

# Health on Course?

## *Key Messages from the 2002 Dutch Public Health Status and Forecasts Report*

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A publication by  
The National Institute for Public Health and the Environment  
PO Box 1  
3720 BA Bilthoven,  
The Netherlands

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RIVM report number: 270551003

## KEY MESSAGES

This brochure presents the key messages of the Dutch 2002 PHSF report (Health on Course?). The *Health on Course?* report presents new data and insights about public health, care and prevention in the Netherlands. It simultaneously examines the past, present and future, and draws comparisons both at home and abroad. These insights may support the Ministry of Health, Welfare and Sport in the development of a medium and long-term vision for health and care. This information is also important for other players in the Netherlands: the public health inspectorate, local government councils, other ministries, patients and consumers, prevention and healthcare providers, health insurers, and health research and research programming organizations. Here we present the major findings and dilemmas, along with their significance for the parties involved.

### Major findings

#### ***We in the Netherlands are living and staying healthy for longer***

Since 1980, male life expectancy has increased by 3.1 years while female life expectancy has grown by 1.4 years. From birth, we can now expect an average life span of, respectively, 75.5 and 80.6 years. The years that have been added over the last decade are generally spent in good health. Statistics Netherlands predicts that life expectancy will increase even more over the next 20 years.

- This increase is mainly due to fewer deaths from *coronary heart disease and stroke*. In addition, fewer men are *dying of lung cancer*.
- The major cause of death is still *coronary heart disease*. Along with *mental ill health and chronic lung diseases*, this disorder also causes the greatest loss of quality of life.
- Around the year 2000, both men and women experienced roughly the same number of healthy years: 61 years are spent in self perceived good health, more than 70 without disabilities, and 68 in good mental health. Consequently, the number of subsequent unhealthy years is considerably higher for women than for men.
- Considering that neither the *incidence* nor the *duration* of chronic disorders has decreased, certain healthcare provisions, such as medical devices and pharmaceuticals, seem to have effectively improved the social participation of the chronically ill.

#### ***Yet the Netherlands drops toward the European average***

However, the Netherlands is falling behind in the EU. Male *life expectancy is increasing less rapidly* than in most EU countries. The *increase in the life expectancy* of women is actually *stagnating* to such an extent that we are now below the EU average (*figure 1*).

- Male *mortality from lung cancer* is still one of the highest in the EU. Female mortality is increasing more rapidly than the European average. Ever more women are also dying from *chronic lung diseases* (COPD). Smoking is the main cause of both lung cancer and COPD.
- The Netherlands has comparatively high infant and perinatal mortality rates. This also applies to mortality from breast cancer, although this has recently fallen.

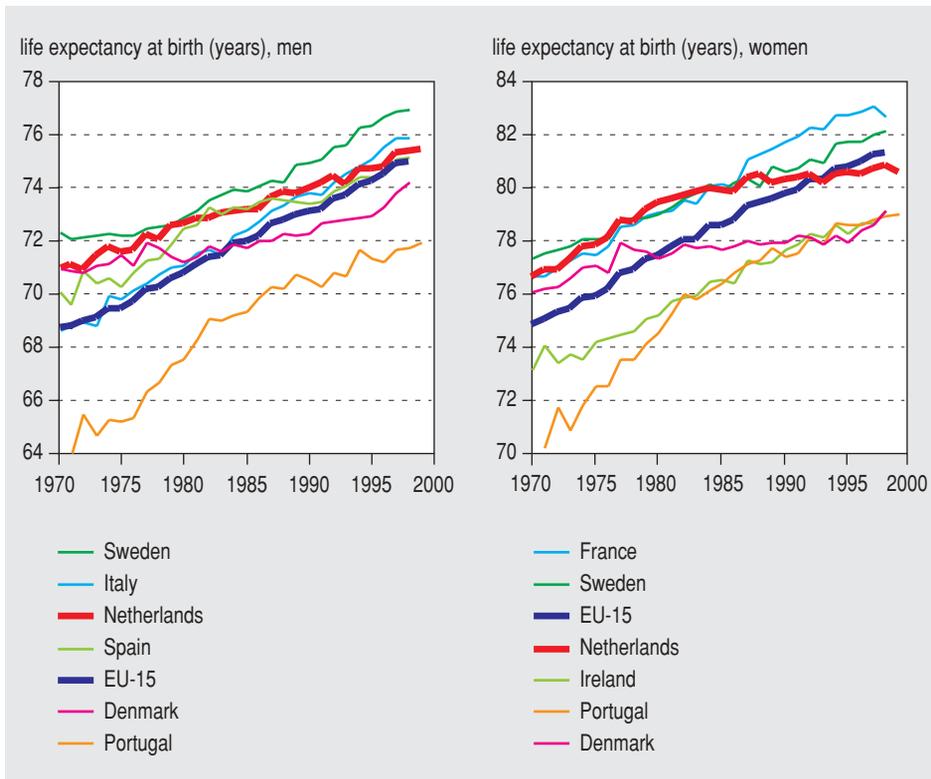


Figure 1: Life expectancy trends for men and women in various EU countries in the period from 1970 to 2000. As well as the Netherlands and the EU average (EU-15), the most and least favourable countries are shown (Source: WHO-HFA, 2002).

- If we assume the most favourable mortality rates in the EU for 14 major causes of death, Dutch life expectancy could still be improved by six years for men and four years for women. However, we would lose four years if we were to have the most adverse rates in the EU for these causes of death.

### **There are also persistent differences in health**

*Health is unequally divided* across the Netherlands. There are considerable differences in health between the rich and the poor, and from one neighbourhood to another. There is no indication that these differences have decreased over the last five years.

- Men with the *lowest level of education* live 5.0 years less than their most *highly educated* counterparts. For women, this difference is 2.6 years. Moreover, men and women with the highest level of education live on average ten years longer without disabilities. In terms of the number of years spent in self-perceived good health, the difference is 16 years for men and 14 years for women (figure 2).
- Comparing *regions or neighbourhoods* also reveals similar differences in health. Poorer health in deprived areas is frequently linked to an accumulation of adverse environmental factors, both social and physical, combined with an unhealthy lifestyle.

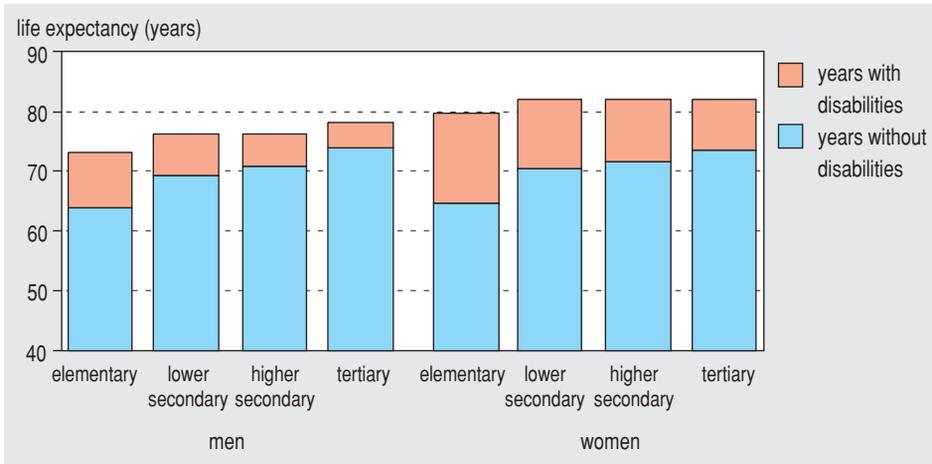


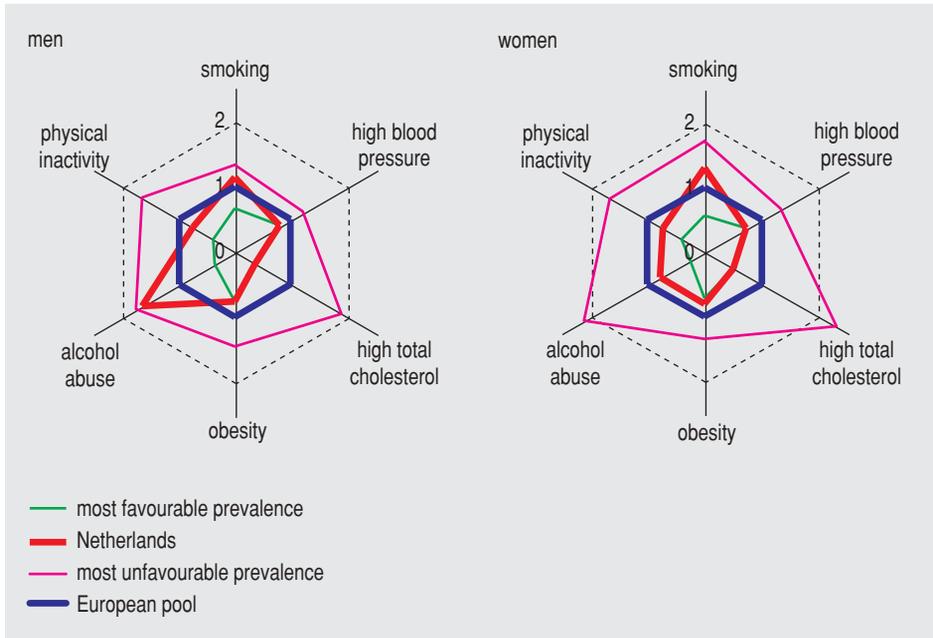
Figure 2: Life expectancy and disability-free life expectancy according to educational level for Dutch men and women, 1995-1999.

- Trends in inequalities in health cannot be reliably established on the basis of the available data. However, there is no indication of a decrease in the existing differences in health.

### **Unhealthy behaviour is the major cause of stagnating health**

*Unhealthy behaviour is the major cause of the stagnating life expectancy* of Dutch adults. Over the last few years, women have acquired many of men's unhealthy behaviour patterns. But adverse trends in unhealthy behaviour are also particularly prevalent amongst the young and can be regarded as long-term investments in 'bad health'. By contrast, the elderly have adopted a healthier lifestyle. Environmental factors also contribute to the Netherlands' total burden of disease. There is no indication that stagnating life expectancies are linked to problems within the healthcare sector.

- There are particularly worrying trends among *young people*, involving smoking, the excessive use of alcohol, not eating enough fruit and vegetables, and taking insufficient exercise. In addition, there is a growing incidence of serious overweight in ever younger age groups.
- The Netherlands scores badly in Europe in terms of smoking and the excessive use of alcohol. By contrast, we do relatively well as far as physical activity is concerned. If we Dutch were to achieve Europe's most favourable level for known risk factors, we would in theory add another 1.4 years to male life expectancy while females would gain 1.2 years (*figure 3*).
- A considerable proportion of the total annual mortality (140,000 deaths in 2000) in the Netherlands is linked to unhealthy behaviour and could therefore be theoretically avoided. The major factors are: smoking (around 15% of deaths each year), the excessive consumption of saturated fat (5%), not eating enough vegetables and fruit (5%), a lack of exercise (6%), high blood pressure (6%) and serious overweight (6%). Rough estimates indicate that the contribution of environmental factors to the Netherlands' total burden of disease does not exceed 5% (*figure 4*).



Men	Cut-off point	Most favourable	Least favourable
Smoking	current smokers	Sweden	Belgium
High blood pressure	systolic BP $\geq 120$ mmHg	Denmark	Finland
High total cholesterol	$\geq 7.8$ mmol/l	Netherlands	Luxembourg
Serious overweight	$\geq 30$ kg/m <sup>2</sup>	Netherlands	Finland
Alcohol abuse	men: $\geq 4$ glasses/day	Sweden	United Kingdom
Physical inactivity	0 hours per week active	Finland	Belgium
Women	Cut-off point	Most favourable	Least favourable
Smoking	current smokers	Finland	Denmark
High blood pressure	Systolic BP $\geq 120$ mmHg	Netherlands	Finland
High total cholesterol	$\geq 7.8$ mmol/l	Netherlands	Luxembourg
Serious overweight	$\geq 30$ kg/m <sup>2</sup>	Denmark	Finland
Alcohol abuse	women: $\geq 2$ glasses/day	Sweden	United Kingdom
Physical inactivity	0 hours per week active	Finland	Belgium

Figure 3: Position of the Netherlands in Europe for a number of lifestyle determinants and personal risk factors. Relatively to the European average, Europe = 1

- A considerable proportion of Dutch healthcare use can be attributed to an unhealthy lifestyle, overweight and high blood pressure. The costs involved amount to between 5 and 9% of total healthcare expenditure.
- Access to Dutch healthcare has been placed under pressure over the past years by, for instance, waiting times and waiting lists. There is no indication that this is in any way linked to the stagnation in the growth of life expectancy, which is mainly due to adverse developments in lifestyle.

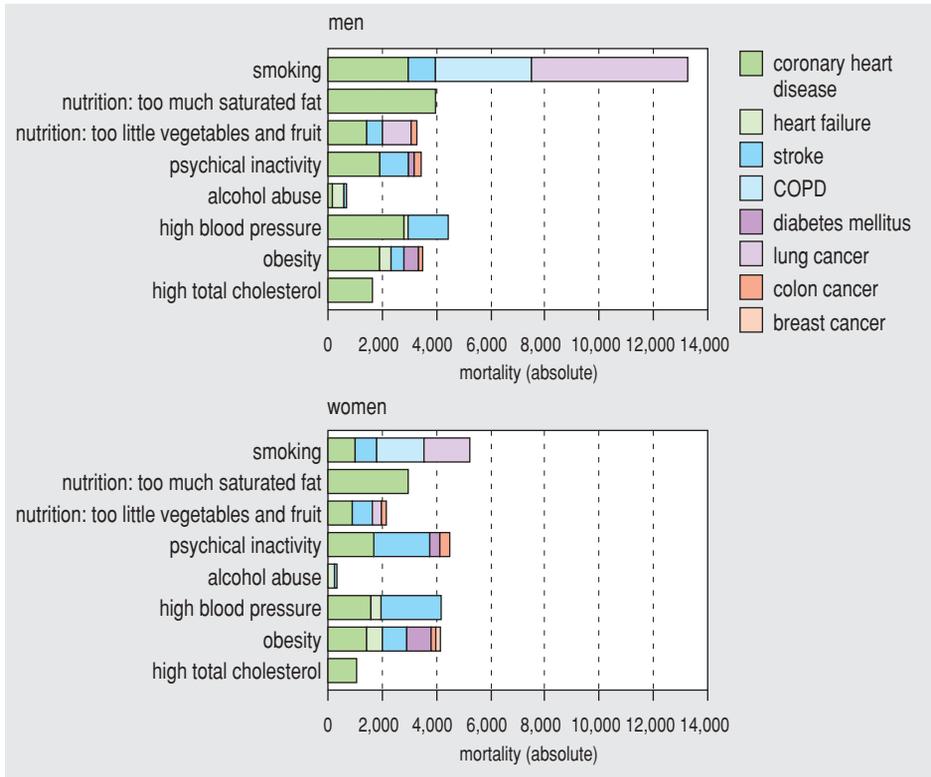


Figure 4: Contribution of important lifestyle factors and personal risk factors to Dutch mortality by eight major causes of death; absolute numbers by sex in 2000. (Total inhabitants in the Netherlands: 15.9 million and total deaths: 140,000).

### **A new approach to prevention can turn the tide**

Prevention, particularly by promoting a healthy lifestyle, *could result in considerable health gains*. A modern approach is based on a stimulating environment and an integrated method within existing ‘settings’ rather than by solely placing the emphasis on influencing behaviour. This could occur by making a healthy lifestyle an obvious part of socio-cultural life: at school, during sport and recreation, at work, in neighbourhoods and in traffic. Moreover, prevention demands a durable vision, and long-term attention and investment. Much could also be gained if prevention were to acquire a more explicit role in the provision of care.

- Along with the Ministry of Health, Welfare and Sport, other government sectors, and public and private bodies can also contribute to the development of better health. Factual information, price incentives, clarity about ‘healthy’ and ‘unhealthy’ products, and the organization of both the workplace and the built environment could entice the citizen into making healthy choices and avoiding unhealthy behaviour. Here, preventive interventions are more effective when supported by legislation and regulations.
- Prevention is more likely to succeed when it involves an approach that is specifically geared towards the particular target group and is based on a long-term vision involving constant support.

- Prevention programs are too rarely evaluated, and successful local initiatives should be more frequently copied at a national level.
- The clear inclusion of prevention within the healthcare sector would benefit both public health and the sector's efficiency. This is often obstructed by the sector's system of budgeting and the lack of financial incentives, for instance, and by other organizational aspects along with the pressure of work. Medical training generally places insufficient emphasis on prevention.

### **More care and different care are needed in the future**

In the future, a growing and more elderly population will result in a considerable increase in the number of disease cases, particularly those involving chronic disorders. If the trend of the last few years continues, the total volume of Dutch healthcare will have to expand by 2.4% each year until 2006 just to maintain its present level. There must also be an additional shift from cure to care. Over the next few years, the elimination of waiting lists and other obstacles will require an estimated further investment of at least 0.6% each year for four years (figure 5).

- Dutch society spent 36 billion euros on healthcare in 1999, which was 9.6% of the gross domestic product. Most of this was for *cure* facilities such as hospitals (29%), pharmaceuticals (10%) and GPs (3%). Caring for the elderly, the chronically ill and the handicapped (*care* facilities) accounted for more than 36% of all expenditure. Less than 4% was spent on prevention, half of which involved occupational health care. This does not cover prevention as included in the provision of care.
- The elderly use more care than do young people. This also accelerates from the age of sixty onwards and applies to both men and women (figure 6).
- In the future, half of the requisite extra growth in volume will be due to population growth and an ageing society; the other half will be caused by advances in medical technology and by the consumer's changing demand for care.

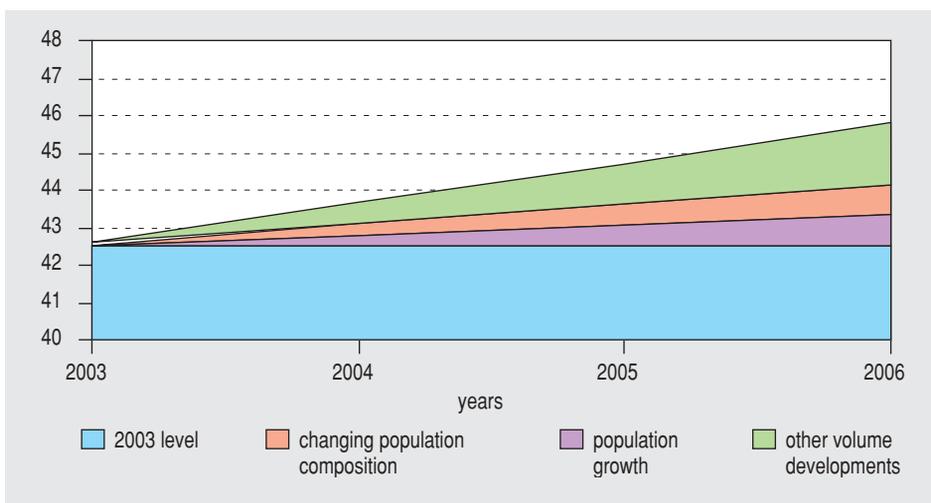


Figure 5: Projection of the development of Dutch healthcare costs split into components for the period 2003-2006 (in billions of euros in constant prices from 1999).

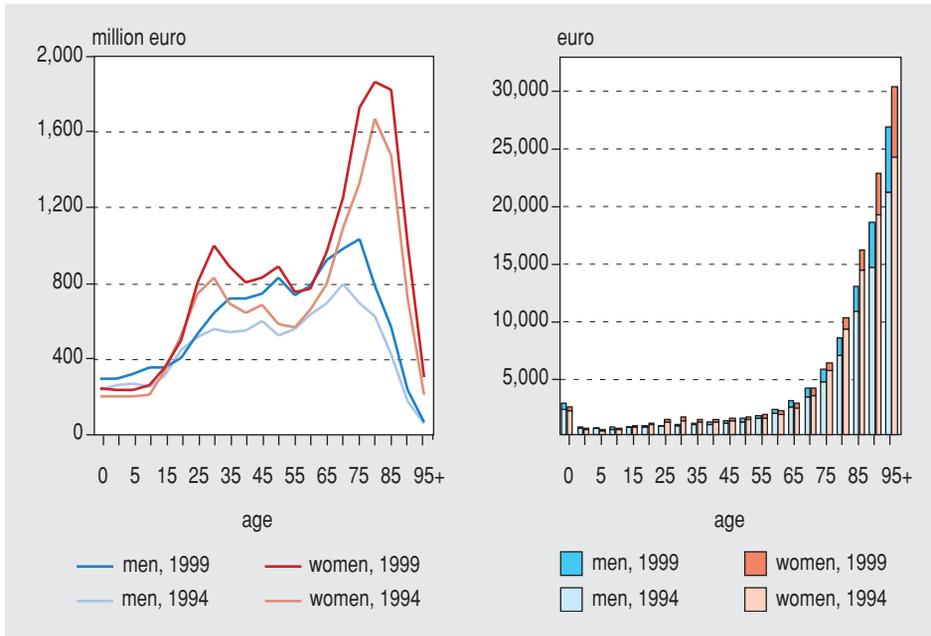


Figure 6: Total costs of Dutch healthcare (left, millions of Euro) and average costs per head (right: Euro) by age and sex in 1994 and 1999 (The Netherlands had 15.9 million inhabitants in 2000).

- There are already considerable waiting times and capacity deficits in the nursing care sector. The extra resources that have been made available in recent years have resulted in a higher level of production. However, recent trends show that as yet most sectors have not experienced any decrease in waiting lists.
- Healthcare use in the Netherlands is average when compared with that of neighbouring countries. This applies to the volume of healthcare, to its share of the gross domestic product and to the average health expenditure per capita. Over the past few decades, the growth in per capita health expenditure has been less than that of our immediate neighbours (figure 7).

### **Care is not only a question of quantity but also of quality**

In the future, it will not only be a matter of *more* care but also of *high quality* care. High quality care means care that is effective, safe and available to everyone. Care could become both more effective and safer if 'best practices' and standards were to be applied effectively, and if the lessons learned in trial projects were to be broadly implemented. Trial projects could, for instance, involve safer or more integrated care. Such qualitative improvements could also reduce costs. Obstacles to the implementation of these improvements are generally of an organizational or financial nature.

- The prompt application of new and effective medical technology and the reduction of unnecessary inter-doctor variations could result in health gains. However, evaluation of the effectiveness and safety in actual practice is still necessary and involves both 'medical technology assessment' and 'post-marketing surveillance'.

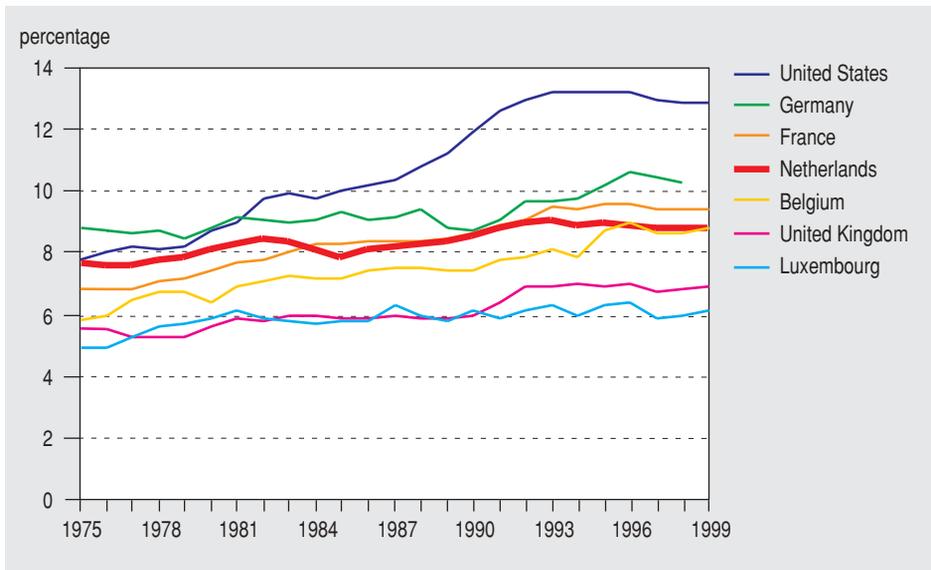


Figure 7: Healthcare costs as percentage of GDP in seven countries over the period 1975-1999 (Source: OECD Health Data).

- Integrated care - optimizing the patient's journey through the care circuit - could result in health gains, in creating a more patient-specific approach and in a more targeted use of resources.
- Research in the United States and Australia has shown that adverse effects of medical treatment may lead to a considerable loss of health involving a decrease in life expectancy of 6 to 12 months. As yet there has been no Dutch research in this area, but the situation in the Netherlands is unlikely to be significantly different. Trial projects have shown that focused alertness can greatly reduce the incidence of certain specific health risks in care such as decubitus ulcers and wound infections.
- There are no indications in the Netherlands of socio-economic differences in access to necessary care. However, those with lower educational levels seem to make less adequate use of care, for example when they have a chronic disease.

### ***Prevention not only better, but also frequently cheaper***

The costs of each additional, healthy year of life gained through interventions can vary considerably from one area of prevention and healthcare to another. *Some interventions reduce expenses while others cost more than one hundred thousand euros* for each additional, healthy year of life. Preventive interventions can result in a considerable health gain, and often at little expense. So prevention is not only better than cure, it is also frequently more efficient. It pays to invest in prevention, particularly in the long term. However, this is not simply a matter of health gains per invested euro, it is also about solidarity and access to cure and care.

- Preventive measures at the beginning of the disease chain, such as the neonatal heel prick, vaccinations or traffic regulations, are often more efficient than interventions at the end of the chain, such as lung transplantation. The general desire for a high level of individual protection also has as a result that sometimes expensive environmental measures are taken.
- However, apart from the cost-effectiveness and efficiency of interventions, there is also the issue of solidarity and of each Dutch citizen's legitimate right to protection, cure and care. Nonetheless, making the relation between costs and health gains more explicit could create greater transparency in the decision-making process.

### ***There are certain gaps in the provision of information***

An effective and constant flow of information is the basis of monitoring, analysis and reporting, as presented by the PHSF reports. Since the 1997 PHSF report, *the flow of information has improved in certain areas, but deteriorated in others*. There are still some major problem areas:

- Many data collections lack continuity, fail to represent the country as a whole or allow insufficient opportunity for regional differentiation.
- Registration and research do not draw sufficiently on information about socio-economic status, ethnicity, domestic situations and other relevant characteristics such as the severity of a disease or the quality of life.
- Care registration is too fragmented and frequently fails to include diagnostic data or to assign a unique number to each patient. This makes it impossible to monitor a given course of care at the level of individual patients.
- Various data collections (including those from the public domain) are compiled and stored by private bodies, as a result of which access to this information is becoming increasingly difficult or even totally impossible.
- Data about the quality, effectiveness, safety and accessibility of prevention and health-care is extremely incomplete.
- There is an increasing need for international 'benchmarking'. Various schemes for measuring 'health system performance assessment' are being developed but the international comparability of data still leaves much to be desired.

## **The findings' significance for the various players**

### ***Central government must invest in prevention to reverse the stagnation in health***

Investment in prevention is vital if we are to break through the stagnation in the development of our health. The government will have to achieve this by creating a *coherent policy framework* and a *long-term vision* for health. Therefore, it must *continue to invest* in existing preventive facilities, and *must strongly encourage* the development, evaluation and national implementation of new, preventive interventions. Here, the focus of attention needs to be directed at strengthening prevention within the healthcare system as well as intersectoral policy.

- The 2002 PHSF report provided the *government* with leads for developing national priorities for collective prevention. The government could subsequently link *quantita-*

*tive objectives* to these priorities in consultation with the other players. This creates the opportunity to monitor the policy's progress empirically. In addition, national objectives may stimulate and inspire the other players to develop and implement their own policy plans.

- The government must continue to invest in existing preventive facilities so as to sustain the existing level of health gain. This entails keeping the existing system of preventive facilities up to standard, which also involves their inspection and maintenance.
- The national implementation of new and effective interventions must be promoted. This could occur through the distribution of information about these interventions in dialogue with the other players, the creation of collaborative alliances and the structural financing of national implementation.
- The government must continue to invest in research into the development, effectiveness, implementation and evaluation of preventive interventions so as to broaden the prevention policy's basis.
- The implementation of effective prevention activities within the healthcare system must be promoted by, for instance, eliminating organizational and financial obstacles or by stimulating *care providers* and *health insurers*.
- The government could encourage health-oriented, intersectoral policy at a *departmental level* by making agreements about common goals within the various policy fields. Here, opportunities include the major cities policy (Ministry of the Interior and Kingdom Relations), sport (the Ministry of Health, Welfare and Sport), schools (Ministry of Education, Culture and Science), employment (Ministry of Social Affairs and Employment), traffic safety (Ministry of Transport, Public Works and Water Management), and housing and the environment (Ministry of Housing, Spatial Planning and the Environment).
- The government could encourage structural co-operation between local government councils and local representatives of *healthcare providers*, *health insurers*, and *consumer and patients' organizations*.

### ***Local-level prevention players should combine forces***

The actual implementation of collective prevention largely occurs at local level. *Councils and municipal medical and health services* are important local players in co-operation with the local representatives of the *care providers*, *the health insurers* and *the requesters of care*. They should combine forces and work together on formulating and developing a local prevention policy with common, local priorities and policy objectives. A national public health policy framework could inspire the local players and provide guidance for drawing up local public health reports and for formulating local objectives.

- Within the national policy framework, local players could promote the development, implementation and evaluation of new interventions within the local setting. They could also stimulate the implementation of effective interventions, which have been adjusted to reflect the local circumstances.
- Local forms of intersectoral co-operation must be strengthened. Here, national agreements could be developed at departmental level, and local initiatives elsewhere could

serve as a source of inspiration for all the players including the national government.

- The local players must jointly examine how effective preventive interventions could be included in the basic responsibilities of the relevant care providers. They must also reinforce the development of new preventive interventions within the healthcare system.
- There must be joint investment in a two-way risk communication system between the government and the citizen which also refers to the citizen's own responsibility. *Consumer and patients' organizations* could make a major contribution to a balanced approach to risks and their perception.

### ***More care, different care and better care are both necessary and feasible***

The 2002 PHSF report was neither willing nor able to deal with the full scope of the healthcare sector. It examines care primarily in terms of attainable health gain. Here, the key words are 'accessibility', 'effectiveness', 'safety', 'costs' and 'efficiency'. *More* and *different* care will be needed in the future, and this is mainly due to a growing and increasingly elderly population. Moreover, there are still many opportunities to improve the *quality* of care.

*More* care and *different* care could be achieved by:

- Keeping the annual increase in the Dutch healthcare budget in step with demographic changes, advances in medical technology and other autonomous developments. An annual increase of at least 2.4 to 3% would appear to be needed until 2006. This can be partly justified by the budget's interrupted growth in the 1990s.
- Solving the capacity deficits by expanding medical training in combination with a long-term vision for developing the capacity of the medical professions.
- Making the necessary shift of investments from cure to care within the required total increase.

*Better* care could be achieved by:

- The explicit inclusion of health objectives when formulating preconditions for a new healthcare system. These could include health gain, promoting quality of life and reducing inequality in health.
- Increasing the quality of care by encouraging the use of standards and guidelines while retaining the flexibility needed for modernizing the healthcare system.
- Eliminating financial and organizational obstacles that needlessly block the adoption of effective forms of healthcare modernization, integrated care and new technology.
- Examining whether, within a patient-specific orientation, a boundary could be defined for the 'medically unjustified' demand for care.
- Extra investment in the availability and, particularly, in the tailoring of care for weaker social groups.
- Encouraging the development of methods for institutions and care providers that measure health outcomes or relevant process parameters. These indicators could be used for improving internal quality, for the external assessment of quality by care market consumers and insurers, and to achieve accountability to both society and parliament.

### ***Dilemmas in prevention and care***

The analysis of prevention and care in the Netherlands reveals a number of dilemmas that sometimes seem to obstruct rational policy choices. Some dilemmas have existed for quite some time while others will only reach practical significance in the future. It is important to *stimulate a political and social debate* on these issues in order to achieve the right social balance for these dilemmas.

- Prevention is a long-term undertaking. Investments generally require time to yield health dividends, and this often occurs gradually and in an imperceptible manner. This means that prevention may suffer in a political arena where short-term problems are fighting for priority.
- The citizen demands maximum safety from the government at all costs yet rejects any restriction on his freedom to, for instance, subject his health to considerable risks. Hence, policy-makers are confronted with the difficult choice of whether to opt for the collective interest of public health or to respect the individual's freedom of choice. Here, a related dilemma concerns the contradiction between the collective interests of public health and the private economic interests of, for instance the drinks and tobacco industries.
- Experts and the public frequently fail to agree about the potential, nature, extent and control of health risks. The public tends to ignore the risk experts' estimates. Hence, the government faces the dilemma of whether to deal with these risks rationally on the basis of 'scientific' estimates of potential risk, damage and the cost effectiveness of safety measures, or to consider the public's legitimate experience of those risks as based on a range of values and norms.
- Investing in preventive measures aimed at avoiding or delaying disease often yields a higher level of health gain than the care provided during the later phases of the disease process. Here, prevention is better than cure and the health gain is frequently obtained in a cheaper way. This in turns leads to a dilemma between the efficient use of limited resources and every Dutch person's right to the best possible care.
- The basic premise of demand-oriented care and the 'right to care' runs counter to an imperative financial framework, whereby care provision is limited. However, a budget ceiling always exists even within an ample financial framework. Improving the functioning of this 'imperfect' care market also entails a considerable number of dilemmas: should solidarity be sacrificed for efficiency through, for instance, individual insurance contributions? Should the basic insurance policy be extended or will people have to opt for additional coverage? Could a useful distinction be made between 'evidence-based' medicine and problems that have been 'unjustly medicalized'?
- Endeavouring to maintain standards in healthcare raises its quality but, in theory, this could also hamper timely modernization and impede a patient-oriented approach.
- Developments in genetics provide us with greater insight into our personal risk and treatment profile. This means that in the future we will be able to apply both prevention and treatment increasingly effectively. However, these developments also entail all manner of moral and ethical dilemmas. This is primarily because the diagnostic potential is increasing far more rapidly than the possibilities for treatment. How do we deal with the right *not* to know which diseases we may develop later on if, as yet, there is no prospect of a cure? How should we treat a technology that produces more disea-

ses and diagnoses them at an earlier stage, yet does not yield any significant health gain? Should the often-pricey pharmaceuticals that compensate for an individual's unhealthy lifestyle be a collective financial burden?

- Some argue in favour of measuring the quality or performance of healthcare so as to increase its quality and make the options of both consumers and insurers more transparent. To what extent should we support the public disclosure of this information? Do we want to use quality measurement to create league tables and rogues galleries? Or should we use it as a lesson for the improvement of quality?

### ***Opportunities to create a more effective flow of information***

An effective and constant flow of information is essential for creating the basis of an 'evidence-based policy'. Hence, the government must develop a long-term vision for its information and research policies, which it must also direct.

- The government must clearly indicate the health and care subjects that need to be regularly supplied with data. The monitoring of quantitative policy objectives could be a part of this process.
- The government could agree on the characteristics and working structure of data collections in consultation with other parties. Central direction enables efficiency gains to be made by improving the co-ordination between data collections. The government must also ensure that private interests do not obstruct access to relevant data collections.
- The government should promote local-level collection of data concerning local needs, in good co-ordination with the existing needs at national level.
- The government must forcefully pursue the development and funding of national public health and healthcare research programs.
- The government could provide an extra stimulus for the on-going development of frameworks and indicators for measuring performance and risks in care and prevention. This will eventually create more effective possibilities for 'benchmarking' at the meso-level (between institutions) and at the macro-level (between countries).
- The government could encourage the Netherlands to become more deeply involved in the efforts of European and other international institutions to make data from different countries more readily comparable. One way in which this could be achieved is to encourage Dutch researchers to make an active contribution to the design and implementation of the European public health programme.

