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Summary

Learning from our neighbours

Cross-national inspiration for Dutch public health policies: smoking, alcohol, overweight, depression, health inequalities, youth, screening

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This summary contains the introduction, key messages and main findings of the report Learning from our neighbours. Parts of the introduction refer to the full report and not to the contents of this summary. The full report is available on <http://www.rivm.nl/bibliotheek/rapporten/270626001.pdf>

1 INTRODUCTION

1.1 Background

The last Dutch Public Health Status Forecast report 'Care for Health' (PHSF 2006) not only shows that the Dutch live longer on average and have more healthy years, but also that the Netherlands no longer ranks among the top countries in Europe as it had for many years. In a comparison of 37 indicators in the areas of health status, health determinants and prevention/care, the Netherlands emerges as a fair average among the EU-25 (De Hollander et al., 2006).

Another message from PHSF 2006 is that people with a low educational level have a shorter lifespan and more health problems than people with a high educational level. These undesired health differences have, moreover, not decreased in recent years. As in previous PHSFs, this report also states that better prevention in a number of areas would result in high health gains. The promotion of health and disease prevention can be used more effectively, in particular through a systematic, integrated and evidence-based approach.

Learning from our neighbours

The then Dutch Minister of Health, Welfare and Sport responded to this last report in the prevention memorandum 'Opting for a healthy life' and stated that the Netherlands must work its way back up to the top of the European list (VWS, 2006). This raises the question of where the opportunities lie for new or improved public health policy and for which areas good examples can be found in other countries. We also need to ask how the developments in the world around us (such as the further development of the European Union) will affect public health in the Netherlands.

This report was compiled at the request of the Ministry of Health, Welfare and Sport to gain more insight into the possibilities for improving health in the Netherlands, by looking at policies in other countries. Its main purpose is to gain inspiration, find out where we can learn from other countries and where there may still be unused chances for Dutch public health policy. It will enable us to take a fresh look at our own policies. This report is mainly looking for inspiration, opportunities and possibilities that can arise from an international orientation towards health policy. To obtain a good impression of the public health policies in other countries, the next section explains what is understood by public health and how we have to look at the policies in other countries (Section 1.2). Section 1.3 describes the scope and the method that was used. This general introduction to the report ends with a summary (Section 1.4) of the rest of the report, namely the seven thematic chapters that discuss smoking, alcohol, overweight, depression, health inequalities, youth and screening.

Text block 1.1: Definition of public health.

'Public health is the science and the art of preventing disease, prolonging life and promoting physical and mental health and efficiency through organised community efforts for the sanitation of the environment, the control of community infections, the education of the individual in principles of personal hygiene, the organization

of medical and nursing services for the early diagnosis and preventive treatment of disease, and the development of the social machinery which will ensure to every individual in the community a standard of living adequate for the maintenance of health'.

Source: Winslow, 1920

1.2 Public health policy: What is it and why look at other countries?

The definition, planning, formulation and implementation of public health policy can vary considerably between countries. In addition, different terms are regularly used in this policy area. Therefore, a few dimensions and approaches are briefly described below.

1.2.1 What is public health?

In the Netherlands, the terms 'public health', 'national health', 'basic health care', 'public health care' or 'collective prevention' are usually used interchangeably and all refer pretty much to the same thing. At the same time, the internationally used term 'public health' appears to have a number of interpretations. The literal Dutch translation of public health (PH), *publieke gezondheid*, has been in vogue for a few years – the Ministry of Health, Welfare and Sport have a Public Health Director - but this term, too, appears to have several meanings.

A well-known definition of public health is that of Winslow from 1920 (Text block 1.1). In addition to mentioning communicable disease, environmental management and disease prevention, it also mentions the political, socio-economic and educational dimensions of public health and health promotion.

The website of Postbus 51 states the following about public health: 'Different parties work together in health care: local authorities, GPs, hospitals, regional institutes for mental health care, home care services, the central government and the health care insurers. The objective of public health care is to protect and promote our health.'

This term 'public health care' is preferred by the Dutch Health Care Inspectorate (IGZ, 2005). The following tasks are also considered to be part of public health: the monitoring of Dutch public health (e.g. the Health Inequalities Monitor (*Monitor Gezondheidsachterstanden*)), the reports on the status of public health (e.g. RIVM's PHSF reports), health and care counselling (by, for example, the Health Council of the Netherlands and the Advisory Council on Health Research), the planning and evaluation of different public health activities (e.g. within the framework of the Netherlands Organisation for Health Research and Development (*ZonMw Preventieprogramma*)), and the necessary background research by, among others, universities. This organizational description of public health

overlaps with a more subject-specific subdivision of prevention in health protection, health promotion and disease prevention. This report mainly focuses on the last two.

In any case, the meaning of ‘public’ is usually: open to the public, provided by the state, and affecting the public. Other countries may interpret things differently or have different scopes, and of course differences in language also play a role. This report takes a pragmatic and educational approach that ensures that policy ‘with a strange name’ is ruled out from the start.

1.2.2 What is public health policy?

In the approach of a European consortium that recently studied PH interventions, public health policy refers to specific activities of public administration, whether at the national, regional or the local level, that are aimed at improving the health of specific groups of people (Banta et al., 2002). Public health policy can be operationalized through legislation, but also comprises other activities, such as decisions on the funding or certain care or prevention and the encouragement of media communication about health and disease. Sometimes, the definition of PH policy is limited to specific policy formulations, for example, the contents of national programmes or well-described priorities and activities in health or prevention memoranda.

In some countries, the national public health policy often has a specific content (spearheads, targets) that is published in well-documented and well-communicated national programmes. The programmes define commitments either for the full breadth of the public health policy or for a number of priority areas (cancer, mental health) for the government parties as well as for the various field parties. When a country’s national main memorandum contains several areas of focus, such as alcohol, tobacco, drugs or diabetes, the government can create a comprehensive policy document or programme for each of the sub areas. The core of the Dutch public health policy is outlined in the prevention memorandum of the Ministry of Health, Welfare and Sport, which generally follows the PHSF report that is published every four years. In the PHSF approach, policy is an integral part of the public health areas (Figure 1.1).

Although all of the countries clearly share a feeling of collective responsibility for public health, there are differences in the way public health policy is formulated and implemented. This has to do in part with the relationship between public health and the national health care system. In health care systems that follow the Beveridge model, care and prevention are funded by the government from tax money and usually form a more or less organizational entity. In health care systems that follow the Bismarck or Social Health Insurance (SHI) model, care funding is linked to an insurance system, but the activities related to public health are mainly financed from public funds. In these countries, which include the Netherlands, there is a relatively strong distinction between public health and health care (McKee et al., 2004; Allin et al., 2004; Drewes, 2005). This is why implementing prevention in health care can be particularly difficult in countries that follow the Bismarck model (De Hollander et al., 2006).

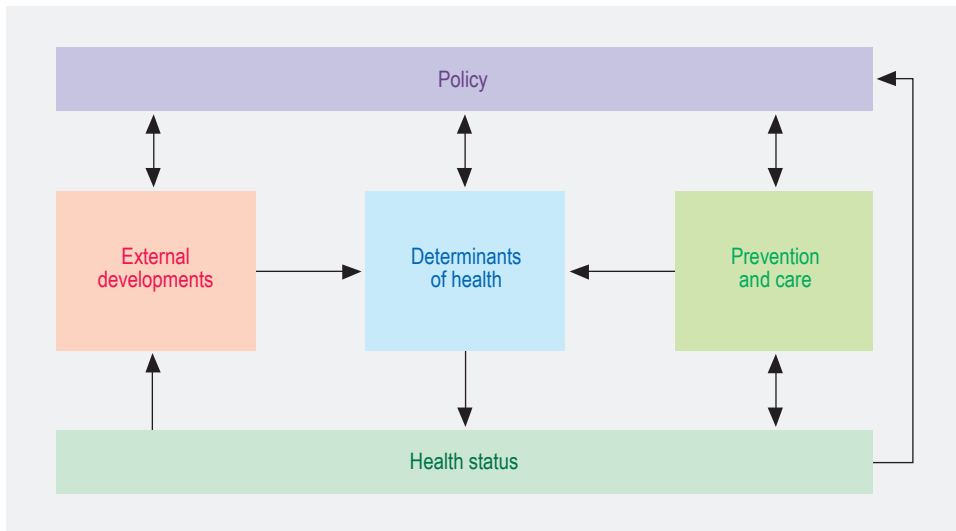


Figure 1.1: Conceptual model of the basic principles governing public health.

The level at which the formulation and the implementation of the public health policy is organized also differs between countries: public health policy is usually formulated and implemented at the national level, but sometimes also at the regional level. And last but not least, a country's political agenda also affects its public health policy: not only in terms of the level of government intervention, but also in terms of what the policy focuses on, for example, more on the healthy lifestyle of individual citizens or more on collective health differences. How these differences in public policy in other countries relate to the status of public health, the health determinants and whether there are more or less effective approaches, are important questions. More insight into this area could be important for Dutch policy.

1.2.3 Learning from our neighbours?

The main reason for collecting information in this report about the public health policies in other countries is to gain inspiration and learn from each other. After all, Western countries are all dealing with the same kinds of public health problems. As already mentioned, the countries do, of course, differ at a number of significant levels, such as the level at which policy is formulated and the process used for this, the organization and funding of policy implementation and the health care system. But other contexts can create other ideas and practices that can be used as examples for Dutch policy and its implementation. In fact, it is exactly those differences that prevent the innovative and successful policy of one country being implemented in the Netherlands without some adaptation. Knowledge of barriers encountered in other countries can actually help overcome or avoid obstacles in one's own country. One can also learn from the way in which policy is devised: as 'top-down' blueprint or 'bottom-up' from the field, incremental policy in small steps with adjustments when necessary, policy that consists of closely following developments, or even policy as a conscience decision to do nothing. Looking

at how other countries do things enables familiar frameworks to be expanded so that new ideas can be developed. Examining other countries can also refresh one's own view of one's current or future policy.

Consequently this report is not a systematic comparison of public health policy that can be used to judge the efficacy of the policy or parts thereof. Such a comparison would not only require consensus on a conceptual model for policy and policy comparison; the underlying question of causality is also extremely complex. If a country has a specific health problem that is bigger than in other countries, although extensive policy has been implemented in that area, one cannot immediately conclude that the policy is or was not effective. The policy might take a while to take effect or the problem may have become bigger without the policy. The information required to draw such conclusions is usually not available, for example, because clear policy objectives have not been formulated, or because the area concerned is not properly monitored. And when a country restricts policy to that which has been explicitly established at a specific moment, comparing public health policy using policy reports can result in the exclusion of previously started and successful activities. There is also a chance that only plans are compared rather than policy that has actually been implemented and can be evaluated.

The implementation and contents of public health policy are, as already mentioned, a political choice and hence also depend on the prevailing vision on health and responsibility, as well as on the priorities of other political objectives. The efficacy and cost of policy measures are also important considerations. All of these elements in a policy process can differ between countries, making it difficult to make international comparisons and assessments, and particularly difficult to draw conclusions on efficacy. But this does not have to get in the way of learning and being inspired.

1.3 Methods and procedures

1.3.1 Selecting the themes for the individual chapters

Public health policy covers a number of different topics, which is why choices had to be made for this report. The themes were selected according to a number of criteria, such as spearheads and policy priorities in the prevention memorandum and the meaning of the 'problem area' according to PHSF 2006. International developments that were potentially interesting for the Netherlands were also a criterion. The selected themes, which are interesting for Dutch public health policy in several ways, are:

- Smoking
- Alcohol
- Overweight
- Depression (in the broader sense of mental health)
- Health inequalities
- Youth
- Screening

These topics are divided into seven chapters – each of which can be read on its own – that were written by authors at the Centre for Public Health Forecasting and RIVM. Of course, extensive contact with and comments from people inside and outside RIVM were immensely useful. The policymakers concerned at the Ministry of Health, Welfare and Sport were consulted on the selection of the themes, as well as on the structure and the elaboration of the report. Each chapter was also subjected to an internal and external review process.

1.3.2 Selecting the countries

Each theme discusses the policy of a number of Western countries in Europe and the Anglo-Saxon language area. A country included in the description can have a historical or contemporary role model or pioneer function in a PH policy area. Another reason to focus on a specific country can be that it has a pattern of disease and mortality that is comparable to that of the Netherlands. The comparability with the Dutch PH system, its organization, its control or its funding can also be a reason to examine a country more closely. In some areas, for example, international comparison data has been used for quite some time for historical reasons. Here too, the availability of information also determines the choice for a country. Because this report focuses on accessible information that is usually in English, English-language countries or countries that often use English are somewhat over-represented (this applies, among others, to the Scandinavian countries; the Netherlands also translates, for example, the PHSF reports and the Dutch Health Care Performance Reports (DHCPR) into English). On the other hand, there may also be socio-economic or cultural reasons why these countries can be compared with the Netherlands.

1.3.3 Collecting information and references sources

Different methods were used to find information, namely:

- Literature research (among others on PubMed) whereby search terms were linked to the topics discussed in the report.
- The collection of policy documents and other documentation such as that already collected for other PHSF projects, such as the PHSF 2006 report (De Hollander et al., 2006), the EUPHIX project (www.euphix.org) and the National Public Health Compass (www.nationaalkompas.nl).
- The use of Internet search engines.
- The consultation of experts in subareas (internal and external) and of people involved in the development of content at the Ministry of Health, Welfare and Sport.
- The consultation of databases such as ‘Health for All’, ‘Nutrition Policy’ and ‘Tobacco Control’ of the WHO (www.who.dk) and the health database of the OECD (www.oecd.org).

Although the search was extensive, it cannot be guaranteed that all of the relevant literature was found. Because the problem areas can be very different, the corresponding thematic chapters also differ in the way they were created and in their contents. The

chapter on screening is based on discussions with a number of experts at RIVM, while other chapters are mainly based on literature research and the study of policy documents.

1.4 Outline of the full report

Each of the following chapters focuses on the subject that is the most relevant to public health and its current policy. Each chapter contains a number of common sections, such as the description of the problem area, the relevant international (EU) frameworks and the implementation of policy in the Netherlands and in so-called 'model countries'. Each chapter ends with a discussion of the findings from which the conclusions are also drawn. The lessons that can be learned by looking abroad are repeated in the key messages at the beginning of each chapter. An attempt to summarize each of the individual PH areas and their policies was made in the general key messages at the beginning of this report. Considering the diversity of the themes, the chapters are structured in such a way that they can be read on their own, meaning that repetitions cannot be entirely ruled out.

Chapters 2, 3 and 4 discuss different forms and effects of consumption and overconsumption, a central dimension of Western lifestyle (among others, Claassen, 2004), namely smoking, alcohol and overweight, which are also the three determinants of health (see Figure 1.1). From a policy perspective, tobacco (Chapter 2) and alcohol (Chapter 3) have a lot in common such as excise taxes and an age limit. An important difference between the two is that smoking is discouraged outright, whereas only excessive consumption is discouraged for alcohol. This also applies to the third problem area that Western countries are increasingly confronted with, namely overweight (Chapter 4); in contrast to alcohol, the international trends show the same patterns.

In addition to implementing (public) health by determinant, policy can, of course, also be directly aimed at existing diseases. Depression and the promotion of mental health are high on every country's policy agenda. This is why Chapter 5 describes the policies and the activities of other countries in this area.

Chapter 6 discusses the differences and inequalities in health as an approach to health that is 'contrary' to the previous approach. Health is obviously not equally distributed across the population; people with a lower socio-economic status and ethnic minorities have relatively poorer health and score less favourably on the key determinants of health. Other countries also have a lot of experience fighting health inequalities.

Chapter 7 focuses on youth. The target-group approach is also contrary to approaching public health problems by determinants or diseases. The trends in lifestyle factors do not indicate a favourable development of the health of the youth. This chapter describes which countries are trying to implement or are implementing a policy that will provide young people with the right knowledge and skills to grow up into healthy adults.

Chapter 8 follows yet another approach; it is dedicated to a means or a strategy, namely screening, meaning the detection of diseases and disorders at an early stage. This subject

is different from the previous subjects in a number of ways. But because both the technological and social developments in this area are taking place so quickly, it makes sense in this international exploratory report to look 'abroad' for initiatives and developments in this area, too.

KEY MESSAGES

Public health policy in other countries can be highly educative and inspiring

This report, 'Learning from the neighbours', describes how different countries design their public health policies and aims to inspire and educate. The 2006 Dutch Public Health Status and Forecasts Report (PHSF-2006) 'Care for health' concluded that the Netherlands no longer ranks among the top EU countries in the area of health. It also concluded that Dutch people with a low socio-economic status have a considerably shorter lifespan during which more years are spent in poor health. A large part of Dutch unhealthiness could be avoided by prevention at the individual and collective level. However, this requires a national public health policy. International comparisons can help us learn from others and find feasible objectives for national public health ambitions. PHSF-2006 also addressed public health policies in other countries and concluded that the Netherlands can learn from its neighbours, for example, in the areas of collaboration, research, policy evaluation and sustainable management in public health.

The seven chapters in this report – each of which can be read individually – describe several examples of public health policies in other countries. The report examines the policies on the lifestyle-related factors smoking, alcohol, obesity, and depression, which are all spearheads of the recent Dutch ministerial prevention memorandum 'Opting for a healthy life'. The report goes on to describe the policies of other countries in areas that are also important in the Netherlands, such as health inequalities and youth. And finally, the report discusses the policies that different countries apply in the constantly evolving area of screening. For each chapter the international context and policy frameworks are briefly described. The examples in this report of health policy in other countries may inspire the Ministry of Health, Welfare and Sport (VWS) and other parties to follow new paths and may also provide useful information on how these paths could be organized. Due to the many differences in how countries organize and finance their public health policy and health care systems, it may not always be possible to implement the examples given without some adaptation. Yet, together with the international frameworks, they may stimulate us to take a fresh look at our own public health policy. The key findings of this study are discussed below. Considering the diversity of subjects in this report and the emphasis on examples, each theme comes with a list of 'inspirations and observations'.

MAIN FINDINGS

Other countries are showing the Netherlands that more and better integrated health policies are needed and possible

Unhealthy behaviour, health inequalities and disease are not only characteristics of individuals, but are also determined to a large extent by the social and physical environment in which people are born, raised and live. This is why public health policy requires a thorough and integrated approach: a combination of instruments that are not only aimed at the individual, but that also take into account the complex relationship between the different areas both within and outside the public health arena. Such an integrated approach has proven to be effective in the Netherlands in the area of tobacco use and road safety and also has potential for alcohol abuse and obesity. Other countries have found more and better ways of applying integrated health policy to improve health, among other things by reducing (socio-economic) health inequalities.

- England and Sweden appear to be reaping the benefits of basing the systematic application of an integrated health policy for youth and health differences on a national strategy.
- An intersectoral approach to a healthy environment facilitates individual healthy behaviour (smoking, alcohol, obesity) and can also affect socio-economic health differences (SEHD) and the health of young people.
- The importance of an integrated health policy also applies to mental health: in Australia, which takes a holistic approach, intersectoral collaboration is carried out in the form of partnerships (housing, employment, education, welfare and justice) to promote an environment that has a positive influence on mental health (depression). In Scotland, on the other hand, the promotion of mental health is used to decrease SEHD (socio-economic health differences).
- The successful realisation of an integrated policy requires an understanding of how policies in other sectors affect health. Sweden, among other countries, uses health impact assessments as an instrument in its policy on health inequalities. Other countries have suggested appointing a senior public health official at each ministry.
- Equally, public health policy also affects (policies in) other sectors. An integrated health policy not only needs to examine the health gain of, for example, screening, but should also consider the economic, political and social effects, such as tension between economic demand stimulation, individual freedom of choice, collective supply restrictions and technological advance.
- Our public health policy is increasingly influenced by international factors, such as the development and implementation of jointly agreed EU guidelines, EU subsidies and EU research programmes, as well as market forces and market regulation (e.g. advertising and self-tests on the Internet). Integrated policy also means proactively and actively responding to this international dimension.

In contrast to the Netherlands, a number of other countries have a national vision and strategy for public health; this stimulates collaboration between ministries

A number of other countries have, more than the Netherlands, an explicit national vision on, among other things, health inequalities and youth. In its national strategy, a country clearly conveys what the policy objectives are, how they are to be achieved and what the different parties at the local, regional and national levels are expected to contribute. This enables policy to be created more systematically and with greater attention to other sectors. It also ensures that there is a long-term, broad political agreement on the policy that is applied to address health inequalities and that there is clear ownership and transparent control. A national vision prevents fragmentation and promotes collaboration between the ministries and with other government bodies and parties. The decentralization of policy and responsibilities may stimulate tailored policy. However, this also appears to create unwelcome regional differences.

- In contrast to the Netherlands, many countries have detailed national public health strategies, action plans and organizational management, as well as local collaboration and tailored implementation. This applies, among other things, to alcohol, obesity (e.g. the UK, Finland, Ireland), depression (Scotland, Finland), SEHD (England) and youth (Flanders, Sweden, England). These programmes often have a high degree of visibility and ownership at the different ministries.
- Clear ownership and transparent control and coordination can be achieved in different ways: one ministry for health policy and social affairs as this strengthens the relationship between social and public health policy (Sweden and Finland); one ministry for fitness (obesity - England); one central commission (various countries, for, among other things, alcohol policy); a central role of the national institute for public health (Sweden, this institute also supports the implementation, monitoring and evaluation of health policy). Another option is to appoint a senior public health official at each ministry, who share information and coordinate activities together.
- England and New Zealand (health inequalities) and Finland (depression) provide a few examples of the added value of a joint effort of many ministries implementing a common policy.
- Having a national vision appears to promote collaboration between different authorities and different social parties and prevent compartmentalization (smoking - Ireland, depression - Scotland, 'Healthy Schools' in England and Scotland).
- Decentralization enables health policy to be tailored, but also appears to result in discrepancies in quality and supply and less attention for innovation and evaluation (e.g. youth - Sweden).
- Flanders shows that a national vision on and strategy for public health or its subareas could also work in 'Bismarck' systems such as the Netherlands.

Policymaking for public health can conflict with other values and interests

Each policy sector focuses on a different interest. These interests can run in parallel to the public health interest, but they can also conflict with this. That can create conflicts within and between governments, between economic and public health policies, but

also between long-term and short-term objectives. The interests of the government, the market and the citizens can, for example, conflict in terms of how tobacco prices are regulated and how screening self-tests are offered. At the individual level there is a paradox between health as an important value and the choice for or the continuation of unhealthy behaviour. In short, the value of (public) health does not seem to have the same importance for everyone.

Integrated policy and collaboration in the form of platforms or partnerships can provide ways of dealing with conflicts between different interests and values, and of creating joint opportunities. The following list provides a number of examples of problems and conflicts that can occur and ways of dealing with these.

- Conflicts of interests arise between levels of government, between departments, between the market and the government and at the individual level: protection of economic profits, free market, and freedom of choice versus protection of health. For example, the EU discourages the use of tobacco but supported its cultivation, and a lot of people continue to behave unhealthily although they know better and are aware that their behaviour is in conflict with their own health interest.
- Market forces affect the way policy is formulated around the world, especially when it comes to lifestyle factors. The alcohol industry recently tried to prevent effective policy – as had previously the tobacco industry – by weakening proof of the negative effects of alcohol. On the other hand the big soft-drink producers in the United States voluntarily reduced the size of their portions.
- Integrated policy, partnerships and platforms can be seen as ways of dealing with conflicting interests. In Australia (depression), integrated policy and partnerships resulted in collaboration between the housing, employment, education, welfare, and justice sectors. In the EU, there are various platforms of which governments, industry and non-governmental organizations (NGOs) are members (Nutrition, Health and Physical Activity and Alcohol).
- The different values appear to be weighed, for example, in Sweden the privacy of young people is sometimes overruled by their health interests. Countries also differ strongly in the way they restrict an individual's freedom of choice to consume unhealthy products. Governmental supply restrictions may vary considerably (pricing measures, taxes, and advertising restrictions).
- The emphasis that is put on public health also depends on the sitting government, its political vision on the task of the government and on how the responsibilities for the task have been distributed. However, an emphasis on one's own choice for healthy behaviour and the government's emphasis on structure (employment, housing, and the environment) rather than being mutually exclusive can actually strengthen each other. In Sweden, the state is primarily responsible for structural changes, but they improve the living conditions, which makes healthy behaviour easier. On the other hand, English policy stimulates the local government, communities and people to collaborate to improve both the behaviour of people as well as their living conditions.

Integrated policy can be more effective: more scientific underpinning, better evaluation

There are more proven, effective policy measures for smoking, alcohol and depression than for health inequalities, youth health and the more recent problem of obesity. Yet, on occasion there appears to be a preference for policy measures for which health gains have not been demonstrated. The area of screening reveals that screening programmes can differ considerably, despite the existence of a scientifically underpinned agreement on the criteria that support the implementation of screening.

- Scientific studies and health policies in other countries clearly show that a lot of policies (including integrated health policy) can be more effective.
- In England and New Zealand, the first evaluations of their broad health inequality policies show that they are reaping the benefits of an integrated approach. And, like in Australia, an evidence-based approach helps to motivate more people to promote and maintain mental health.
- ‘Healthy Schools’ appear to be an effective example of an intersectoral, multi-factorial and positive approach towards youth health (England, Scotland). This approach is audited and accredited, and a knowledge base is being developed.
- At the same time, many countries, including the Netherlands, are not sufficiently monitoring and evaluating activities that are linked to concrete policy objectives. Monitoring and evaluation are, however, absolutely essential for conducting research into policy effectiveness.
- England and Sweden, which both have concrete indicators for integrated policy on youth and health inequalities, demonstrate that it is possible to monitor and evaluate integrated policies. In Australia, each state can use monitoring and evaluation to compare each other’s performance (depression).
- Although education and self-regulation are popular in policy circles, their effect on health is not always demonstrated. In several other countries, proven effective measures such as price regulation, supply restrictions and their control (smoking and alcohol) and lifestyle counselling (obesity) are used more stringently and cohesively. This also applies to a few Southern European countries that often do not promote themselves as strongly in the area of ‘public health’.
- Despite consensus about the ‘evidence’ and application of the same screening criteria, there are considerable differences between countries. For example, some countries offer colorectal cancer screening (Germany, Italy and England) and others such as the Netherlands, do not (yet). The number of diseases that are screened using the heel prick also varies a lot.

INSPIRATIONS AND OBSERVATIONS - DID YOU KNOW THAT...?

Smoking

- Throughout Europe, smoking continues to be a major and unnecessary cause of premature death, especially in groups with a low socio-economic status.
- From an international perspective, the Netherlands is behind on the decline in smoking, but that could change rapidly.
- The price of a packet of cigarettes is twice as high in some European countries (United Kingdom) as in the Netherlands. It is a well-known fact that increasing the price results in less smoking.
- The smoking ban in bars, restaurants and clubs in Italy has been (unexpectedly) positively received and has led to a decline in smoking prevalence. The smoking ban in pubs, restaurants and clubs has also been well received in Ireland and Norway.
- Compared with other countries, the Netherlands does not have a strict tobacco control policy.

Alcohol

- There are effective measures to reduce alcohol consumption among Dutch youths, such as decreasing the availability and increasing the prices.
- Germany, Switzerland, France and Denmark impose an additional tax on premixed drinks (Breezers).
- France has a special law ('Loi Evin') that heavily restricts the advertising of alcohol targeted at, for example, youths and children.
- Half of the EU countries ('wine countries') do not have a tax on wine, but a tax is sometimes imposed on beer or liquor.
- The alcohol sector recently tried to stop an authoritative book on effective alcohol policy (T. Babor et al. Alcohol: No Ordinary Commodity, 2003) being used as a reference for Dutch policy.
- It was concluded that the former alcohol policies for youths in Quebec, Finland and the United Kingdom were not effective.
- The Netherlands has a moderately restrictive alcohol policy that could be applied more strictly and given a more integrated approach.

Obesity

- Since 1980, obesity among children and adults in Western countries (including the Netherlands) has increased threefold.
- Many countries have developed numerous policies on obesity, but not one country has as yet reported any successes.
- A good policy on obesity can only be developed if the roles of the market, government and individuals are carefully balanced.
- Many countries are developing new policies on obesity that go further than the individual's own responsibility. The Netherlands can learn from this.

- Sometimes the market thwarts policy (in the US, for example, industry gave the Lithuanian government a dressing down for forbidding soft drinks in schools) and sometimes it creates opportunities (for example, 'Victory Camps' for obese children).
- Regulating the supply (subsidies/taxes) and marketing of obesogenic foodstuffs are policy instruments that are still rarely used.
- The prevention of and fight against obesity would benefit from a European approach.

Depression

- In contrast to international recommendations, the promotion of mental health is not part of the Netherlands' policy on the prevention of depression.
- In relation to international recommendations and three model countries, the Netherlands is behind on the implementation of an integrated health policy:
- Scotland stimulates health programmes at school and work that promote physical and mental health in a positive way. The schools include self-esteem and dealing with bullying in their programmes.
- Finland bases its national recommendations and municipal guidelines on a national project that stimulates the development of local policy on mental health.
- Australia has a holistic approach to mental health. Integrated health policy and the joint implementation of prevention programmes have become a matter of course. This is why the mental health care sector shows little fragmentation and compartmentalization.
- The current Dutch policy on the prevention of depression could be further elaborated into a nationally cohesive long-term policy framework.

Health inequalities

- Other countries show that an integrated approach to health inequalities is possible.
- The English Department of Health has a small Health Inequalities Unit that works interdepartmentally to achieve the objectives of the English action programme.
- Policy needs clear objectives as well as instruments to measure the achievement of these objectives on health inequalities.
- Swedish public health policy has broad objectives that include economic and social security, working conditions and a healthy and safe environment. This is why a large part of their implementation takes place outside of the health care sector.
- The Netherlands lacks a national strategy aimed at fighting health inequalities.

Youth

- The Dutch youth are predominately healthy, but appropriate preventive care is needed to ensure today's healthy youth remain healthy.
- In recent years, a number of countries have had a clearer national direction on preventive youth health care than the Netherlands.
- In the Netherlands (and Germany), few schools have a school health policy, while all schools in England and Scotland must become Healthy Schools soon.
- An integrated approach, with attention for mental health, healthy food and physical activity has proven an effective way of promoting health at school.

- Other countries have interesting variations of the Dutch Youth and Family centres: 'Sure Start Children's Centre' and 'Children's Trust' (England), Integrated Youth Services Child & Family, and Centres for Pupils Counselling (Flanders), and the 'Socialtjänst' and 'Family Welfare Centres' in Sweden.
- Other countries put a strong emphasis on a positive approach (England, Sweden and Flanders) and on an integrated and intersectoral approach in their youth policy.

Screening

- Despite the broad international application of the Wilson and Jungner criteria for screening, there can be considerable differences in the countries' screening programmes.
- Breast cancer screening starts in Japan, Sweden, the United States and Iceland at age 40 and in Hungary at age 45, although a favourable effect of screening up to the age of 50 has not yet been shown.
- The number of smear tests for cervical cancer taken during a patient's life also varies strongly between the countries: from seven in Finland, Lithuania and the Netherlands to more than fifty in Luxemburg and Germany.
- Very few women are aware of the relationship between cervical cancer and the Human Papilloma Virus (revealed by studies in the United Kingdom and the United States) and hence have difficulty choosing for or against HPV screening.
- In Western countries, neonatal screening practices sometimes differ strongly in terms of the number of diseases screened, counselling and the freedom of participation.
- In Europe, the Netherlands is leading with the extended heel prick.
- After a long period of cautious policy in the Netherlands, since 2007 all pregnant women must be informed about the possibilities of prenatal screening.
- Few European countries have a policy on chlamydia screening; the Netherlands and England are running pilots.
- The Netherlands is facing the challenge of carefully weighing the pros and cons of screening, while making sufficient use of new technology.

2 SMOKING

Eveline van der Wilk

Smoking has not decreased in the Netherlands as much as it has in other countries; however, short-term progress is possible

After a significant decrease from 2002 to 2004, further reduction in the prevalence of smoking in the Netherlands failed to occur. Various countries have demonstrated that a substantial decrease in the prevalence of smoking in the Netherlands, for example, from 28 per cent (2005) to approximately 20 per cent, could be achieved within a few years.

In contrast to some other countries, the Netherlands has no strict tobacco discouragement policy

There are a number of effective policies available that various countries have already implemented:

- Smoke-free hospitality industry, such as in Ireland, Italy and Norway, among other countries
- Better use of excise tax, such as in the United Kingdom, Ireland and France, where the prices for tobacco are considerably higher than in the Netherlands
- Expanding the availability of assistance to stop smoking
- A substantial budget increase for tobacco discouragement, for example, by financing it with the revenues from tobacco excise tax ('dedicated tax')



Measures against smoking in the Netherlands and other European countries can contribute to a considerable reduction of undesirable health differences

Price increases for cigarettes and rolling tobacco, along with a general 'no smoking' rule that includes the hospitality industry, will have a greater health impact on low socio-economic groups than on high socio-economic groups, which would contribute to the reduction of health inequalities.

3 ALCOHOL

Peter Achterberg

Effective measures can be taken to downregulate the supply of alcohol, i.e. by decreasing its availability and increasing the price, in order to reduce alcohol consumption in young people in the Netherlands

In recent years, the youth in the Netherlands and in Europe have tended to drink too much and at much too young an age. With unchanged policy, this leads to a negative impact on health and high social and societal costs. The ineffectiveness of current policies has led to the need for prompt, effective action. International research repeatedly refers to the effectiveness of available measures in the supply area.

The Netherlands has a moderately strict alcohol policy that could be refined and provided with a more integrated approach

There are still effective policies possible that have already been implemented in other countries which reduce the harm caused by alcohol consumption; we mention: excise tax increase, advertisement restrictions and more strictly enforcing existing regulations. An integrated and intersectoral approach with more attention for research, policy evaluation and monitoring seems to be advised.



Alcohol policy in the Netherlands would benefit if the Netherlands would follow EU policies with relevance for alcohol more proactively

As new EU policy in different policy areas may influence national alcohol policy both positively as well as negatively, a proactive attitude from the Netherlands is necessary in the European Union; especially with respect to policies in the areas of agriculture, market regulations, public health including social affairs.

4 OVERWEIGHT

Eveline van der Wilk and Peter Achterberg

In all Western countries, overweight poses an ever-increasing and serious public health problem for which little effective policy has been developed to date

The Netherlands shares the serious and increasing problem of overweight with many other countries. Most countries recognize that some people are particularly at risk, such as youth and certain disadvantaged groups, and that they will inevitably develop negative health effects in the long run which will lead to a substantial increase in health costs. It has also been acknowledged that hardly any long-term effective measures are available.

Many countries are currently working on new policies for overweight that go one step further than making individuals responsible for their own health. This provides an opportunity to share experience and learn from other countries

Many countries are looking for and experimenting with new policies and interventions regarding diet and exercise that focus not only on an individual's personal responsibility but also take local settings and other issues such as socio-cultural, economic and market-related preconditions into account. This provides many opportunities to learn from other countries but also requires policies on overweight and obesity from other countries to be actively followed.



The control and prevention of overweight will benefit if is tackled from a European Union perspective

Due to the strong international market influence and the regulatory power of the European Union, health policies related to food and nutrition that can help to counteract overweight should be developed at the level of the European Union. This requires good collaboration between the countries involved as well as a proactive attitude on the part of the Netherlands.

5 DEPRESSION

Susan Meijer, Jantine Schuit and Nicoline Tamsma

In contrast to international recommendations, the promotion of mental health is not a component of Dutch policies on the prevention of depression

Policies that promote mental health could be a valuable supplement to the current policies aimed at the prevention of depression. A positive approach emphasizes the importance of activities that enhance people's capacity and reduce the risk factors for depression. Moreover, this approach contributes to the increasing realization that mental health is a significant condition for a healthy society. Scotland, Finland and Australia could be sources of inspiration for this.

The Netherlands lags behind in executing an integrated health policy in comparison to international recommendations and the three model countries of Scotland, Finland and Australia

Dutch policies on prevention of depression so far have been aimed at individual risk factors, such as depression symptoms. However, the risk for depression can also be reduced by assuring healthy living conditions, such as a healthy and safe home environment, proper social conditions, proper social relationships and a good education for the entire population. The national government also has a chance to reduce such environmental risk factors by including them in its policy on preventing depression. This is correlated with measures to reduce socio-economic health inequalities.



The current Dutch policy on the prevention of depression could be further specified in a nationally cohesive long-term policy framework

Such a policy framework that is further specified provides municipalities support by formulating and executing a cohesive long-term policy on preventing depression. It could give impulse for local councils to continue to invest in mental health and the prevention of depression. At the same time, it provides guidelines for a cohesive intervention option based on a national vision of behaviours. Moreover, indicators can be established that are suitable for evaluating the objectives of a policy on the prevention of depression.

6 HEALTH INEQUALITIES

Carola Schrijvers and Lea den Broeder

Other countries demonstrate that an integrated approach to health inequalities is possible

A number of factors influence the rise and continuance of health inequalities. This is why the policy to tackle them must be as broad as possible and carried out by every policy sector, as is done, for example, in England, Sweden and New Zealand. In England, the departments work together to tackle health inequalities. In Sweden, the integrated approach is aimed at a broad range of health determinants, which are mainly influenced by factors that are outside of the health sector. New Zealand has a broad inequalities policy that encompasses all of the departments; tackling health inequalities is part of this policy.

Policy needs clear targets and instruments to measure their achievement

In the Netherlands, reducing the gap in healthy life expectancy between socioeconomic groups has been the only policy target for health inequalities since 2001. The health inequalities monitor does not yet contain any information about this target primarily because of the lack of information on mortality differences by socio-economic status.

The addition of these data to the monitor is planned for this year. The monitor does contain data on trends in the extent of education differences in health, lifestyle, prevention and the use of care, but no policy objectives have been formulated for these data. The progress of policy (who does what to tackle health inequalities) is not monitored in the Netherlands. England can be used as a model country because it extensively monitors the progress and results of its policies.



The Netherlands does not have a national strategy aimed at tackling health inequalities

In its national strategy, a country clearly conveys what the objectives are in the area of health inequalities, how they are to be achieved and what the different parties at the local, regional and national levels are expected to contribute. Such a strategy prevents fragmentation but is lacking in the Netherlands. We can learn how to create a national strategy as framework for a local approach from England, Sweden and New Zealand.

7 YOUTH

Maartje Harbers

The Dutch youth is predominantly healthy, but appropriate preventive care is needed to keep today's youth healthy in the future

Even though the Dutch youth is still predominantly healthy, they and their European peers, are investing in poor health at a later age. In addition, a substantial part of the disease burden among young people is caused by psychosocial problems. This is why integrated (preventive) care is needed for children with health or psychosocial problems.

In recent years, a number of countries have had a clearer national direction on preventive youth (health) care than the Netherlands

Like the Netherlands, England, Belgium (Flanders) and Sweden have carried out a number of initiatives to improve collaboration in the area of youth policy and prevent fragmentation. Local governments and services play a major role in the strengthening of general and preventive youth tasks. In the aforementioned countries the national governments have defined stronger legal frameworks for local activities than in the Netherlands. This is an area in which they can be interesting examples. The Dutch national government should at least impose minimum requirements for what councils should be responsible for at the local level.



Other countries also put a strong emphasis on a positive approach and on an integrated and intersectoral approach to their youth policy

In recent years, 'Operation Young' (Operatie Jong) has enabled the Netherlands to give a strong impetus to child and youth care for young people with problems. A number of other Western countries are also focusing on a broad and positive vision on youth policy with the aim of helping all young people develop as best as possible. Moreover, this positive starting point also creates an integrated and intersectoral approach to improve the health and well-being of young people.

8 SCREENING

Katia Witte, Matthijs van den Berg and Ingeborg Bovendeur

The international Wilson & Jungner criteria are applied by most countries but can be interpreted in many different ways

Most countries have indicated that they use the Wilson & Jungner criteria for determining whether or not a screening programme should take place. In spite of this, there are international differences on the diseases that are screened, how the screening is organized and what information is given to relevant parties. These differences caused by differences in the interpretation of the criteria. Screening policies are also influenced by a combination of public opinion, both national and international, political and commercial interests, the public health problems in a particular country and the way in which the health care systems are organized.

The Netherlands pays careful consideration to the advantages and disadvantages of each screening programme

Compared to many other countries, the Netherlands carefully considers the advantages and disadvantages of screening tests before they are implemented. In many other countries, the decision to perform screening, apply new techniques or expand current screening programmes is made faster. The Netherlands faces the challenge of continuing with its



policy of carefully weighing up the advantages and disadvantages of screening tests whilst at the same time making full use of the advantages that new technology offers.

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Learning from our neighbours

Cross-national inspiration for Dutch public health policies: smoking, alcohol, overweight, depression, health inequalities, youth, screening.

Developments in other countries' public health policies can be relevant for national policy making because they announce trends, unveil new visions or contain interesting examples and learning moments. What are new priorities and why? What were the success factors? Where did things go wrong? Which laws and regulations were implemented? Which organization forms were implemented? Is the implemented policy really working? It is therefore important that the Dutch Ministry of Health, Welfare and Sport is aware of the health policies in other countries.

Insight into the discussions on national health issues that the international community is having is also useful when preparing one's own policy. Organizations such as the World Health Organization (WHO), the World Bank, the Council of Europe and the European Union (EU) can play a supporting or even leading role in policy renewal by holding up mirrors and by providing policy frameworks and evidence.

Cross-national comparison of public health policies implies shooting at a moving target as countries change, improve and rearrange these policies all the time. The original Dutch report was compiled in 2007 and in the meantime new policies may have been developed or even implemented in the Netherlands as well as in other countries. The comparison is however still worthwhile. It enables both an insight into how policies come into existence and can serve as an inspiration for other countries.

This summary contains the introduction, key messages and main findings of the translated report *Learning from our neighbours* (in Dutch: *Leren van de burenen*).

The full translation of *Learning from our neighbours* is available on:

<http://www.rivm.nl/bibliotheek/rapporten/270626001.pdf>

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