Raad
Volksgezondheid
& Samenleving

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Agenda of the Council for Public Health & Society 2020-2024

Contents

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The **&**. The symbol of the inseparable connection between the two aspects of our field of work: Public Health **&** Society. The **&** symbol stands for the awareness that developments in our society have meaning for our individual and collective health and for how we organise care and support together. Conversely, the health of individual citizens is not only their own business, but also of great social importance and of value to all of us. The **&** symbol symbolises this too.

With this focus on the & symbol, the Council for Public Health & Society (RVS) focuses on questions that also arise outside treatment rooms and consultation tables in the care and social domain. This extends beyond the hectic pace of everyday life in The Hague, beyond the issues professionals encounter nowadays, and beyond system changes or system modifications alone. Our approach is broader than this: it is about how changes in the way we live, reside, work and relax together affect our health and our ability to care, for ourselves and for each other.

Our agenda for the coming four years focuses on five social challenges at this intersection of public health **&** society. They arise from a changing society that puts the prevailing views on care and the way it is organized, the social domain and (public) health under pressure. These tasks can, therefore, not be addressed from a care perspective alone. We see the search for the interface between public health, care and society as a precondition for finding new answers and action perspectives. In this agenda, we describe which tasks are involved, how they emerge from a changing society and which projects we will be working on in concrete terms.

Change as a source of social challenges

Our society is constantly developing, often in small steps, sometimes in big leaps. These dynamics may vary from year to year and from decade to decade. The present time feels rather turbulent, and most studies and predictions indicate that the speed of change will only increase in the coming period. Digitisation will be an important driver, as well as the impact of issues such as climate change, migration and an ageing population.

In such a rapidly changing society, the question arises: how do we take care of each other now and in the future? How do these changes impact how we handle health? **&** what does our health require from society? What do we want, what can we do and how are we going to achieve it? Several developments present us with particular challenges.

We are living longer than ever before and that brings new questions of life to the fore (RIVM 2018). The ratio between young and old people will change dramatically in the coming years (CBS 2018). An ageing society leads to a reduced labour force **&** increasing demand for care.

"We live longer than ever before and that brings new questions of life to the fore."

We also live longer with chronic or multiple disorders (SCP 2016a; RIVM 2019), especially when problems do not fall within one domain or cannot be tackled with a single intervention. The organisation of care and support **&** what people want, are capable of and need do not always match up.

Not only do we live longer on average, the differences in how we grow old are also increasing (RIVM 2019; Pharos 2019). Sometimes this is something worth celebrating, when diversity can flourish. At other times, it can be problematic, when dividing lines can no longer be bridged. In such cases, differences lead to chasms between groups. As a result of the rapid changes, not everyone manages to keep in touch with social life. In any case, differences between people mean that we all need something different (customisation) **&** that as a society we must continue to look for what connects us (solidarity).

We also see an increase in knowledge and opportunities, in healthcare and beyond. On the one hand, technological innovations, hypes and medical breakthroughs follow one another in rapid succession. The available and accumulated knowledge is enormous, rich and hopeful. On the other hand, innovations and improvements do not necessarily find their way to citizens (SCP 2019a) and healthcare practice. At the same time, there is a call for more room for people's personal stories and attention to context. Objective knowledge is more often disputed and used for individual truths. Rapid developments thus lead to new questions **&** may become inaccessible for some groups or unaffordable for us as a society.

Finally, we also see that our living environment is changing drastically (RIVM 2018). Cities are becoming more crowded, while in other areas the population is declining and our lives are increasingly taking place in a digital world. The risks of these changes are becoming increasingly clear for health and well-being **&** for social cohesion in society. However, a changing environment also offers opportunities, for example, for new forms of encountering people.

Five central tasks

The ageing population, pressure on the labour market, increasing complexity, opportunities and limitations of growing knowledge, a changing living environment: these are movements that will shape and challenge our society in the coming years. This will happen across the boundaries of existing domains and disciplines.

Policy frameworks and principles that looked so promising on the drawing board will become increasingly limiting. We are approaching the limits of what can still be achieved together, the available resources, the guiding principles behind our health care system, the social engineering of life and the authority of expert advice. At the same time, new horizons are beckoning: new collectives, sustainable initiatives, renewed social security, valuable (care) technologies and creative solutions that transcend domains. The underlying values of the welfare state as we know it are due for conceptual innovation. This affects society as a whole, and public health in particular. On what values should we focus healthcare and the social domain? How can care and support be appropriate for everyone **&** also remain affordable for us as a society?

"The underlying values of the welfare state as we know it are due for conceptual innovation."

The key to solutions for complex problems lies in establishing connections and knowledge exchange between practice and different policy areas, to learn from practical experiences and promising initiatives. Going beyond one's own box and the short-term thinking that this requires is easier said than done. The complexity

of the rapid changes still too often appears to paralyse policy-makers and administrators: sometimes it is unclear where to start.

Within this changing society, the Council for Public Health **&** Society wants to offer perspective to the cares of **&** for tomorrow. To this end, this agenda focuses on five tasks.

Consultation
A broad dialogue preceded the selection of these five tasks. We spoke with professionals in the care and social domain, with language ambassadors, municipal directors, the elderly, senior civil servants in The Hague, managers of trade, professional and patient associations, volunteers at a Food Bank and many others. Through the online consultation *Ranking the topics*, we surveyed the preferences of more than 10,000 respondents within these themes and collected ideas about how to work out these assignments. The appendix provides an overview of who we consulted.

1. **Differences in society**
2. Due to growing differences in what people have, can or want, they find themselves at a greater distance from each other. More and more differences are not justifiable or difficult to justify, while other differences deserve more appreciation. How can care and support better respond to diversity, and what can be done about problematic differences in health and well-being?
3. **A healthy and social living environment**
4. The living environment can make an important contribution to our health and well-being. Conversely, our environment can also cause illness, stress and loneliness. What is a contemporary and future-proof perspective on a healthy and social living environment? What is the interaction between collective and individual prevention, and how do we bring about change?
5. **Limits to curing and improvement**
6. Due to growing medical possibilities, a social ideal of social engineering appears to be increasingly within reach. This makes dealing with vulnerability, suffering and death complicated. How can we create a better dialogue about this in the field of care and with each other?
7. **Care in a tight labour market**
8. The need for care and support is increasing as a result of the changing population. At the same time, the care sector is faced with staff shortages and absence due to illness as a result of, among other things, loss of job satisfaction. The professionalism of care and assistance providers is under pressure, as well as quality and accessibility. How do we continue to care for each other in a tight labour market?
9. **Systems at odds**
10. Due to multiple or chronic problems, more and more people are faced with multiple systems of care and support. These systems do not always dovetail with one another. Getting the right help can be difficult or frustrating. This leads to a loss of public trust and solidarity. What can we learn from bottlenecks, and what is a suitable perspective for the future?

These five tasks are not isolated. They are intertwined because social changes affect them simultaneously, or because they influence each other. Tackling problematic differences, for example, cannot be seen separately from thinking about a healthy and social living environment. Prevention is central to both tasks. The tight labour market and the systems at odds with one another raise the question about the position of citizens, informal carers and social initiatives in relation to the

professional supply, just as limits to healing and improvement and the tight labour market demand attention for the opportunities and risks of new technologies. Needless to say, we take these interrelations into consideration in the elaboration of the questions.

How we want to contribute: our ambition

In the midst of a changing society, the Council wants to rise above partial interests within these five tasks as an independent party, and provide direction to the multiplicity of voices.

Retrospect

The Council for Health & Society has been active for four years. Since the merger of the Council for Public Health and Health Care (RVZ) and the Council for Social Development (RMO), we have carved out a position for ourselves. We have offered a change of perspective on topics such as debts, the development of medicines, evidence-based practice, mental pressure among young adults and the perceived accountability in healthcare. We have put 'diversity' on the map as the fourth core value of the healthcare system, in addition to the public interests of quality, affordability and accessibility formulated by the government. We are proud of the many Dutch people who participated in our online consultation for *a healthy society, the Care Agenda* and the many conversations, meetings and focus groups that we have organised.

The Van der Schoot Committee evaluated our work last year (RVS 2019) and concluded that the Council's recommendations are highly appreciated and of a high standard. Field parties in particular indicate that our advice offers a fresh and critical voice in the complex interplay of politics, policy and practice. In their opinion, our advice provides a welcome boost to the discussion about change. At the same time, the evaluation has made it clear to us that we need to work on a stronger impact of our advice in current and future policy.

We aim to contribute to the question of how sustainable change can be achieved within these five complex social tasks. In order to do so, we work with concrete issues, both solicited and unsolicited. Sometimes, we do so by offering a change of perspective in order to inspire or challenge; other times by sketching clear action perspectives for the short term. We make use of the various backgrounds and expertise that are represented in our council. This includes networking, knowledge and experience in practice, policy and science, from the care sector, the social domain and beyond.

With this aim in mind, we focus first and foremost on *deepening* issues, by seeing and listening to all those involved, selflessly and with a broad view. We also want to *broaden* issues and show different perspectives, for example, by involving artists and designers or by including insights from abroad. And thirdly, we want to *connect*, by facilitating the discussion about excellent initiatives or desired improvements, and by challenging all participants to hold themselves and each other to account on their responsibility for care and society. This is how we make the connection between politics, policy, practice and research.

Deepening, broadening and connecting requires a continuous dialogue. Offline and online, in large groups or small work groups, in word and in imagination: communication with all those involved is at the heart of how we collect and interpret information. And that makes it the foundation of our advice. We are nourished by young professionals from our talent network VeRS and innovators

from the KennisRing (Knowledge Circle) that we are setting up this year. Our legal assignment also requires us to pay special attention to the tasks of local and regional authorities. As a result, we welcome requests for advice from ministries as well as local and regional authorities in the coming period.

Even more than before, we want to examine the impact of what we advise: our contribution to the intended change in policy and practice. We will pay additional attention to new forms of advice. Sometimes it is helpful to clarify an issue. Sometimes we will focus on strong recommendations about how things can be done differently. Sometimes a topic requires a series of meetings and encounters, at other times learning by doing is required – this also applies to the Council.

Preface

On the pages that follow, we will elaborate on the five tasks that we have formulated. We will frame them, outline how we intend to make a contribution, and through which first concrete projects we will do so in 2020 and 2021. In this way, this agenda guides us and makes clear to the outside world what we are going to do and how we are going to do it. Nevertheless, the agenda is certainly not exhaustive or static. We keep an open mind and, where necessary, also in consultation with our clients, tackle new issues at the intersection of public health **&** society.

Task 1: Differences in society

Due to growing differences in what people have, can or want, they find themselves at a greater distance from each other. More and more differences are not justifiable or difficult to justify, while other differences deserve more appreciation. How can care and support better respond to diversity, and what can be done about problematic differences in health and well-being?

Social task

People distinguish themselves from one another in many different ways. This diversity is often something worth celebrating. We have pointed out its merits before (RVS 2016). Yet there are also differences that are problematic, for example, if they reinforce and enlarge each other, or if the same people continue to lose out. Such differences appear to be unbridgeable or are no longer noticed because groups become separated from one another (SCP 2014a). Social polarisation happens gradually, sometimes across several generations: the *haves* versus the *have nots* and the *cans* versus the *can nots*. Unequal opportunities for a good and healthy life arise. The willingness to help pay for the care or help that others need is under pressure (SCP 2019b). Groups of citizens and professionals feel disadvantaged or treated as less important.

Differences are expected to increase in the coming years, including within the care and health domain. People with a lower level of education have a lower life expectancy than those with a higher level of education, and live fewer years in good health (RIVM 2018). The gap between young and old is growing. There is a growing group of elderly people who depend on care and ever fewer young shoulders to bear that burden (CBS 2018; SCP 2018a). Gender differences also require attention. Medical and technological possibilities raise questions, too: for example, whether everyone can or should benefit from them.

Traditional solutions are proving insufficient to counteract these differences. It raises the relevance of the question of how we can better anticipate diversity and what we can do to combat problematic differences. There is often a tendency to fill in what the other person needs based on one's own idea of a good life, as well as scientific insights. But can it also be done differently, with more attention for the context and what people themselves find important?

Our contribution

Formulating an answer to the question when differences in health or well-being are problematic cannot be done without a social discussion. Although solution directions are, by definition, a matter of ideological preferences, discussions in a politically divided landscape should never lead to groups of people falling between two stools.

The Council contributes by interpreting and mapping out differences, and by examining their complexity. Where do differences arise, and how are different forms of inequality related? We also think about how policy solutions can consider personal circumstances or cultural differences, and, therefore, do not necessarily have to be the same for everyone.

Where differences are problematic, they require action perspectives for an appropriate approach. Such an approach must be explored at all levels: micro, meso and macro. We try to find those moments in life where differences accumulate among groups of people, become irreconcilable or are not yet sufficiently on the agenda. We also advise on what to do about it.

What we are going to do in any case (consultancy projects 2020-2021)
In order to rise to this task, the Council will in any case focus on the following subjects in the coming years:

- ***Homelessness***
- *We explore what the perspective of a right to a home can mean for tackling homelessness in the Netherlands. In doing so, we will not only zoom in on the people who are known to be homeless, but also on the 'precariously housed': the growing group of people who, as a result of a life event such as a divorce, are (temporarily) in danger of ending up on the street.*
- ***Complex inequality***
  Differences are intertwined, for example, the link between education and inadequate livelihood and health. We make this complexity visible in order to investigate when differences between social determinants and differences in the course of life can best be tackled, and how cross-domain investments or approaches can help – as input for a renewed social debate.
- ***Solutions for people in precarious situations***
- *A large group of Dutch people are permanently in a precarious situation as a result of a combination of poverty, debt and, for example, a language deficit or mild intellectual disability (SCP 2014b; SCP 2018b; Ministry of Finance 2019). That situation can determine people's entire life, from growing up in poverty, an insecure working life with hardly any financial buffers, to a vulnerable old age. Even government assistance often offers only temporary solutions for one problem and hardly helps them, if at all. They are permanently prone to setbacks. It puts their health and well-being under pressure. We dive into the problems and explore unorthodox solutions to turn the tide. For example, what does this require in terms of access to care and assistance, and what opportunities do forms of social prevention offer?*

Task 2: A healthy and social living environment

The living environment can make an important contribution to our health and well-being. Conversely, our environment can also cause illness, stress and loneliness. What is a contemporary and future-proof perspective on a healthy and social living environment? What is the interaction between collective and individual prevention, and how do we bring about change?

The social task

We look for solutions to health problems primarily in the medical field, with healthcare professionals. At the same time, healthcare is under pressure. The potential of an environment that promotes healthy behaviour remains untapped (RIVM 2017). In fact, if nothing happens, changes in our environment risk becoming detrimental to health or well-being (RIVM 2018b). After all, cities are becoming busier, while other areas are becoming emptier and the environment is under pressure (CBS 2019a). In an increasingly individualised, digital world, we no longer automatically look after the people in our immediate environment. Our digital environment can also threaten our well-being, through reduced physical encounters, less exercise and new addictions. This is how living environment and lifestyle touch each other.

All this certainly puts the nearby physical living environment (the neighbourhood, the area, the city district or the village), but also our digital living environment, as it were, under high voltage. As a result of an ageing population, more people will have to rely on facilities close to home. The movement towards more care at home and in the neighbourhood requires new concepts and facilities. At the same time, this also creates an opportunity to redesign that environment and to respond to the opportunities that digital innovations also offer – as an important tool for reducing distances and loneliness. This requires a living environment that not only contributes to better health, but also continues to respond to the various needs and possibilities of all its residents and users.

Our contribution

In this theme, we are looking to improve public health outside of care, at the heart of society. Our contribution lies first and foremost in imagining what a healthy and social living environment might look like in the coming years; not only socially, but also physically and digitally. This requires a contemporary perspective. After all, every neighbourhood is different, has local challenges and has local potential. We offer a representation by actively experimenting where possible, and by utilising the imagination of designers and others.

Secondly, our contribution is also about the governance of a healthier nearby environment. Connections between health and other policy areas such as living or working do not materialise automatically. Within the care sector, too, it appears difficult to do more justice to the potential health gains of a healthy lifestyle. Where are the barriers? What is a way out in case of conflicting interests? How can we better identify potential health benefits? And what is the role of actors outside the care sector, such as housing associations or designers of public spaces and buildings? We are exploring how thinking about health can go hand in hand with other social tasks, such as the energy transition, thinking about the city of the future or tackling shrinking regions.

What we are going to do in any case (consultancy projects 2020-2021)

In order to rise to this task, the Council will in any case focus on the following subjects in the coming years:

- ***Policy for a healthy environment***
  Based on insights about broad determinants of health, including in the (nearby) living environment (RIVM 2017), we are considering how policy-makers can address these appropriately. How far should the government go in creating a healthy environment and focusing on behavioural change? We offer a perspective on preventive health policy as a follow-up to the current prevention agreement and follow up on the RVZ advice 'Take care of your health!' (RVZ 2010).
- ***Living, working and caring in the neighbourhood: a follow-up to the Who Cares competition***
  Based on the inspiring entries for the Who Cares competition from 2017, we will continue to think about innovative forms of living, working and care in the neighbourhood. How do we create not only smart, but also caring cities and villages and make connections with, for example, the value of work? We also translate experiences from existing initiatives into smart ways to invest in facilities in the neighbourhood.
- ***Healthy digital environment***
  Our lives increasingly take place in a digital environment. For young people in particular, this digital environment can become burdensome and addictive (RIVM 2018a). Augmented *and* mixed reality, *for example, blend* the *digital and physical environment even more. How do we keep this digital environment social and healthy as well? But also: how do we seize the opportunities digital resources can offer to create a caring and social environment?*

Task 3: Limits to curing and improvement

Due to growing medical possibilities, a social ideal of social engineering appears to be increasingly within reach. This makes dealing with vulnerability, suffering and death complicated. How can we create a better dialogue about this in the field of care and with each other?

Social task

Life and social engineering appear to become increasingly synonymous Thanks to medical innovations and technological developments, we live longer and we do not immediately succumb to many diseases or disorders. A pill, a new body part, an artificial organ: medicine is always looking for new possibilities. We appear to be able to gain control over health and illness, and even improve ourselves physically and mentally through the use of apps, aesthetic interventions, or DNA technology: our lives seem to be engineerable.

Too often, we forget that vulnerability, suffering and death are also part of life. Medicine cannot always provide the hoped-for cure, and longer treatment does not always offer better quality of life. We may be able to postpone death for longer, but we cannot conquer it. Living longer goes hand in hand with new forms of suffering. The fact remains that we are mortal, and we all have to deal with illness, setbacks, and loss, of ourselves or our loved ones. Disorders are more often chronic, and collective resources are limited. In parallel to the understandable desire to live longer in good health, the question arises: how do we learn to live with vulnerability and finiteness? Are we having 'the right conversation' about this, and how do we learn to respond better to the wishes and fears of patients and caregivers? This can be quite difficult in the doctor's surgery, where the conversation is often still mainly about healing and staying alive. How can doctors and other healthcare workers be better equipped to have discussions about whether or not to continue treatment, and about the quality of life and death?

Our contribution

Every member of society will inevitably be confronted with vulnerability, suffering and death, even in times of social engineering. Although initiatives are being taken to discuss this, it remains a difficult topic. The Council wants to give these difficult but important discussions a more prominent place in the care process. To this end, we need to break the taboo, in society as well as in the care sector. In addition, we are exploring new forms of care that help support those living with disease and vulnerability.

What we are going to do in any case (consultancy projects 2020-2021)

In order to rise to this task, the Council will in any case focus on the following subjects in the coming years:

- ***Talking about dying***
- *It is not always easy to talk about death in a society that is focused on life and social engineering. This certainly holds true for the care sector as well. How can we improve the discussion about the way we live, die and deal with dying?*
- ***Gap between curative and palliative care***
- *Too often, people die in the hospital even though they would rather die at home. The step towards the palliative or terminal phase can be daunting and abrupt. How can we bridge the gap between curative care and palliative care, both in elderly care and beyond?*
- ***How to live with lifelong or life-determining illnesses or conditions*** *Research into lifelong or life-determining illnesses such as diabetes, mental health problems, dementia or Parkinson's disease is often aimed at preventing or curing it. Less attention is given to a perspective on what a good life with these and other*

disorders looks like. How can we better put this into practice? And how do we organise our society accordingly?

Task 4: Care in a tight labour market

The need for care and support is increasing as a result of the changing population. At the same time, the care sector is faced with staff shortages and absence due to illness as a result of, among other things, loss of job satisfaction. The professionalism of care and assistance providers is under pressure, as well as quality and accessibility. How do we continue to care for each other in a tight labour market?

Social task

In a doubly ageing and dejuvenating society, not only are there fewer workers and informal carers, but the demand for care is also rising. People live longer, but more often need ever more complex care (RIVM 2018). At the same time, there is an increasing scarcity of personnel in the care sector. The number of difficult-to-fill vacancies is increasing (UWV 2019), care workers are more likely to leave their jobs (EY 2019) and the high absenteeism rate exacerbates this shortage. Care workers' job satisfaction and professionalism are under pressure. Regulatory pressure, administrative burdens and high expectations from society (both professional and private) create work pressure and stress. Healthcare workers find it more difficult to link their view of good care with changing expectations from regulators, financiers, politicians and patients.

The task to provide care in a tight labour market requires a new interpretation of professionalism and a revival of inspiration in the workplace. How can we ensure that healthcare workers can better use their professional expertise and experience in a way that benefits patients and clients?

From a broader perspective, it also requires a different approach to our demand for care. How do we want to live together and what place do we give care in this sense? Should we consider caring as something that will become a part of life throughout all our lives, even outside the (semi) professional framework? To what extent are we, as people, willing or able to care for, help or support each other?

Our contribution

We shed light on the current personnel shortage in a more fundamental way than an HR issue alone would. It is a problem that is difficult to solve and requires a broad, integrated approach. We do this in the first place by reconsidering the professionalism of the care sector and care workers, in light of a changing society that is affecting their work. We investigate how this requires a different interpretation of the concept of professionalism.

Secondly, in the coming years we will also investigate the place of care in society. This question is interwoven with social expectations of the collective facilities in healthcare and the coherence between care from the formal and informal circuit. How can a new perspective on how we want to live and care for each other contribute to solving current and future personnel shortages?

What we are going to do in any case (consultancy projects 2020-2021)

In order to rise to this task, the Council will in any case focus on the following subjects in the coming years:

- ***Professionalism in connection***
- *We are investigating a new interpretation of the concept of professionalism in order to be able to retain care professionals and allow them to work in a more meaningful way again, in line with the demand for care, now and in the future.*
- ***'Living differently' paradigm***

- *How can we offer an alternative to the current care paradigm (RVS 2017)? What does it mean (for our society) if we want to embed care more in normal life, and what does this require from citizens? Another aspect of a new paradigm is appropriate alignment between formal and informal care and the re-evaluation of the value of the knowledge and skills of citizens, patients and informal carers.*

"We try to find those moments in life where differences accumulate among groups of people, become irreconcilable or are not yet sufficiently on the agenda."

Task 5: Systems at odds

Due to multiple or chronic problems, more and more people are faced with multiple systems of care and support. These systems do not always dovetail with one another. Getting the right help can be difficult or frustrating. This leads to a loss of public trust and solidarity. What can we learn from bottlenecks, and what is a suitable perspective for the future?

Social task

The provision of care and support is covered by various legal frameworks, such as the Health Insurance Act [Zorgverzekeringswet], the Appropriate Education Act (Wet passend onderwijs), the Long-Term Care Act (Wet langdurige zorg) and the Participation Act (Participatiewet). These systems differ in nature, for example in their objectives, how provisions are paid for and how access is regulated. Language and culture may also vary considerably. As a result, systems are not always properly connected. Collaboration across borders – based on what people need – is also difficult to realise.

However, more and more people require care or support from different systems. Vulnerable people in particular are more often sent from pillar to post (RVS 2019). It puts their 'capacity to act' (WRR 2017) to the test and not everyone is able to find (timely) appropriate care or help. Care providers and organisations also spend much time on coordination and administration. Citizens find it difficult to grasp the value and intent behind the systems (National Ombudsman 2018). This undermines legitimacy and confidence in the government and in healthcare and support systems (SCP 2016b). Willingness to contribute to collective provisions is under pressure, especially now that the costs of care are rising (CBS 2019b), particularly because citizens do not feel sufficiently able to participate in decisions on how their care or support is organised. Systems that are at odds are therefore a bottleneck for individual citizens as well as a social problem.

Our contribution

The future of the current care and support systems is high on the agenda. A possible redesign is being considered in a variety of places. In the essay *Complex problems, easy access* (RVS 2019), we recently drew attention to this.

This debate is now gaining momentum and we want to provide it with direction in the coming years from the perspective of a changing society, by investigating where conflicting paradigms, values and normative views under the organisation of care and the social domain come from. What are the assumptions under current laws and what might a renewed relationship between government, market, social initiative and citizens look like in these sectors?

To this end, we examine several concrete cases where systems that are at odds or lack of cooperation lead to acute bottlenecks, for example, in acute care and care for youth or the elderly. We want to improve the focus on yields, but also on the flaws and contradictions in the current system, and investigate how things might be done differently. In this way, we build concrete directions for a longer-term narrative. We also involve the perspectives of, for example, visuospatial thinkers, writers, aid workers and experts by experience.

We link this reflection to more concrete discussions on, for example, strengthening regional cooperation. We also link it to the question of whether the entire system should be overhauled, or whether, for example, better cooperation across borders can help to

cope with the current complexity of and future demand for care and support. And how do we prevent new policy from accumulating while failing to result in the desired change?

What we are going to do in any case (consultancy projects 2020-2021)
In order to rise to this task, the Council will in any case focus on the following subjects in the coming years:

- ***Acute care***
- *In response to a question from the House of Representatives, we are investigating how public values relating to acute care can be better safeguarded in the future. We will work out different scenarios for the organisation, coordination and financing of acute care. In this way, we offer input for policy-making about the future of acute care.*
- ***Reflection on direction in the care sector and the social domain***
- *Building on these and other cases, we reflect on the principles and intentions behind system changes in the past 15 years, and their translation into practice. In this way, we also offer reflections on current discussions about regional cooperation to achieve more management in the region. What exactly do we understand the term 'region' to mean, and are the expectations of management in the region realistic? When does the level of the individual patient, the neighbourhood, the municipality, the region or even the national or international level actually make sense?*
- ***The art of innovation***
- *Learning from each other, scaling up good ideas, or 'de-implementing' old rules: why is this so difficult in the care sector and social domain? Stubborn attitudes such as 'not invented here' or 'it is probably not allowed' are often in the way, just like, for example, poor knowledge transfer or communication problems as a result of specialist expertise. How can inadequate innovation be explained based on the organisation of systems and professional and institutional values and cultures? And how can it be changed? What does this require, for example, from the leadership of administrators, regulators and the government?*
- ***Privacy and data exchange***
- *How can ICT and better data exchange help citizens and professionals experience smoother transitions between systems, disciplines and organisations? And what does this require in terms of leadership from directors and supervisors of healthcare or IT companies and from the IT skills of healthcare providers and patients and clients? What is required to achieve this, for example, in balance with medical professional secrecy, and how we think about privacy in healthcare?*

Literature

CBS (2018). *Prognose: 18 miljoen inwoners in 2029 [Forecast: 18 million inhabitants in 2029]*. Consulted via https://www.cbs.nl/nl-nl/nieuws/2018/51/prognose-18-miljoen-inwoners-in-2029, 10 December 2019.

CBS (2019a). *Waar groeit of krimpt de bevolking? [Where is the population growing or shrinking?]* Consulted via https://www.cbs.nl/nl-nl/dossier/dossier-verstedelijking/hoofdcategorieen/waar-groeit-of-krimpt-de-bevolking-, December 10 2019.

CBS (2019b). *Solidariteit in de gezondheidszorg. [Solidarity in health care]. Views on health insurance premiums and lifestyle*. The Hague: Statistics Netherlands

Van der Schoot Committee (2019). *Evaluatie van de Raad voor Volksgezondheid & Samenleving (2015-2018) [Evaluation of The Council for Health & Society (2015-2018)]*. The Hague: Council for Public Health and Society.

EY (2019). *Barometer Nederlandse Gezondheidszorg 2019 [Dutch Health Care Barometer 2019]*. Consulted via https://www.ey.com/Publication/vwLUAssets/EY-barometer-nederlandse-gezondheidszorg-2019/$FILE/EY-barometer-Dutch Healthcare-2019,pdf, 10 December 2019.

Ministry of Finance (2019). *Interdepartementaal beleidsonderzoek Mensen met een licht verstandelijke beperking [Interdepartmental policy research People with mild intellectual disabilities]*. The Hague: Ministry of Finance.

National Ombudsman (2018). *Zorgen voor burgers: onderzoek naar knelpunten bij de toegang tot zorg [Caring for citizens: research into bottlenecks in access to care]*. The Hague: National Ombudsman.

Pharos (2019). *Factsheet gezondheidsverschillen [Factsheet health differences]* Consulted via https://www.pharos.nl/factsheets/sociaaleconomische-gezondheidsverschillen-segv/, 10 December 2019.

RIVM (2017). *Investeren in gezonde leefomgeving bevordert gezond gedrag [Investing in a healthy living environment promotes healthy behaviour]* Consulted via https://www.rivm.nl/nieuws/investeren-in-gezonde-leefvironment-bevordert- Gezond-gedrag, 10 December 2019.

RIVM (2018a). *Themaverkenning 1 [Theme Exploration 1] Zorgvraag van de toekomst [Healthcare requirements of the future]* Consulted via https://www.vtv2018,nl/druk-op-jongeren, 10 December 2019.

RIVM (2018b). *Themaverkenning 2 [Theme Exploration 1] Brede determinanten van gezondheid [Broad determinants of health]* Consulted via https://www.vtv2018,nl/themaverkenningen, 10 December 2019.

RIVM (2019a). *Chronische aandoeningen en multimorbiditeit [Chronic disorders and multimorbidity]*. Consulted via Volksgezondheid.info, 10 December 2019.

RIVM (2019b). *Gezondheidsverschillen [Health differences].* Consulted via https://www.rivm.nl/gemeente/preventie-zorg-en-welzijn/gezondheidsverschillen, 10 December 2019.

RVS (2016). *Verlangen naar samenhang [Longing for cohesion] Over systeemverantwoordelijkheid en pluriformiteit [About system responsibility and diversity]* The Hague: Council for Public Health and Society.

RVS (2017). *Recept voor maatschappelijk probleem [Recipe for a social issue] Medicalisation of phases of life*. The Hague: Council for Public Health and Society.

RVS (2018). *Gezien en gehoord [Seen and heard]. 17.000 ervaringen met zorg en hulp [17,000 experiences with care and help]* The Hague: Council for Public Health and Society.

RVS (2019). *Complexe problemen, eenvoudige toegang [Complex problems, easy access]* The Hague: Council for Public Health and Society.

RVZ [Council for Public Health and Care] (2010). *Zorg voor je gezondheid! [Take care of your health!] Behaviour and health: the new order.* The Hague: Council for Public Health and Health Care.

SCP (2014a). *Gescheiden werelden? [Separate worlds?] Een verkenning van sociaal-culturele tegenstellingen in Nederland [An exploration of socio-cultural contradictions in the Netherlands]* The Hague: The Netherlands Institute for Social Research.

SCP (2014b). *Verschil in Nederland [Differences in the Netherlands] Social and Cultural Report 2014*. The Hague: The Netherlands Institute for Social Research.

SCP (2016a). *Overall rapportage sociaal domein 2015: rondom de transitie [Overall report social domain 2015: around the transition]* The Hague:
The Netherlands Institute for Social Research.

SCP (2016b). *Zorg en onbehagen in de bevolking [Care and unease among the population] Een verkenning van de publieke opinie op verzoek van de Raad voor Volksgezondheid en Samenleving (RVS) ter voorbereiding van zijn congres op 10 oktober 2016 [An exploration of the public opinion at the request of the Council for Health and Society (RVS) in preparation for its conference on 10 October 2016]* The Hague: The Netherlands Institute for Social Research.

SCP (2018a). *Sterke daling van potentiele mantelzorgers in de toekomst [Sharp drop in potential family-based carers in the future]*. Consulted via https://www.scp.nl/Nieuws/Sterke_daling_van_potenti_le_mantelzorgers_in_de_toekomst, 10 December 2019.

SCP (2018b). *Als werk weinig opbrengt [When work doesn't pay much] Working poor in five European countries and twenty Dutch municipalities*. The Hague: The Netherlands Institute for Social Research.

SCP (2019a). *De sociale staat van Nederland 2019 [The social state of the Netherlands 2019]* The Hague: The Netherlands Institute for Social Research.

SCP (2019b). *Burgerperspectieven 2019|2 [Citizen Perspectives 2019|2]* The Hague: The Netherlands Institute for Social Research.

UWV (Employee Insurance Agency) (2019). *Zorg. Factsheet arbeidsmarkt [Care. Factsheet labour market]* Consulted via https://www.uwv.nl/overuwv/Images/factsheet-zorg-2019.pdf, 10 December 2019.

WRR (Advisory Council on Government Policy) (2017). *Weten is nog geen doen [Knowing what to do is not enough] A realistic perspective on self-reliance*. The Hague: Scientific Council for Government Policy.

Creation of agenda

How did we arrive at our agenda?

We did not draw up this agenda independently. In recent months, we have listened to people in various areas of healthcare and in society, in a variety of conversations, focus groups and through a broad digital consultation. We provide an overview below. In this way, we want to thank all of our interlocutors for their suggestions.

As a Council, we advise independently. The discussions we had during the preparation of this agenda, therefore, do not have the character of creating support. The interlocutors have not committed themselves to the content of this agenda.

Ranking the Topics

10,127 respondents responded to our digital consultation *Ranking the Topics*. We presented them with five topics and five subtopics. We also asked them to rank these. Which themes should be at the top of the RVS's agenda? There was also room for the respondents to put forward other topics. The results can be found on the website www.rankingthetopics.nl. We prepared the online questionnaire in collaboration with communication agency WeThePeople.

We would like to thank the following partners for sending out the questionnaire to their members or followers: ActiZ, BPSW, De Jonge Specialist, Divosa, GGD-GHOR, GGZ Nederland, Harteraad, Ieder(in), InEen, KNMG, LOC Zeggenschap in Zorg, MantelzorgNL, Mind/ LPGGz, NFU, NIP, NVVG, NVZ, Patiëntenfederatie NL, Per Saldo, PGGM&Co, PGO Support, Sociaal Werk NL, V&VN, VGN, VNG, VNVA and VvAA.

Dialogue meetings in the field and in practice

- Representatives of stakeholders, industry and professional associations and knowledge institutes in the care and social domain (16 and 23 September 2019)
- Taalambassadeurs (25 September 2019, in collaboration with Pharos)
- Guests of Buurthuis De Speler in Utrecht (September (26 2019, in collaboration with Pharos)
- Designers, artists, architects and spatial professionals (7 October 2019)
- Representatives of elderly people's organisations (24 October 2019, in collaboration with KBO-PCOB)
- Volunteers from Voedselbank Haaglanden (30 October 2019)
- Elderly people (11 November 2019, in collaboration with KBO-PCOB)
- Youth panel Jong én Perspectief of FNO (5 November 2019)

Discussions with clients and governments

- Jeanne van Loon (Knowledge Directorate) of the Ministry of Education, Culture and Science (20 August 2019)
- Fokke Gietema (Directorate of Management, Finance and Regions) and Pieter van Winden (Director of Corporate Support, Strategy cluster) of the Ministry of the Interior and Kingdom Relations (29 August 2019)
- Managing directors of the Ministry of Health, Welfare and Sport (September-November 2019)
- Netwerk Directeuren Sociaal Domein (20 September 2019)
- Ministers of Health, Welfare and Sport (26 September 2019)
- Executive Board of the Ministry of Health, Welfare and Sport (27 September 2019)
- Niels-Ingvar Boer (Chief Science Officer) of the Ministry of Social Affairs and Employment (29 October 2019)

- Standing Parliamentary Committee on Public Health, Welfare and Sport of the Senate (5 November 2019)
- Standing Parliamentary Committee on Public Health, Welfare and Sport of the Lower House (19 November 2019)
- Association of Netherlands Municipalities (10 January 2020)

Conference 10 October 2019

Our annual conference on 10 October 2019 at The Student Hotel in The Hague also focused on the discussion of relevant topics for our new agenda. An impression of this day can be found here.

VeRS

Finally, for this agenda, we gratefully made use of the brainpower of VeRS, the talent network of the RVS. They provided input at a meeting on 11 April 2019.