy will increase by a further 2 to 3 years. The number of people living with chronic illnesses will rise to 7 million. Other trends are expected to shift. Some negative trends in lifestyle factors have been mitigated in recent years, but it remains to be seen whether that will be sustained. The most uncertain of all trends is the future evolution of health care spending. It is not yet known what the longer-term effects will be of many of the planned or recently implemented policy measures.

On the basis of trend data alone, we cannot determine whether to attach more importance to the rising health expenditures or to the rising numbers of people with chronic diseases. That is highly dependent on societal values and norms: everyone sees it differently. And the issue is further complicated by the fact that measures designed to reverse one trend may have positive or negative effects on other trends. Part B will focus on these kinds of discussions.



Part B

Perspectives on the future

Part B explores the most desirable future for Dutch public health. There is no consensus on this issue. Which of the four societal challenges for public health is considered most essential depends on people's normative preferences. We shall now make this diversity of visions more explicit by distinguishing four perspectives on public health. Each perspective is centred on one of the four societal challenges for public health. Policy originating from one such perspective usually has consequences for the other challenges. Those consequences may be positive, but they may also be negative. Taking these anticipated 'side-effects' into consideration, we discuss the strategic opportunities and options for the future.

Four perspectives

The four societal challenges for public health constitute the starting point for part B of this report. These challenges were formulated during our discussion sessions with stakeholders. They are not new. Similar challenges can also be discerned in various policy papers and reports from recent years on health care and public health. They also figure prominently in societal debates about public health.

1. To keep people healthy as long as possible and cure illness promptly
2. To support vulnerable people and enable social participation
3. To promote individual autonomy and freedom of choice
4. To keep health care affordable.

Working with stakeholders, we formulated these societal challenges into four perspectives on public health. These are entitled *In the Best of Health*, *Everyone Participates*, *Taking Personal Control* and *Healthy Prosperity* (see pages 32-33). Each perspective centres on one of the four challenges; the others are subordinated. A survey in the Dutch adult population by the research agency TNS NIPO has shown all four perspectives to be recognisable and sufficiently distinctive.

As can be seen on pages 32-33, notions such as 'health', 'prevention', 'health care' and 'quality of care' have different meanings in each perspective. In the *Best of Health* perspective, for example, 'health' is understood mainly as the absence of disease, whereas in the *Everyone Participates* perspective clinical diagnoses do not always matter, since social participation is the vital concern. The third perspective, *Taking Personal Control*, contains no universally valid conception of health; individual people determine that for themselves. In the fourth perspective, *Healthy Prosperity*, 'health' stands mainly for as little health care spending as possible.

In the Best of Health



Concerns and motivations

- > Long, healthy lives
- > Healthy lifestyles
- > Protection from health hazards
- > Effective prevention and care

Health

You're healthy if you do not have a disease; a healthy lifestyle is a healthy diet, sufficient exercise and not smoking.

Prevention and care

Care consists of prevention and curative treatment.

Definition of health care quality

Quality care means curing the ill and preventing premature death.

> Four perspectives on public health

Everyone Participates



Concerns and motivations

- > Protection and support for vulnerable people
- > No person excluded
- > Social participation by people with health problems
- > Prevention and care targeted at vulnerable groups

Health

You're well if you participate.

Prevention and care

Care extends beyond medical care and includes services for welfare, occupational health, mental health and rehabilitation.

Definition of health care quality

Quality care enables social participation, with a particular focus on the vulnerable.

Taking Personal Control



<i>Concerns and motivations</i>	<ul style="list-style-type: none"> > We know best what is good for us > The quality of our own lives is the prime concern > Government enables individual initiatives > Health care providers listen to us
<i>Health</i>	Health primarily means quality of life; individuals determine for themselves what that involves.
<i>Prevention and care</i>	Prevention and care are broad notions that may include alternative medicine and life coaching.
<i>Definition of health care quality</i>	Quality care ensures well-being, as determined by each individual.

Healthy Prosperity



<i>Concerns and motivations</i>	<ul style="list-style-type: none"> > Prosperity for both current and future generations > Government retains wherewithal for education and other public services > Insurance premiums stay affordable for individuals and employers > Cost-effective care for those who really need it
<i>Health</i>	You're healthy if you generate no costs for curative or long-term care.
<i>Prevention and care</i>	Collectively funded care is narrowed to essential services.
<i>Definition of health care quality</i>	Quality care is relevant and cost-effective, as determined by the health ministry and insurance companies.

Quality of care is important, as everyone will agree. However, the interpretations given to the notion of 'quality of care' are different in each perspective (see pages 32-33). In the Best of Health perspective, health care quality means that illnesses are cured and premature death is avoided, whilst under Everyone Participates the emphasis is on the effects of health care on social participation. In Taking Personal Control, each individual determines what good-quality care is, and in Healthy Prosperity good care is primarily cost-effective care for those who really need it.

The four perspectives make explicit the diversity in visions that exists on the notions of health and care. The perspectives could aid politicians, policymakers, local portfolio holders, health professionals and patient organisations in forging links between various stakeholders. Such links can develop only if each discussion partner is cognisant of the diversity of viewpoints and takes these into account.

For each of the perspectives, we have drawn up a future scenario in which the envisaged outcome can be achieved, with possible societal developments taken into consideration. The scenarios should be seen as ideal-typical visions of the future. They are hypothetical in the sense that none of the scenarios will become reality in isolation from the other challenges.

To identify potential interrelationships between the four public health perspectives, we organised four expert meetings to explore how engagement based on each particular perspective would affect the other three societal challenges. This approach was designed to clarify areas in which positive spin-offs could occur and productive links between perspectives could be created. It would also identify areas in which negative side-effects could arise and where political and other choices or more intensive efforts would be necessary.

The method we applied enabled us to follow the sometimes heated discussions from a distance. We expressly have not formulated a preference for any one perspective. We summarise the most important results below, supplementing the expert judgments with research findings when possible.

Opportunities and options



Promoting health and promoting participation are mutually reinforcing

When health and longevity are promoted from the Best of Health perspective, that results in fewer activity limitations for people with long-term illnesses – one of the concerns in the Everyone Participates perspective. Conversely, when from the latter perspective more effort goes into boosting educational and labour participation in vulnerable social groups, that could help lighten the overall burden of disease – one concern in the Best of Health perspective.

Work is an integral part of many people's lives. Paid employment provides a source of income, opens opportunities for personal development, engenders self-esteem and self-confidence, provides challenges, orientation and structure in life, and can also foster good health. In our theme report on health and social participation, we discussed a research study by the Erasmus Medical Centre in which unemployed people were referred to a reintegration centre. Within six months, resumptions of paid employment were associated with positive health effects, especially at the psychological level, as well as with fewer activity limitations and improved social functioning.

'Work is healthy and workplace health could be better' is a quote from the Dutch cabinet's policy paper *Alles Is Gezondheid* (Everything Is Health). One would think that the ministries of public health and social affairs would be pursuing a joint agenda on this issue in their respective policy domains. And this would presumably apply not only to national-level policymakers, but also to local ones, and even to cooperating health professionals like occupational physicians and general practitioners. Such does not happen automatically, however. It requires a culture shift for all concerned. When health is mentioned in the social affairs domain, that is primarily in the context of deleterious working conditions or the implementation of health promotion measures in the workplace. The fact that working per se usually has positive health effects often remains undiscussed. In the public health domain, on the other hand, the fact that treatment helps many people to resume work, or to continue working if they have long-term illnesses, tends to be overlooked.

Such observations can be broadened to include participation in educational or voluntary activities. Attending school daily, or coaching football every Saturday, has positive effects on most people's health. Here again, health and participation mutually reinforce each other. This does not necessarily apply, however, to the provision of informal care as a form of social participation. Although informal care can be a source of great fulfilment, it can also have adverse effects on health, particularly for people whose care activities are intense and protracted. It can then erode personal well-being and autonomy. More than other people, informal carers need to find an equilibrium between their work and their care activities. That must be a flexible equilibrium, too, as it depends on the highly fluctuating demands that are often made on informal carers.



Health and participation boost prosperity

As shown above, health and educational or work participation reinforce one another. In due course, improvements in health, education and labour productivity – key outcomes in the Best of Health and Everyone Participates perspectives – jointly foster greater affluence, an important outcome in the Healthy Prosperity perspective. That would make more financial resources available for health care.

Prevention work and health care are of vital benefit to individuals in society. They can live longer, work more and accrue higher pensions. If people bring their better health to bear by getting more education and working more, that leads to greater prosperity nationwide. In the coming years, the Dutch retirement age is to rise in tandem with life expectancy. That will also result in more labour participation by older members of the workforce and hence in more prosperity. To truly reap those gains from the additional labour power, we will require efforts by employers and employees to ensure sustainable employability, for example in occupations where work is physically demanding. The Dutch social affairs ministry has adopted a rather broad interpretation of sustainable employability in its policies: the aim is to keep people healthy, motivated and well trained at work. Job satisfaction and a sense of involvement are important factors.

The costs of health improvement are borne mainly by those who pay insurance premiums and social contributions as well as by health insurance companies, local authorities and the national health ministry. The benefits accrue mainly to people receiving treatment, to incapacity insurance providers and to employers. Such benefits may also be credited as returns from the work of the ministries of education and social affairs. To encourage those who pay the costs of health improvement to continue doing so in the interest of overall prosperity, it is important to articulate common objectives and make joint investments.



Better health, more participation, higher expenditures

If, on the basis of the Best of Health and Everyone Participates perspectives, more effort is put into improving health and participation and narrowing health disparities between groups, that may lead to higher health care spending. Conversely, if sustainability of expenditures is promoted under the Healthy Prosperity perspective, that could have negative effects on health, participation and health disparities.

This problem of choice may be broken down into two concrete questions. How can good-quality care be provided, with the inclusion of vulnerable groups, without triggering excessive growth in health care expenditures? And how can the growth in health care spending be curtailed without causing excessive negative effects on the health, health disparities and participation of socially vulnerable groups? When these questions are addressed in the literature, the discussions focus mainly on efficiency gains and cost-effectiveness. Endeavours in that direction are already being made at various levels of the Dutch health care system. One example involves experimentation with forms of population-based health care funding at several local trial sites. For the coming years we expect that cost-effectiveness will acquire an increasingly prominent place in the treatment guidelines of the health care disciplines.

We have seen in part A that many policy changes, designed in part to rein in expenditures, are now being introduced in both the curative and the long-term care sectors. To what extent such measures will succeed in curbing the upward trend in expenditures cannot yet be determined. The coming years should bring more clarity. It will also emerge what effects the measures have on public health, autonomy and the social participation of more vulnerable groups – developments that themselves warrant continued monitoring.

A promising method for making cost-effectiveness estimates of policy measures would be social cost-benefit analysis, as our theme report on that method has shown. It produces monetary estimates of potential health effects and labour effects of new measures. These can then be directly compared to anticipated changes in health care expenditures resulting from the same measures. Although the careful mapping of all potential costs, benefits and shifts in affluence between social groups that arise from policy measures cannot take the place of the political decision-making process, it can be very helpful in strategic discussions.



Improving population health by supporting vulnerable groups

If, on the basis of the Everyone Participates perspective, support and assistance were to be provided to vulnerable groups – such as people with physical or mental impairments or residents of deprived neighbourhoods – that could lighten the disease burden for the entire population, which is one concern in the Best of Health perspective.

One way to increase the average life expectancy would be to improve life expectancy in vulnerable groups. Concrete measures would be to target unhealthy factors that are more prevalent amongst the lower educated, such as smoking, obesity and less favourable housing and environmental conditions.

Currently there is considerable interest in interventions designed to target specific at-risk groups. These focus on both individuals and their surroundings and address multiple risk factors simultaneously. The accompanying broad, integrated initiatives are intended to prevent a range of chronic illnesses. Such activities might encourage policymakers to reflect on measures to improve public health that go beyond a focus on specific diseases.

The intended decentralisation of various health care functions in the Netherlands could be an incentive for local authorities and health insurance companies to collaborate to improve health conditions in deprived areas. Within the local policy arena, councils could

coordinate, or even integrate, policy measures under the Public Health Act, the Social Support Act, the Youth Act and the Participation Act. Studies of integrated neighbourhood approaches in disadvantaged areas have shown that measures to revitalise neighbourhoods also give rise to positive health effects.

Self-direction not always feasible for everyone

If more room is created for diversity and freedom of choice – concerns under the Taking Personal Control perspective – there will be some vulnerable groups that are insufficiently equipped to cope with it. That makes them unable to fully participate in society, a concern in the Everyone Participates perspective.

Self-direction and freedom of choice presuppose self-reliance on the part of the individual. Yet not all individuals are equally self-reliant, as emerged from our theme report on citizens and health. There are vulnerable groups in society that have fewer potentials and skills to exercise individual self-direction. That is true in particular of the lesser educated and the vulnerable elderly. There are vulnerable groups such as the homeless that will always need client-tailored support. Public-sector authorities will continue to be tasked with this function in the future, for instance via the Social Support Act.

The health care sector faces similar challenges. About 40% of patients are insufficiently capable of self-managing their chronic disease or arranging their own care. Older people, the lesser educated, single people and those with a poor general health status, emotional problems or physical disabilities are relatively less capable of self-direction. Many of them are vulnerable in multiple respects, such as having limited financial means or lacking social networks. This necessitates greater efforts on the part of health care providers.

Support for vulnerable groups fosters autonomy

If effort is made to enhance participation in vulnerable social groups on the basis of the Everyone Participates perspective, then that could promote well-being, autonomy and shared decision-making – concerns in the Taking Personal Control perspective.

It might seem a contradiction at first sight, but services for vulnerable people which have long been made out to be rather patronising in nature may ultimately foster more independent, autonomous individuals. Such initiatives are now underway in many



neighbourhoods and community centres. They have been developed in day-to-day practice and do not derive from existing, empirically tested interventions. Not much evidence has emerged yet that such initiatives indeed result in greater autonomy.

Theory development about the relationships between providing assistance and engendering autonomy is also still fragmentary. The notion of empowerment is often employed by patient organisations. There are researchers who highlight the Swedish civil society model, which concentrates on well-being. The capabilities approach, which derives from international development work theory, could serve as inspiration in this field as well. These and other ideas may contribute to a better understanding of the relationship between client guidance and autonomy.

At present there is virtually no consensus about what is precisely meant by ‘self-direction’ or ‘autonomy’, nor about how these might be measured. If autonomy and self-direction are to be defined as important outcomes of care, then consensus is needed soon to ensure effective outcome monitoring in the future.

Room for autonomy does not materialise by itself

Efforts from the Best of Health perspective to improve health and longevity could increase pressure on people to practise healthy living, thereby potentially resulting in less autonomy and shared decision-making – concerns in the Taking Personal Control perspective. Similar consequences could arise if freedom of choice in health care were to be constrained on the basis of the Healthy Prosperity perspective in an attempt to curb rising expenditures.

Many policy papers and reports advocate a stronger role for individual citizens. The role of individuals will not be strengthened, however, unless targeted efforts are made; autonomy and freedom of choice easily get relegated to the background when other concerns are at stake. If a long, healthy life is the highest goal, patients’ freedom of choice often gets seen as a problem. Or if equal rights are the highest goal, that often leads to complex regulation that defines entitlements so precisely that freedom of choice almost has to be in jeopardy. If controlling health care expenditures is the main goal, then many economists regard patient freedom of choice as a cost-push factor. They assume that the more leeway patients have in deciding what care they need, the costlier the care will become. It would be interesting to assess whether that effect indeed arises in all cases; there is some evidence that critically minded patients are better able to say ‘no’ to some of the services offered by health care providers.

More latitude for autonomous patients will require a structural change in health care culture, whereby not the package of services on offer, but the preferences and expectations of the patients become the frame of reference. A consultation between a patient and a health care provider could clarify the personal and environmental factors that inform those preferences. Together they would then consider the appropriate and feasible objectives and the ways to achieve them. The aim would not be to pull a ready-made intervention from the shelf, but to jointly devise a client-tailored solution. Whether this would also produce better health effects is a key question to investigate. Such research would also evaluate the effects such an approach has on health care spending, self-management, self-reliance, quality of life and client self-esteem.

Autonomous individuals expect health authorities and health care providers to devise different ways of organising and delivering treatment and care. A wide variety of local initiatives of this nature are currently in progress, some of them successful, others less so. Many more are expected to follow in the years to come. What effects these will have in terms of health, care, participation, and health care and prevention expenditures is yet unknown. Who will benefit the most, and who will experience less favourable effects?



Summary

No consensus exists on the most desirable future for Dutch public health. The answers depend on the normative preferences that people have about which societal challenges are most important. The four perspectives on public health that we have been exploring here have made that diversity in visions more explicit. This can be of help in strategic discussions that take place within and between various groups of stakeholders.

In part B we have highlighted a number of different opportunities for establishing links between various stakeholders and interests. One conclusion of our exploration has been that measures to address certain challenges may also lighten other challenges. Efforts to improve public health tend to stimulate social participation, thereby boosting societal prosperity. Fostering participation by vulnerable groups may lead to greater personal autonomy. Focusing explicitly on 'side-effects' like these helps to forge links between the various public health challenges. And in cases where certain challenges do not seem compatible, such a focus can clarify issues where choices or additional efforts need to be made, as when prevention measures clash with individual freedom of choice and autonomy.

Afterword

Since 1993, the Dutch Public Health Status and Foresight Reports (PHSF) have developed into the source par excellence for integrated knowledge about public health in the Netherlands. This sixth edition continues that tradition. This time around we have also organised stakeholder participation and consultation activities to address the major public debate topics of the moment. That process has by no means been completed with the publication of our 2014 edition. In fact, it is just beginning, and these are the initial results. Our ultimate goal is to see our analyses being put to use in a wide range of strategic discussions and determinations.

In some areas this is already happening. The Ministry of Health, Welfare and Sport, for instance, has employed our trend scenario in formulating long-term objectives for its National Prevention Programme (NPP). The four perspectives we have highlighted may also be of help in the further implementation and monitoring of the NPP objectives. The Netherlands Organisation for Health Research and Development (ZonMw) has given our four highlighted challenges a central place in its new Fifth Disease Prevention and Health Promotion Programme.

We have directed explicit attention to local policymakers as well. To familiarise them with the PHSF-2014, we developed a serious game that is playable at both national and local levels. It is available in Dutch on our website www.eengezondernederland.nl. Several community health services have contacted us about employing this scenario method – which involves stakeholders, projections and perspectives – at the local level.

Interest has also been expressed from the health care sector, partly in response to a small series of articles about the PHSF-2014 in the medical journal *Nederlands Tijdschrift voor Geneeskunde*. We are currently consulting with a number of different organisations. We also invite other organisations to meet with us to determine how our method and results could be adapted for use in their discussion and decision-making processes.

The National Institute for Public Health and the Environment (RIVM) will be evaluating all these experiences in the coming months to gain knowledge that can be useful in designing the next PHSF. During that process we will continue to supplement and improve our arsenal of models and the quality of the required data.



Authors and advisory committees for the Dutch 2014 Public Health Status and Foresight Report

This summary of key findings has been extracted from the Dutch publication *Een Gezonder Nederland: De Volksgezondheid Toekomst Verkenning 2014*.

Authors of the PHSF-2014

N. Hoeymans (project leader), **A.J.M. van Loon** (project leader), **P.W. Achterberg**, **M. van den Berg**, **M.M. Harbers**, **F.R.J. den Hertog**, **H.B.M. Hilderink**, **G.J. Kommer**, **J.M. Melse**, **J.A.M. van Oers**, **M.H.D. in 't Panhuis** - **Plasmans**, **R.A.A. Vonk**, **C.G. Schoemaker** (project leader)

Project support staff and editors

A.M. van Bakel, **L.I. Hartman**, **N. Kupper**, **E.M. Slichter**

Scientific Advisory Committee

Dr R.V. Bijl	Netherlands Institute for Social Research (SCP)
Prof. J. Brug	VU University Amsterdam
Prof. A. Burdorf	Erasmus University Rotterdam
Prof. W.A. van Gool	Health Council of the Netherlands (GR)
Prof. T.E.D. van der Grinten	Erasmus University Rotterdam
Prof. P.P. Groenewegen	Netherlands Institute for Health Services Research
Prof. K. Horstman	Maastricht University
Prof. M.J. IJzerman	University of Twente
Prof. J.A. Knottnerus	Scientific Council for Government Policy (WRR)
Prof. D. Ruwaard, MD	Maastricht University
H. Smid, MSc	Netherlands Organisation for Health Research and Development (ZonMw)
Prof. J. Spijker	Radboud University Nijmegen
Prof. K. Stronks	University of Amsterdam
Prof. A.N. van der Zande (chair)	RIVM
Prof. J.A.M. van Oers	RIVM

Policy Advisory Group

Y.M. Boersma	Ministry of Education, Culture and Science (OCW)
A.M.P. van Bolhuis, MBA	National Institute for Public Health and the Environment
A. Derksen, MSc	Association of Netherlands Municipalities (VNG)
Prof. M.C.H. Donker (chair)	Ministry of Health, Welfare and Sport (VWS)
M.H. Floor, LL.M.	Ministry of Health, Welfare and Sport (VWS)
H.M.A. Geron, MSc	Ministry of Social Affairs and Employment (SZW)
L.J. van der Heiden, MSc	Ministry of Health, Welfare and Sport (VWS)
E.J. Hemke	Ministry of Economic Affairs (EZ)
Dr L.M. van Herten	Ministry of Health, Welfare and Sport (VWS)
M. Holling, MSc	Ministry of Health, Welfare and Sport (VWS)
M.J.M. van der Hoog, MD	Ministry of Health, Welfare and Sport (VWS)
J.C. Hulleman, MSc, secretary	Ministry of Health, Welfare and Sport (VWS)
Dr J.B.F. Hutten	Ministry of Health, Welfare and Sport (VWS)
M. Koorneef, MPH	Ministry of Health, Welfare and Sport (VWS)
L. Leliveld, MSc, secretary	Ministry of Health, Welfare and Sport (VWS)
G.C.C. Molenaar, MSc	Ministry of Health, Welfare and Sport (VWS)
Dr M.N. Pieters	National Institute for Public Health and the Environment
Dr H.A.J.M. Reinen	Ministry of Health, Welfare and Sport (VWS)
Dr P.G.J. Reulings	Health Care Inspectorate (IGZ)
Dr J.W.A. Ridder	Ministry of Education, Culture and Science (OCW)
E.C.S. van der Stegen, MSc	Ministry of Social Affairs and Employment (SZW)
J. Tanis	Ministry of Health, Welfare and Sport (VWS)
M. van der Voet	Ministry of Health, Welfare and Sport (VWS)

J.B. van den Wijngaard, MSc
A.J.M. Zengerink, MSc
M. van der Zouw

Ministry of Health, Welfare and Sport (VWS)
Ministry of Health, Welfare and Sport (VWS)
Ministry of Social Affairs and Employment (SZW)

Feedback Group National Institute for Public Health and the Environment (RIVM)

Dr M.J. van den Berg
A.M.P. van Bolhuis, MBA
X. Gravestein, MSc
Dr M.E.E. Kretzschmar
Prof. E. Lebrecht
Prof. J.A.M. van Oers (chair)
Dr M.N. Pieters
Prof. J.J. Polder
Prof. A.J. Schuit
Dr M.T.M. van Raaij
L. Stokx, MSc, MBA, MD
Dr M.A.B. van der Sande
Dr A. de Vries
N. Tamsma, MSc

Previous PHSF-2014 publications

Hoeymans N, Loon AJM van, Schoemaker CG (2011). Scoping report for the National Public Health Status and Forecast Report 2014. Bilthoven: RIVM Report 270241002/2011 (in Dutch).

Hoeymans N, Loon AJM van, Schoemaker CG (2012). Design of the National Public Health Status and Forecast Report 2014. Bilthoven: RIVM report 270241003/2012 (in Dutch).

Harbers MM, Hoeymans N. Health and social participation: Thematic report of the Public Health Status and Forecasts Report 2014. Bilthoven: RIVM Report 010003001/2013 (in Dutch).

Berg M van den (ed.), Post NAM, Hamberg-van Reenen HH, Baan CA, Schoemaker CG (ed.). Prevention in health care: Thematic report of the Public Health Status and Forecast Report 2014. Bilthoven: RIVM Rapport 010003002/2013 (in Dutch).

Hoeymans N, Gijzen R, Slobbe LCJ. 59 important health problems; A selection of diseases for public health monitoring. Ned Tijdschr Geneeskd. 2013;157:A5994 (in Dutch)

Hoeymans N, Kooiker S (ed.). Self. RIVM-SCP magazine on citizens and health. Bilthoven: RIVM, 2013.

Gils van, Schoemaker CG, Polder JJ. How much should a gained life-year cost? Study on the assessment of a QALY. Ned Tijdschr Geneeskd. 2013;157(52):A6507 (in Dutch).

Pomp M, Schoemaker CG, Polder JJ (2014). Towards social cost benefit analyses in prevention and health care: Thematic report of the Public Health Status and Forecast Report 2014. Bilthoven: RIVM Report 010003003/2014 (in Dutch).

Kooiker S, Hoeymans N (2014). Citizens and health: Thematic report of the Public Health Status and Forecast Report 2014. Bilthoven: RIVM Report 010003005/2014. (in Dutch)

Schoemaker CG, van Loon AJM, Hoeymans N. A trend scenario and four perspectives for 2040: the Dutch Public Health Status and Forecast 2014. Ned Tijdschr Geneeskd. 2014;158:A7477 (in Dutch).

Hoeymans N, Harbers MM, Hilderink HBM. Living longer, with more disease and less disability; trends in public health 2000-2030. Ned Tijdschr Geneeskd. 2014;158:A7819 (in Dutch).

Authors

N. Hoeymans | A.J.M. van Loon | M. van den Berg |
M.M. Harbers | H.B.M. Hilderink | J.A.M. van Oers |
C.G. Schoemaker

This summary of key findings has been extracted from the Dutch publication Een Gezonder Nederland: De Volksgezondheid Toekomst Verkenning 2014, our sixth exploratory study on the future of public health in the Netherlands. The study focuses on four societal challenges in the field of public health:

- To keep people healthy as long as possible and cure illness promptly
- To support vulnerable people and enable social participation
- To promote individual autonomy and freedom of choice
- To keep health care affordable.

Part A of this summary provides an up-to-date overview of the most important trends in Dutch public health. In part B we explore the future by reflecting on four perspectives on public health. Each perspective places its primary emphasis on one of the societal challenges. The report is one of the RIVM's contributions to Dutch public health policy. The Ministry of Health, Welfare and Sport makes use of the report in drawing up its national policy papers on public health. The information can also support other ministries, local authorities, health professionals, civil society organisations and individual citizens in their strategic discussions.

This is a publication by:

**National Institute for Public Health
and the Environment (RIVM)**

PO Box 1 | 3720 BA Bilthoven | Netherlands
www.rivm.nl

September 2014