Preventing disease of affluence

Effectively and efficiently organised

Summary

Diseases of affluence, or loss of health due to lifestyle habits associated with modern affluent society, usually feature far less in prevention policy compared with infectious diseases and accidents. This is disproportionate to the degree of widespread illness they cause; improved lifestyle habits could increase not only life expectancy, but also the number of healthy years and years free of disability/chronic conditions. Right now we are seeing a (sometimes significantly) increase of life expectancy without a corresponding increase in the number of years free of disability/chronic disease. Within the context of increasing demand for care, prevention offers major societal advantages in terms of both paid and unpaid productivity and participation. Prevention is one possible solution to rising healthcare costs and the looming and imminent difficulties in the labour market.

Prevention faces many challenges, such as the Netherlands' poor smoking record compared with other countries (especially among women). But even in those areas where we score relatively well, we cannot rest on our laurels. Obesity is one such area: although our performance is not bad, with over ten per cent of the population significantly overweight it remains a cause for concern. The resulting illnesses include lung cancer, COPD and diabetes. Depression is also related to modern lifestyles. There is a significant disparity between the health of women that have been educated at the higher professional or university level and that of women with only primary education, whose life expectancy without disability is 14 years lower and who can expect to live 20 fewer years in good health.

The range of available prevention instruments has grown in recent years, particularly those for selective prevention. Positive urban initiatives have also appeared, with promising results. However, these types of policies are unstable and incidental due to the lack of permanent funding. This policies contrasts strongly with the healthcare sector, which is once again set to grow considerably in the years to come. In practice, the widespread accessibility of curative care proves to be more of an obstacle to prevention than a stimulus. The national government also appears to demonstrate little willingness or decisiveness on the matter; political and ideological motives and individual freedom of choice sometimes take priority over ill health itself. Partly due to these circumstances, public health is lagging behind when it comes to lifestyle illnesses.

This analysis gives rise to a clear range of solutions.

First and foremost, the imbalance between preventive and curative care must be corrected. Prevention must be seen more frequently as the initial logical step: staying healthy instead of repairing illness, or switching the focus from illness and treatment to health and behaviour. This is only possible if the financial incentives are turned around. Supplementary to previous arguments by the Council for Public Health and Care (RVZ) for modifying the incentives for care providers (i.e. working with health objectives instead of treatment and production targets), it is also necessary that insurers have a more explicit interest in health. This can be achieved via ex-ante risk equalisation,

although this system is so esoteric that further investigation into how it actually works will be required first. The Council believes that adjustments to the equalisation must not result in decreased accessibility to necessary care, but instead must be aimed at increasing awareness of prevention.

This research may cause no delay. It is already possible to set up a prevention fund in the short term and to fortify local health policy as described by the minister in the national policy document. The fund will be set up so that a fraction of premiums (1% or €350 million) is set aside for prevention; administration will be the responsibility of municipal authorities and health insurers, who will conclude an agreement for this purpose. The municipal authorities and health insurers will be able to apply for funding for joint health policy that meets clear criteria. The epidemiological analysis must have been carried out at neighbourhood/suburb level (per 4-digit postcode), with an approach based on proven effective interventions by a professional organisation. Municipalities will also contribute financially, with the explicit objective of reducing the burden on first-line care (i.e. substitution).

A provision was recently added to the Public Health Act (*Wet publieke gezondheid*, Wpg) obliging municipal authorities to include a statement in their four-yearly health policy documents of how they plan to execute the national priorities. The Council believes that the Act should also prescribe the performance of a detailed epidemiological study, which essentially involves the more efficient coupling of existing insurer and municipal databases. A further consideration could be the inclusion of provisions in the Public Health Act aimed at providing guidance to municipal authorities on this joint policy.

An approach of this nature (which also ultimately addresses citizens' own responsibility) can only succeed if the minister ensures sufficient complementary policy. Education in schools on smoking, alcohol and a healthy diet will be much more effective and efficient if educators can draw from clear national legislation. Education is schools on smoking becomes more difficult when students can see people smoking on school grounds. Incidentally, this is essentially also a matter of health protection, as children in general do not have a good grasp of the choice of whether to smoke or not, and are easily impressionable. Reduction of salt and other additives in their diet also qualifies as health protection, and not promotion of healthy habits. These measures should not be qualified as limiting freedom of choice, as even the most rational consumer does not always notice the hidden temptations and risks that can result in loss of health or addiction.

Lastly, the Cabinet could make a contribution by enacting logical tax legislation. From a health perspective, duties on tobacco can never be too high; alcohol duty could also be raised. Levies on food are too low, given the excessive amount of consumption and the rise of conditions such as diabetes and osteoarthritis. From the macro perspective, it would seem more logical to place more taxes on food and less on labour – this will reduce sickness and produce more jobs. The Council wishes to ask the Cabinet to investigate ways in which a fats tax or a higher VAT rate could be implemented.