WRR

THE NETHERLANDS SCIENTIFIC COUNCIL FOR GOVERNMENT POLICY

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From disparity to potential

A realistic perspective on socio-economic health inequalities

2019

In this policy brief, the Scientific Council for Government Policy (*Wetenschappelijke Raad voor het Regeringsbeleid*, WRR) proposes a new perspective on ways of designing and evaluating health-prevention policy in the Netherlands. For decades, the main aim of such policy has been to reduce health inequalities between groups of higher and lower socio-economic status. Now, several decades later, we can conclude that the Dutch have become healthier as the result of policy efforts. We are living longer, and the number of years we feel healthy is increasing. Health inequalities between socio-economic groups have hardly declined at all, however, and they have even widened in some respects.

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SUMMARY

The WRR proposes to reinvigorate health-prevention policy by re-directing our attention from health *inequalities* towards health *potential*. From this perspective, we must consider where the greatest possible health gains lie, and how to keep health losses to a minimum.

Three priorities have emerged:

- Emphasis on early interventions (ranging from shortly before pregnancy up to the age of 18 years).
- Greater focus on those with the greatest health disadvantage (e.g. people with low socio-economic status).
- Targeting smoking, obesity/poor diet/lack of exercise and problematic alcohol consumption, all of which constitute a substantial health burden in the Netherlands.

We also advocate exploring mental health as a new and urgent priority. Mood and anxiety disorders are correlated with high disease burden, are more common within low socio-economic population segments and are becoming increasingly common amongst young people. Finally, we call for much-needed investments in research and monitoring. We know too little about the effects of policy and interventions with regard to reaching the available health potential in general, let alone differentiated according to vulnerable groups in society.

WRR Policy Briefs are short publications offering reflection on current issues in policy, which WRR uses as a foundation for making policy recommendations and for issuing supporting information.

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FOREWORD

This policy brief by the Scientific Council for Government Policy (*Wetenschappelijke Raad voor het Regeringsbeleid*, WRR) aims to reinvigorate current health policy targeting health inequalities between socio-economic groups. As indicated by available data, Dutch people are now healthier as the result of prevention policy. We are living longer, and the number of years we feel healthy is increasing. Health disparities between socio-economic groups have hardly declined at all, however, and they have even widened in some respects.

The WRR proposes to enhance prevention policy by shifting attention from health *inequalities* towards health *potential*. To obtain the greatest possible health gains, we have set priorities for prevention policy in healthcare, formulated as policy recommendations.

We are indebted to a great many people for the production of this policy brief. First, we would like to thank Fons van der Lucht (Senior Public Health Researcher) and Ellen Uiters (Senior Researcher for life-course epidemiology), both employed by the Netherlands National Institute for Public Health and the Environment (RIVM). Their collaboration throughout the process of writing this policy brief was both constructive and fruitful, and it is to them that we owe much of the scientific basis for our policy recommendations.

The data forming the framework for this policy brief were obtained from RIVM and Statistics Netherlands (CBS).

We are highly grateful to Annemarth Idenburg (the original Project Coordinator) and Anne-Greet Keizer (both members of the WRR support staff), and to Maaike de Vries (then Manager of the RIVM Public Health Foresight Study) for their formidable brainpower.

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A final word of gratitude is due to those who kindly shared their ideas with us during two expert sessions addressing health inequalities in general, as well as the approach to be taken.

PREAMBLE

Let us begin with an example[1]: Smoking is a major cause of health problems in later life. Suppose that the government were to launch a policy initiative aimed at discouraging smoking, which led to the following results:

- A decline in the percentage of smokers from 35% to 25% amongst people with low socio-economic status (SES)
- A decline in the percentage of smokers from 25% to 10% amongst people with high socio-economic status (SES)

The relative success of this policy depends on how it is measured. In terms of absolute health benefits, the policy has been a success: the number of smokers has dropped across the board, thereby greatly increasing likelihood that individuals will remain healthy into old age. In terms of equal outcomes, however, the policy has not succeeded. The gap between the percentages of smokers in populations with high and low SES has actually widened (from 10% to 15%). This means that the difference in the likelihood that people from backgrounds of higher and lower SES will remain healthy into old age has also increased.

The effects reported here are far from hypothetical, and the figures cited actually constitute a good overall reflection of smoking trends in the Netherlands since 1990. This pattern is not unique, as similar progressions have been observed in other health indicators as well. Dutch life expectancy has increased significantly across the board, but, despite these positive gains, researchers, health professionals and policymakers are still disappointed. After decades of effort, the differences between lower and higher socio-economic groups have remained the same or, in some cases, even increased.

As described here, the various aspects of this issue raise questions concerning how they should be evaluated. With this policy brief, we aim to shift the perspective from a focus on health *disparities* to a focus on health *potential*. In other words, we have adopted a focus on opportunities for achieving health gains or preventing health losses.

From this new perspective, the elimination of health inequalities is *no longer an end in itself.*

1 This example was taken from an article by Johan Mackenbach, Professor of Public Health at Erasmus University Rotterdam and one of the world's first health-inequality researchers. In the article, Mackenbach discusses the relative and absolute decline in mortality rates amongst people with high and low income from both a numerical and an epidemiological perspective (Mackenbach 2015).

1 INTRODUCTION

Considerable health inequalities exist between populations with higher and lower socio-economic status (SES), and they have shown little to no change over the past decades. This applies to the Netherlands, as well as to most other Western welfare states.[2] On average, wealthier and more well-educated populations live longer, and remain in better health.

It stands to reason that disparities are often discussed in terms of injustice and that researchers, healthcare professionals and policymakers are committed to closing the gap. After 35 years of policy and effort, most indicators show that the differences have remained virtually the same: the relative discrepancies are large, stable and, in some cases, even growing. This makes the problem both frustrating (due to the apparent lack of improvement) and morally unsatisfying (given the persistent injustice of the discrepancies). The problem might even seem nearly insurmountable when formulated in terms of socio-economic health inequalities and policy.

Despite the reality of the frustrations described above, they are only part of the story. The persistent inequalities obscure much of the subtle dynamics present in the data. Some health problems have improved markedly over time. For example, the number of smokers has dropped across the board in recent decades. Because groups with higher and lower SES have remained in step (or perhaps because those with higher SES have tended to reap more of the benefits), the relative *disparities* have remained the same or even increased. In terms of relative disparities, this outcome is poor, despite the fact that many people with both higher and lower SES have benefited in an absolute sense.

A relevant question thus concerns how these results should influence preventive health policy. With this policy brief, we advocate examining the problem through a different lens. Instead of seeking to reduce health *disparities*, it would be better to focus on achieving the greatest health benefits possible, while keeping health losses to a minimum.

The question guiding this policy brief is therefore as follows: Where does the greatest health potential lie, and how can it best be achieved? Although this altered perspective still calls for greater attention to and effort for those with lower SES, the effects of SES on health *disparities are no longer the primary focus.*

Terminology

This policy brief contains many references to health *disparities/inequalities*, health *gains/benefits*, health *losses* and health *potential*. It would be useful to define these terms.

2 Van der Lucht & Polder (2010); Mackenbach (2012); Mackenbach et al. (2016); Jansen (2017); Hilderink & Verschuuren (2018).

Before we can define these terms, however, we must determine a 'unit of measurement' for health. This is no simple matter, as the concept of health has no measurable limitations.[3] According to many experts, health is more than merely the absence of disease or other physical problems.[4] For example, Haverkamp and colleagues highlight the existence of various concepts of health, each of which is embedded within a specific context that is subject to specific key health aspects.[5] Recent years have also seen an increased focus on what individuals themselves define as health, and the popularity of 'feeling fit', 'feeling good', 'being able to do what I want' and similar notions has increased. Subjective interpretations of health can nevertheless complicate matters, due to differences in the ways in which individuals perceive and evaluate health, as well as in the approaches to health that are adopted by experts. When referring to health, people with lower SES often refer to their day-to-day problems, and their long-term views (especially in cases of multimorbidity) are far more limited than those adopted by experts.[6,7]

In this policy brief, we adopt the pragmatic approach of the RIVM Public Health Foresight Study, which draws on a variety of simultaneous indicators. As such, two outcome measures are used:

- Life expectancy, which is an indicator of the age that people reach.
- *Healthy* life expectancy, which indicates the number of years that people can expect to live in good health. This measure is based on life expectancy and several quality-of-life indicators.

The use of these outcome measures makes it possible to express differences in health as the difference in life expectancy and healthy life expectancy between groups with lower and higher SES.

The core concept in this policy brief is health *potential*, which refers to both health *gains* that can be obtained and health *losses* that can be avoided. Health *gain* refers to the additional years of life expectancy or healthy life expectancy realized within a certain period. Health *loss* refers to the years of life expectancy or healthy life expectancy lost within a certain period.

In this policy brief, we interpret health gains and losses in an absolute sense, involving no comparison between various population groups. This means that health gains in groups with lower SES are seen as positive, regardless of any health gains obtained in other socio-economic groups.

3 For an overview, see Polder et al. (2012).
4 WHO (1984).
5 Haverkamp et al. (2017).
6 Kooiker (2010).
7 Stronks et al. (2018).

People with relatively poor health (e.g. groups with lower SES) demonstrate greater health potential, as they have more room for improvement than do those who are already quite healthy. Young people also have considerable potential, as they have many years before them in which they could potentially achieve health gains or avoid health losses. The crux of the matter is obviously whether the available potential will actually be realized. This depends on a variety of factors, including the personal traits of individuals and the characteristics of their living environments. We address these aspects in greater detail in Section 4.

Socio-economic status

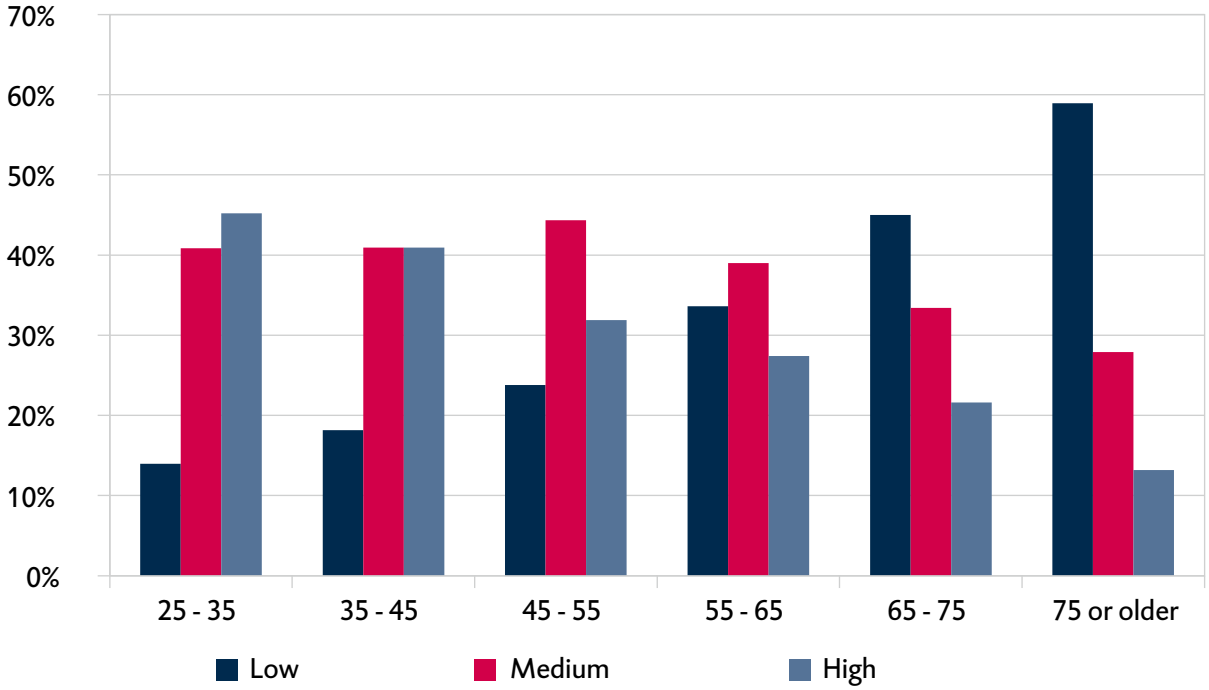
Socio-economic status (SES) can be measured by examining a variety of factors, including income, employment status or level of education. Following common practice in the Netherlands, this policy brief focuses on level of education, applying the frequently used scale developed by Statistics Netherlands (CBS), which distinguishes between low, medium and high levels of education.[8]

When making comparisons over longer periods, it is important to note that the composition of the various educational populations changes gradually over time, due to changes in the proportions of Dutch citizens attending school, as well as to changes in the duration of such schooling. For example, in 1930, around 80% of all Dutch citizens had completed only a 'low level' of education.[9] This percentage has dropped remarkably since then. We are currently experiencing 'credential inflation', meaning that a diploma that once corresponded to better jobs and accompanying SES (i.e. 'climbing the corporate ladder') does not necessarily do so currently. Credential inflation changes how education influences the social standing of individuals. Over time, these developments have also altered the difference between the average ages of groups having lower and higher SES (as determined by educational level). Older cohorts are becoming increasingly dominant in groups of lower SES, while those with higher SES are becoming increasingly younger (see Figure 1.1).

8 Statistics Netherlands defines 'low education' as having completed primary education, preparatory secondary vocational education (VMBO), the first three years of senior general (HAVO) or pre-university (VWO) secondary education, or assistant training (MBO-1). Medium education includes the upper three years of HAVO/VWO, basic vocational training (MBO-2), vocational training (MBO-3) and management/specialist training (MBO-4). High-level programmes are those taught at research universities (WO) and universities of applied sciences (HBO).

9 Jansen (2017).

Figure 1.1 **Highest level of education achieved, by age (2016)**



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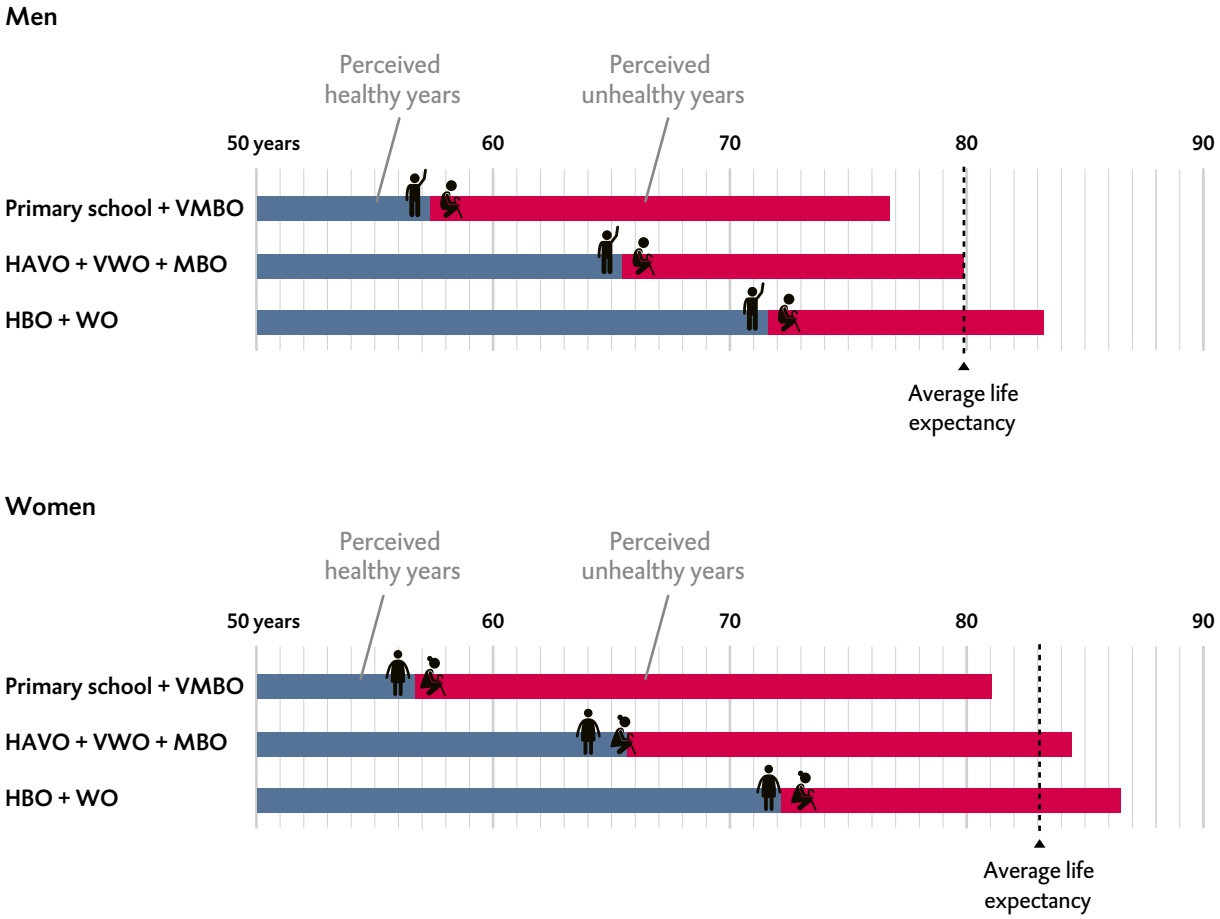
In the future, therefore, the health potential of groups with lower SES might be more limited than it is currently. Although the group of people with lower levels of education is becoming smaller, the health problems occurring within this group are likely to become worse. A further complication has to do with changes in the ethnic composition of this group. Groups with lower SES comprise a relatively large number of people with a background of migration, who also tend to have poorer health.[10] Compared to several decades ago, greater efforts will probably be necessary in order to achieve health benefits or to prevent current or future health losses within groups with lower SES.

2 THE FIGURES: PERSISTENT DIFFERENCES, SIGNIFICANT GAINS

Regardless of how SES is measured, the overall picture presented by the figures is that the health of people with lower SES lags significantly behind that of people with higher SES. Differences between two of the aforementioned key indicators – life expectancy and healthy life expectancy – are displayed in Figure 2, according to level of education.

10 Ruijsbroek et al. (2011).

Figure 2.1 **Correlation between education and (healthy) life expectancy (2013-2016)**



WRR & RIVM | Source: Volksgezondheidenzorg.info 2018, Statistics Netherlands (CBS) Statline

Table 2.1 **(Healthy) life expectancy, by level of education (2013-2016)**

Gender	Type of life expectancy	Low	Medium	High
Men	Life expectancy	76.8	79.9	83.3
Men	Healthy life expectancy	57.4	65.4	71.6
Women	Life expectancy	81.1	84.4	86.5
Women	Healthy life expectancy	56.7	65.6	72.2

WRR & RIVM | Source: Volksgezondheidenzorg.info 2018, Statistics Netherlands (CBS) Statline

This figure and the accompanying table make it painfully clear how differences in education are correlated with health. On average, women with low levels of education have a life expectancy that is 5.4 years lower than do those with high levels of education. The differences in *healthy* life expectancy are even greater (14.2 years in men and 15.5 years in women).

The notion that groups with different SES have different health outcomes is hardly new. Such disparities have existed for a long time.[11] Since the 1980s, the socio-economic health inequalities measured over long periods have appeared to be virtually insurmountable. The relative inequalities measured using such indicators as life expectancy and perceived good health are so stable that, in 2015 (more than 35 years after the problem first appeared on the Dutch political agenda), the government did not formulate any ambition beyond ensuring that 'by 2030 these inequalities will have remained the same, or better still, reduced.'[12]

Inequalities according to SES can also be observed when examining two key predictors of health problems in later life: smoking (for people 25 years of age and older) and obesity. The details of the example cited at the beginning of this policy brief are presented in Figure 2.2. Although the number of smokers has dropped significantly in all SES groups, the reduction is more pronounced amongst groups with higher SES. On balance, the percentage difference in the number of smokers has therefore increased and, with it, the difference in the likelihood of eventually suffering from smoking-related conditions. The same trend is represented in Figure 2.3, albeit in the opposite direction, with regard to the number of people 25 years of age and older who are suffering from obesity. This percentage has increased in all SES groups, and it is expected to undergo significantly greater increases in groups with lower SES than it is in groups with higher SES.[13]

11 Van Poppel et al. (2009).
12 Ministry of Health, Welfare and Sport (2015).
13 Hilderink & Verschuuren (2018).

Figure 2.2 Percentage of daily smokers (age 25+)

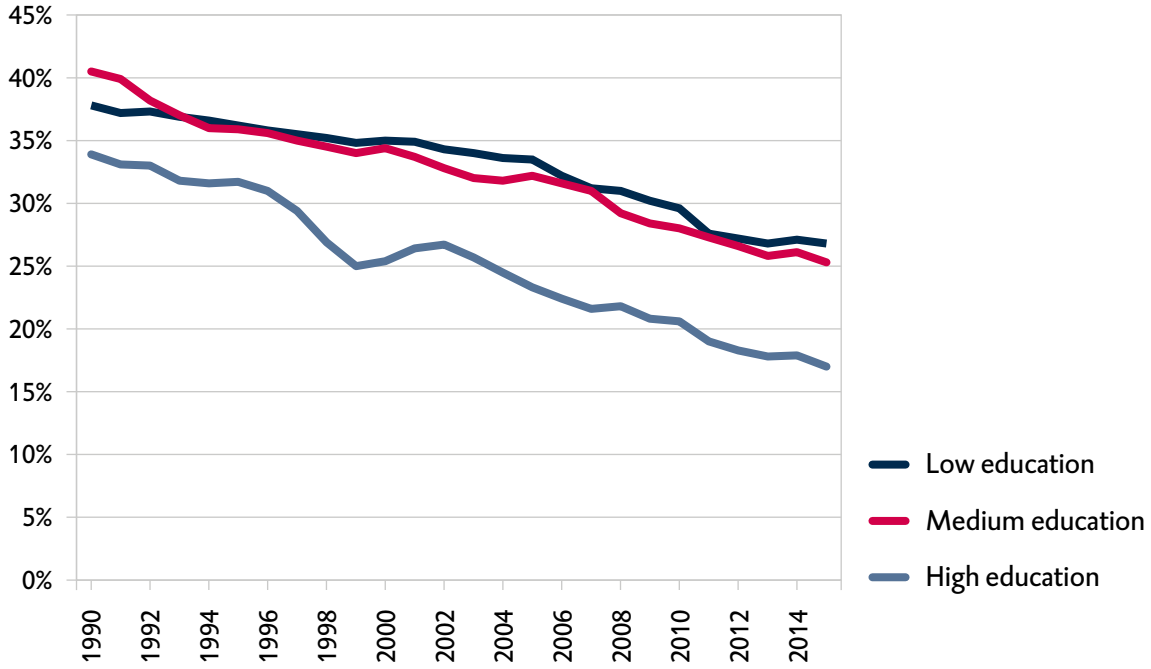


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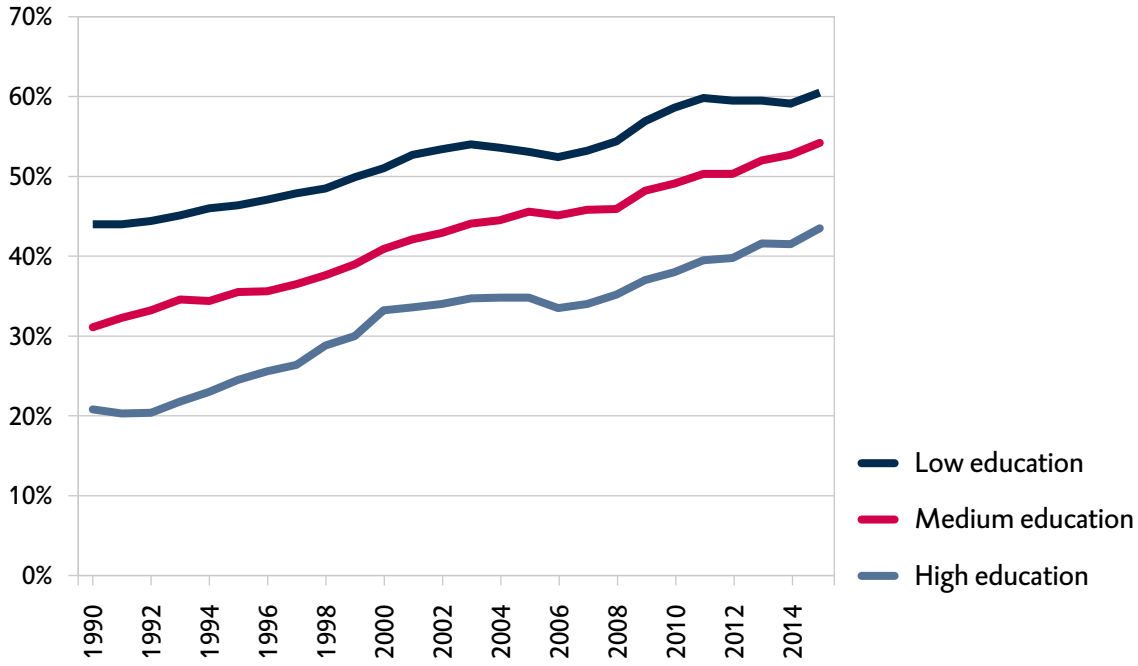
Figure 2.3 Percentage of people (age 25+) with obesity (BMI≥30)



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Conclusion

The Dutch have become much healthier in recent decades. At the same time, however, relative health disparities between those with higher and lower levels of education have not receded and, in some cases, they have even widened. With regard to healthy life expectancy and smoking, the existing health disparities are reminiscent of a phenomenon known as the 'Matthew effect', which has been observed in a wide range of social domains.[14] Although policies and measures that can be of particular benefit to groups with the poorest outcomes may have a positive effect in these groups, they tend to have an even *greater* effect on groups whose outcomes are already reasonable, or even good. As a result, overall disparities increase, even though everyone benefits. This paradoxical result can occur when a blanket policy is implemented across an entire population. For reasons including differences in capability and financial or other resources, this can result in inequalities.

All in all, the situation outlined above raises questions concerning the relative feasibility or utility of trying to reduce or eliminate health inequalities. Perhaps it would be better to replace the perspective of reducing health inequalities with one that is more realistic.

3 AN ALTERNATIVE POLICY FRAMEWORK?

This is a sensitive point. Intuitively, health inequalities feel unjust: on average, those who are already better off in terms of wealth are also healthier. The moral outrage over health inequalities is therefore a prominent element of the debate, in both the research community and policy.

In this section, we propose a different policy perspective, one that does not emphasize differences, but potential health gains to be realized.

Investing in health potential

The emphasis in previous decades on the injustice (whether actual or perceived) of health inequalities has somewhat obscured the fact that good health is not simply an end in itself, but also a prerequisite for other things that people value in life. This applies at both the individual and collective levels. Poor health can prevent people from leading what they personally consider to be a good life, as it can impede social, economic or community participation. Poor health can also thwart collective goals by increasing costs to society and reducing economic productivity.

14 Coined by Merton (1968), the term 'Matthew effect' was popularized in the social sciences, especially by Deleeck and colleagues (1983). The term is a reference to Matthew 13:12: 'For whosoever hath, to him shall be given, and he shall have more abundance: but whosoever hath not, from him shall be taken away even that he hath'.

It is perfectly legitimate to question how resources for preventive healthcare can best be deployed in order to realize the greatest possible health potential within society. The importance of this issue extends beyond the individual level, as effective preventive healthcare is also an investment in *human capital*, which can benefit society as a whole.

This conceptual shift took place in education several decades ago. Although it is hardly imaginable today, quality education was viewed purely as an expense, and not an investment, in financial/economic terms until a few decades ago. Although those days are now behind us, a similar conceptual shift is now being advocated in the field of healthcare, but the investment perspective is less widely accepted.

We wish to emphasize that the approach adopted in this policy brief has its limitations. It does not *exclusively* concern economic efficiency, a point that can be illustrated by a simple thought experiment. Suppose that achieving gains is the only objective. In that case – and from a purely economic perspective – it would initially seem logical to assign priority to the groups with the poorest average health (usually those with lower SES). This is because this group would stand to benefit the most, and it would therefore have the greatest potential for improvement (at the individual level). On the other hand – also based purely on the numbers – it could be more logical to prioritize the groups whose health is already reasonably good (in this case, groups with middle and high SES). The reason for this is the possible difference in the *likelihood* that the available potential will actually be realized. Although groups with higher SES may have less room for improvement, the *likelihood* of realizing the improvement is potentially higher, because the conditions for behavioural change in groups with higher SES are more favourable than they are in groups with lower SES. Higher SES groups are more likely to have the knowledge, skills and opportunities required in order to move in social circles in which a healthy lifestyle is the norm, to live in neighbourhoods in which healthy alternatives are available and to have greater financial leeway to afford these alternatives. Conditions in lower SES groups are less favourable, and they entail more persistent problems, combined with individual characteristics and environmental determinants that impede behavioural change. It is therefore likely that greater effort will be required to achieve comparable health benefits within this group.

In summary, assuming that the goal is to achieve the greatest possible health potential in society, a purely mathematical approach can still result in more resources going to those who are already at the upper end of the scale. Many are likely to perceive such outcomes as unfair.

Six moral stances

There is more at play than pure economic efficiency. Additional questions thus include: What conclusion are people likely to consider fair? How does this influence who should receive *priority* when deploying the scarce resources available for preventive healthcare?

This brings us back to disparities. Many believe that we should not be truly satisfied until all health inequalities have been completely eliminated.

To those that hold this belief, inequality in and of itself is virtually equivalent to injustice. Other people adopt different moral stances, however, possibly with different interpretations of what is considered 'fair'. Political philosophy has devoted considerable study to examining when a given distinction can be considered fair, and it has been shown that 'unequal' does not automatically correlate to 'unfair'. First, various theories uphold egalitarianism as a basic principle, while permitting certain exceptions in light of good arguments. For example, differences are tolerated that can be traced back to individual free choices (e.g. deciding to work hard, or to do nothing). Other theories go a step further, completely abandoning the fundamental principles of egalitarianism and equal outcomes. For example, the objective of sufficientarianism is not an equal distribution of wealth, but for everybody to have a certain fixed minimum (e.g. the minimum resources required to ensure survival and permit participation in society). In prioritarianism, the principle (as suggested by the name) is to prioritize those who are at the greatest disadvantage. It is their situation that must be improved first. In short, there are multiple possible interpretations of what is considered socially just.

There is obviously a difference between actual health and the limited resources that are central to political philosophy, for health is not something that can be *re*-distributed. Money can be redistributed (e.g. through taxes), but health cannot. This is an important distinction, which is examined further in the conclusion to this brief. Political philosophical and theoretical development can nevertheless help to demonstrate that multiple moral stances are possible with regard to health. Inspired by this body of theories, the table below identifies six possible stances in this regard. In Table 3.1, the three distribution principles outlined above (egalitarianism, sufficientarianism and prioritarianism) are combined with two possible answers to the question of *what* exactly should be redistributed: health *outcomes* or health *opportunities*.

Table 3.1 Six moral stances

	Egalitarianism	**Sufficientarianism**	**Prioritarianism**
Focus on health **outcomes** (**in**sensitive responsibility)	1. Everyone has the right to the same number of healthy life years and life expectancy.	2. Everyone should have at least x years of good health and reach the age of [y].	3. The number of healthy life years and life expectancy of those who score the lowest should increase.
Focus on **opportunities** (sensitive responsibility)	4. Everybody should have *equal* opportunity to maximise health potential.	5. Everyone should have a *decent minimum* of opportunities to maximize health potential.	6. People whose potential is the least activated should receive more and better opportunities to do so.

Concisely summarized, *all of these positions are defensible and valid*. It is quite possible that some positions enjoy greater political support than others; some might also be easier to realize than others, and some may ultimately result in greater long-term health gains than others might – *but none of them are a priori better than any other.* All positions are a conceivable representation of social justice.

Two conceptual shifts

The notion that health inequalities should ultimately all be eliminated is represented in the upper left of the figure. As indicated by the table, this is only one possible moral position, and not necessarily the only conceivable or correct one. Nevertheless, it is undoubtedly the most ambitious of all six. Given that all experiences to date suggest that this position is not tenable in practice, it is logical to question whether we should be pursuing this ideal.

We propose two conceptual shifts. First, there are good arguments for putting the emphasis on the options in the bottom row of Table 3.1 (i.e. focusing more on opportunities rather than outcomes). Strictly speaking, there is no other option, given that, as mentioned above, health *itself* cannot be redistributed. The health debate always concentrates on the limited resources that can be deployed in order to promote health (e.g. the accessibility and affordability of healthcare or on approaches that address the physical environment). This already points towards a redistribution of opportunities rather than outcomes. Another argument in favour of the bottom row rests on the principle of individual responsibility.

The WRR subscribes *neither* to any rationale in which the government bears full responsibility for health outcomes *nor* to a policy that makes citizens fully responsible for their own health outcomes. Citizens nevertheless do have a part to play in their own health, just like the government has a responsibility to compensate for factors (e.g. of a financial, cognitive or practical nature) that prevent citizens from exercising their own responsibility. It makes a difference whether health disparities are the result of personal choices (lifestyle), avoidable through human or other intervention, or unavoidable.[15]

A debate is currently raging over what constitutes 'individual responsibility' (and its limitations) with regard to avoidable, lifestyle-related conditions. The notion of 'individual responsibility' has dominated the political debate for the last decade (see Chapter 5). One may question, however, whether the government's expectations are always realistic in this regard. There are indications that, in many cases, people's capability to make and maintain 'healthy' choices is severely over-estimated.[16,17] Moreover, environmental factors (e.g. quality of housing, availability of facilities, working conditions or family circumstances) can also make it difficult (or even impossible) to make 'responsible choices'. While an emphasis on 'individual responsibility' might absolve the government of some responsibility, it is precisely this perspective that demands government initiatives and interventions to make healthy lifestyles possible for citizens.

15 Stronks and Gunning-Schepers (1993).
16 WRR (2014, 2017).
17 Council for Health and Society (Raad voor Volksgezondheid en Samenleving, RVS) (2016).

The government also has a major responsibility to protect its citizens. Based on the harm principle, the philosopher Marcel Verweij (2017) reasons that a policy of 'denormalization' is desirable with regard to smoking. This is particularly true for contexts in which the health of children is at stake, given that young and unborn children are unable – either morally or legally – to make autonomous choices. Verweij goes on to reason that moral responsibility is not a *zero-sum game*, in which a larger role for one automatically means a smaller role for the other.[18] 'By pursuing an effective anti-smoking policy, the government does not assume the responsibility of individuals, but does the minimum of what can be expected from it'.

Second, as stated above, we argue for a shift in focus from health *disparity* to health *potential*. We wish to tap into an approach that the British physician and professor of epidemiology and public health Michael Marmot refers to as 'proportional universalism'. In this approach, policy is universal and aimed at all citizens, but is supplemented with support for particular target groups. The intensity of this targeted support is determined by the vulnerability of the group in question. The aim is therefore to improve health across the socio-economic spectrum, while also giving the greatest possible consideration to the actual deficits in groups with lower SES, in absolute terms, as well as with regard to their opportunities and capabilities. Because proportional universalism does not focus unilaterally on lower socio-economic groups, it is also more inclusive with respect to shifts between and within groups with differing SES. While the size of the various groups changes over time, so too does their practical socio-economic significance. The groups themselves are therefore also fluid, lending further weight to the importance of a universal approach as a foundation.[19] In practice, the latter can take one of two forms. One option is to take the specific characteristics and circumstances of groups with lower SES into consideration when developing and implementing universal policies; another is to supplement the universal policy with measures that specifically target the relevant groups. Referring back to the table, proportional universalism can be viewed as a combination of the two moral positions represented in the lower left and the lower right.

Conclusion

In this policy brief, we opt for an approach that concentrates on realizing the greatest possible health potential, rather than on the reduction of health inequalities as an end in itself. Our focus is also not on areas where, based purely on the available figures, the most potential gains are to be achieved (or the greatest loss prevented). Moral considerations also compel us to invest in the groups where the need is the greatest.

18 Verweij (2017).

19 '. . .actions must be universal, but with a scale and intensity that is proportionate to the level of disadvantage. We call this proportionate universalism' (Marmot et al. 2010: 15).

4 POLICY PRIORITIES

Where should our priorities lie? As mentioned above, the answer is determined in part by where the greatest potential gains lie. This aspect is dependent on four factors:

- The *severity* of the real or anticipated health problem – high severity means high potential.
- The *scope* of the health problem – the more people who suffer from a particular problem, the higher the aggregated potential.
- The *duration* of the health problem – early-onset problems represent greater potential.
- The *combination* of health problems – compounded health problems (multimorbidity) mean high potential.

These four factors are obviously not mutually exclusive, and they can serve both to cancel out and to exacerbate one another. For example, addressing a serious health problem (e.g. smoking) has greater potential if the group of smokers is large, and less potential if the group is small. If a group can be reached early in life, the effect on health potential is high, as the resulting gains can be enjoyed throughout the remaining lifespan. This would suggest concentrating not only on groups with lower SES, but also starting early (e.g. from before conception to the age of 18 years). As mentioned above, this policy brief interprets health gains in an absolute sense, without making comparisons between various population groups.

One key question obviously concerns whether the available potential can or will be realized. In other words: To what extent are health problems avoidable? The answer depends on many factors, the first of which is the nature of the health problems themselves. Some illnesses and conditions are virtually unavoidable (e.g. certain hereditary conditions) or simply cases of bad luck. Other conditions (e.g. a number of infectious diseases) are preventable through vaccination and/or basic hygiene. Enormous health benefits have been obtained in this area in the 20th century. Yet other health problems are related to environmental aspects, including air/noise pollution and working conditions. In many cases, realizing the available potential requires interventions in domains that are not categorized under those responsible for health policy. Finally, some health problems are related to behaviour and lifestyle (e.g. unhealthy diet and smoking). The ability to realize the available potential also depends on the extent to which people are capable of and willing to change their behaviour, as well as the opportunities that their physical and social environments offer to facilitate such changes.

Based on the considerations stated above, we have determined three priorities:
- Smoking, alcohol abuse and obesity
- An additional focus on low socio-economic groups
- Early intervention

Smoking, alcohol abuse and overweight/obesity

This priority should come as no surprise. According to the 2014 and 2018 Public Health Foresight Studies, unhealthy behaviours (e.g. smoking, obesity due to lack of exercise and poor diet, and problematic consumption of alcohol) together account for nearly 20% of the entire burden of disease. All of these determinants represent significant potential gains.

Given the health hazards of smoking combined with the percentage of Dutch citizens who still smoke (25% in total, and 20% of pregnant women), there is still much health ground to be gained. Although the positive downward trend in all socio-economic groups gives cause for hope, it does not justify removing smoking from the list of priorities. Passive smoking especially (particularly within families) remains a major problem for children.[20] At the same time, we may very well be approaching the limits of what can be achieved through campaigns of a general nature. Although it is certainly important to continue these campaigns – there are always new cohorts that need to hear the message – the real challenge involves reaching those who continue to smoke. Some of them are unwilling to stop, but most (80%) are unable to stop, due to the addictive nature of smoking. This second category is particularly likely to include many people who are experiencing compound problems, of which smoking is only one and not necessarily perceived as the most important.[21] It is precisely this group that needs to be reminded of how their behaviour will affect the next generation. Various initiatives aimed at a tobacco-free future generation are already underway.[22]

There is still much potential health gain with regard to alcohol consumption. Reliable figures on this count are scarce, as they are entirely dependent on self-reporting. Research has indicated that even many highly-educated people report alcohol consumption that exceeds the recommended limits. Although people with higher levels of education have traditionally been shown to drink more, the pattern is reversed with regard to extreme alcohol abuse.[23] Studies have revealed an 'alcohol harm paradox'[24], in which higher SES groups report greater alcohol consumption, but lower SES groups are most affected by 'alcohol-related harms', particularly with relation to binge-drinking.[25] In both groups, therefore, there is much potential benefit to be gained. The severity of alcohol-related health problems – particularly before conception, during pregnancy and while breastfeeding[26] – combined with the widespread nature of drinking, add up to massive potential.

20 Health Council of the Netherlands (2003); *Volksgezondheidenzorginfo*.2018 (https://www.volksgezondheidenzorg.info/onderwerp/roken/cijfers-context/huidige-situatie-volwassenen#!node-meeroken).
21 Kooiker (2010).
22 De Kanter (2016).
23 https://www.volksgezondheidenzorg.info/onderwerp/alcoholgebruik
24 Lewer et al. (2016).
25 Schmidt et al. (2010).
26 Health Council of the Netherlands (2004).

Obesity is another area with high potential. As a condition, obesity has major cumulative effects on health. Many serious conditions are linked to obesity,[27] including psychosocial problems (e.g. bullying and depression), arthritis, hypertension, type-2 diabetes and cardiovascular disease. It can also result in the inability to work. A good start in life is the key to avoiding obesity problems later. High birth weight is positively correlated with weight problems during childhood.[28] The trend in the Netherlands is clearly adverse: cases of overweight and obesity are increasing in all socio-economic groups (high, medium, low), and they are predicted to continue increasing in the future.[29]

Additional focus on lower socio-economic groups

The rationale behind this choice was discussed above: because the health of these groups is already low compared to the others, this is where the greatest benefit can be obtained. The groups with higher SES are already closer to the limits of what can be achieved. As mentioned previously, however, this is also a moral choice. It is only fair to provide additional support to those whose health is the poorest, consistent with the 'proportional' part of the universalism proposed by Marmot.

Focus on early intervention

In addition to prioritising smoking, alcohol abuse and obesity, while concentrating on lower SES groups, a potential-based approach should focus on early intervention (specifically targeted at the stages of preconception, pregnancy, infancy and school-age children). This is because reaching a given group earlier in life can lead to greater cumulative health benefits, and as such benefits continue throughout the entire lifespan.[30] Care for children is also a strong motivating factor for parents. People may not always be inclined to do what is best for themselves, but they can often be convinced to do what is best for their children.

Mental health

Evidence of the many potential health benefits to be gained with regard to smoking, alcohol abuse and obesity is provided by the burden of disease attributed to these factors. These calculations, however, are based on a model that does not include mental health. If the disease burden is broken down by condition, psychological conditions rise to the top of the list.[31,32] Within this broad category, symptoms of depression and anxiety account for the greatest burden.

27 BMI between 18.5 and 25 is considered to indicate a healthy body weight; BMI between 25 and 30 is considered overweight; 30 or higher is considered severely overweight, or obese. From a public-health perspective it is important to target policy towards both of the latter categories, as being overweight can be regarded as a preliminary stage of obesity.

28 De Hoog et al. (2011).

29 See https://www.vtv2018.nl/gezondheidsverschillen

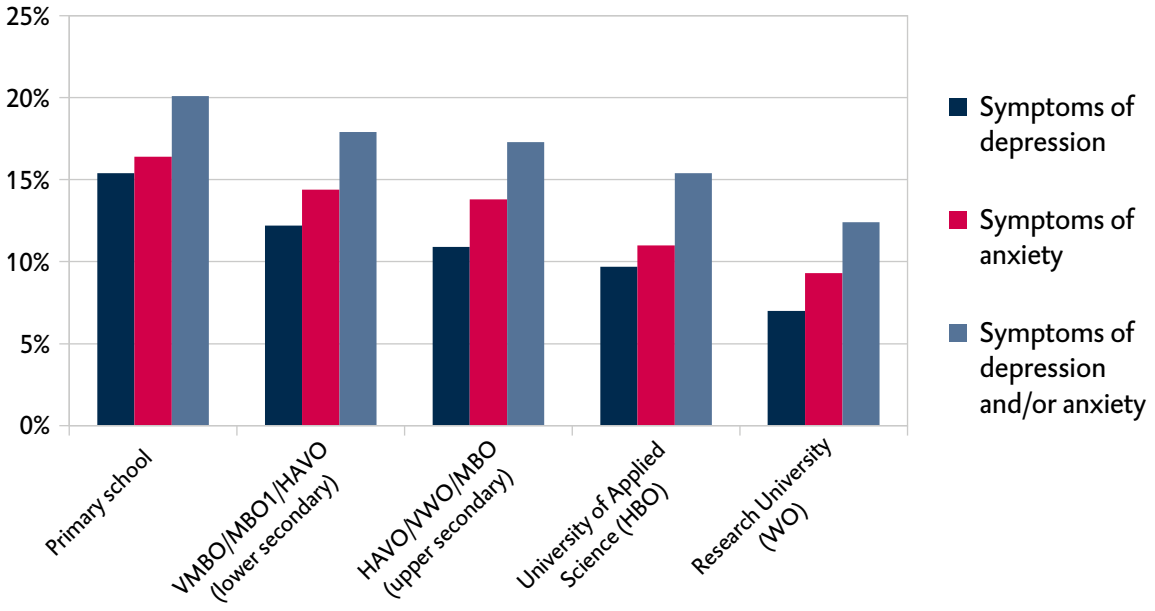
30 Leopold (2016).

31 Hoeymans et al. (2014); RIVM (2014).

32 http://www.eengezondernederland.nl/Heden_en_verleden/Ziekten

There are also significant differences in the extent to which mental health symptoms affect people of different educational levels, with the lower SES groups showing greater susceptibility (see Figure 4.1).[33]

Figure 4.1 Percentage of people with symptoms of depression and/or anxiety (aged 12+), 2013



We aim to prioritize mental health on the research agenda, as problems of this nature are likely to increase in the near future. According to the most recent Public Health Foresight Study, psychological pressure on young people appears to be undergoing a particular notable increase, with possible consequences for their mental health.[34] This area offers significant health potential, due to the severity of the disease burden, the cumulative effects and the pressure on lower socio-economic groups. Compared to 'traditional' problems (e.g. smoking and alcohol abuse), however, less is known about the extent to which mental health problems can be addressed or prevented.

Conclusion

Assuming a focus on health potential, it would seem obvious to put the onus of policy on smoking, alcohol abuse and obesity, determinants that cause a major health burden. In an absolute sense, progress has been made in these areas in recent years (particularly with regard to smoking). It is nevertheless important for universal policy to continue to focus on *all* Dutch citizens. Specific supplementary measures are therefore necessary, aimed at lower socio-economic groups and early intervention. This area offers particularly high potential for health gains. Finally, there is a pressing need for more data regarding the prioritization of mental health issues.

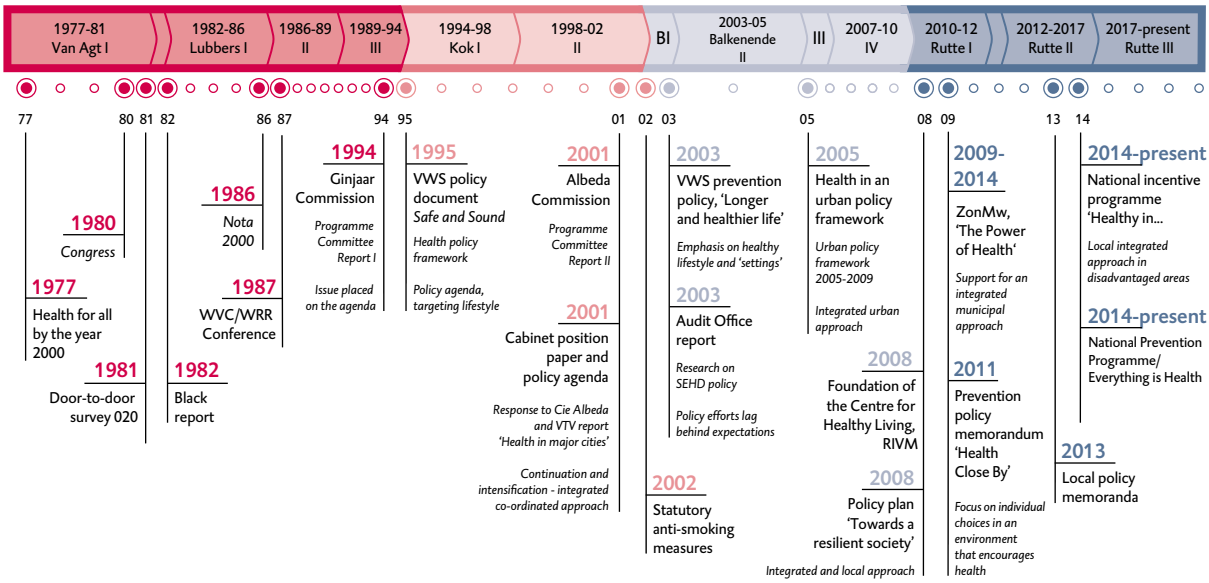
33 https://www.volksgezondheidenzorg.info/onderwerp/psychische-gezondheid/cijfers-context/huidige-situatie#node-prevalentie-psychische-klachten-naar-opleiding. Source: Statistics Netherlands Health Survey. These data refer to psychological symptoms, and not to diagnosed conditions. Respondents were asked whether they had experienced any symptoms of anxiety or depression over the past year.

34 https://www.vtv2018.nl/druk-op-jongeren

5 POLICY HISTORY

As mentioned above, socio-economic health disparities (SEHD) have remained unchanged despite 35 years' worth of policy efforts. This is a good reason to look back on the policies that have been implemented during that time (Figure 5.1). In this section, we provide a brief summary of government policy since 1989.

Figure 5.1 Overview of the focus (in policy and elsewhere) on socio-economic health inequalities



1989-2002: The start of SEHD policy

From 1989 through 2002, successive governments expressed a sense of urgency regarding health inequality. Authoritative reports both from the Netherlands and abroad[35] identified considerable health disparities between socio-economic groups. Action was deemed necessary, and the Ministry of Health, Welfare and Sport (VWS) promptly financed two national research and intervention programmes. These programmes culminated in two final reports by the Ginjaar and Albeda commissions (see Figure 5.1), and they ultimately produced a long-term strategy for reducing the various inequalities, with four specific focus areas.

35 World Health Organization (1977); the annual congress report by the General Dutch Association for Social Medicine [*Algemene Nederlandse Vereniging voor Sociale Geneeskunde*] on inequality in health and healthcare (1980), an Amsterdam door-to-door survey report (Lau-IJzerman A. et al., Municipal Medical and Health Service [GG & GD], 1981), the Black report from the United Kingdom ('Inequalities in health', 1982) and *Nota 2000* (on developments in health policy: data, review and policy goals (1986)).

In addition to targeting behavioural health and other behaviours directly, the policy addressed other factors that are relevant to health, including psychosocial work stress, living conditions, education and income.[36]

In 2001, then Minister Borst (VWS) proposed a policy agenda to the House of Representatives. The agenda included an integrated and coordinated approach across multiple policy fields, given that, although poor health in disadvantaged areas was partly attributed to unhealthy lifestyle, it was also considered the result of compounded unfavourable social and physical environmental factors. Although political developments would ultimately block the implementation of this agenda,[37] measures were still taken to improve health[38] (e.g. stricter laws regarding smoking in public spaces).

2002-2007: Individual responsibility for healthy/unhealthy behaviour

Between 2002 and 2007, the UK and Scandinavian countries established major policy programmes aimed at combatting health inequalities.[39] In the Netherlands, however, priority was given to the implementation of a new healthcare system by 2006, and not to reducing health inequalities. The Ministry of VWS received severe criticism from the Netherlands Court of Audit as a result,[40] and the average life expectancy in the Netherlands proved only mediocre amongst European countries, with unhealthy behaviour cited as the primary cause. Various reports painted an alarming picture, which led to a prevention policy in 2003 focusing on the promotion of healthy lifestyle.[41] The policy made individual citizens responsible for their own choices, whether healthy or unhealthy, while also stressing that lifestyle interventions are much more effective if they include environmental aspects as well.

The prevention policy devoted specific attention to persistent health inequalities in large cities, as well as in the South Limburg and north-eastern regions of the Netherlands.[42]

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36 Four focal areas for reducing socio-economic health inequalities: 1) narrowing gaps in education level, income and other socio-economic factors through education, income and poverty policy; 2) reducing the negative effects of health problems on education, employment level and income (benefit management and paid work for the chronically ill, effectiveness of healthcare, bolstering primary healthcare in disadvantaged areas); 3) reducing the negative health effects of low education level, low employment status and low income (including such behavioural factors as smoking, obesity, lack of exercise, physical and psychosocial stress at work and unfavourable living conditions); and 4) increasing the accessibility and effectiveness of healthcare for low socio-economic groups.

37 The fall of the Kok II cabinet due to the Srebrenica incident, and the death of Pim Fortuyn.

38 (First) Prevention programme 1998-2002.

39 Crombie et al. (2005). Sweden and Northern Ireland in particular aimed their policies at lower socio-economic groups, focusing on the factors that bear the greatest influence on living conditions, work, lifestyle and similar aspects. The United Kingdom instituted the Programme for Action (2003-2006).

40 The Netherlands Court of Audit criticized the lack of urgency in the SEHD policy (2003).

41 Ministry of Health, Welfare and Sport (2003).

42 Health and healthcare are areas in which citizens and local parties formulate objectives at the neighbourhood level (uniting physical and social pillars). In 2007, the 'neighbourhood-based approach' (wijkaanpak: 'from problem area to star neighbourhood') was introduced. A 10-year deadline was set for achieving the significant improvement of 40 neighbourhoods in terms of safety, liveability and the socio-economic position of the residents. An evaluation revealed no measurable improvement relative to other problem neighbourhoods in which no interventions were carried out (Netherlands Institute for Social Research/SCP (2013)).

A combined approach targeting both individual responsibility for lifestyle choices and environmental factors was advocated in this context as well. In 2006, the Netherlands National Institute for Public Health and the Environment (RIVM) noted the following: 'In the Netherlands, the focus on individual responsibility is slowly growing, particularly with regard to healthy behaviour and health. Individual freedom of choice is often relative, however, particularly due to the aforementioned impact of the social and physical environment on lifestyle and health, combined with individual and personal character traits. "Healthy" alternatives must therefore not only be made easy and appealing, but must also be achievable for everybody'.[43]
Despite calls for a greater focus on the impact of environmental factors, there was not enough momentum to get a broader, coordinated and integrated approach off the ground.

2007-2010: New keywords: 'integral' and 'local'

During this period, multiple policy memoranda were released in quick succession. Building on the policies from the previous period, the focus again turned towards behavioural change. The possibility of including preventive interventions (programmes aimed at exercise and cessation of smoking) as new additions to basic health insurance packages was considered as well.[44] One new aspect was that the minister, supported by a recommendation by the Social and Economic Council (SER),[45] also pointed out the economic and social importance of investing in health ('health is wealth'),[46] in addition to stressing the need to 'make the healthy choice the easy choice'.

In his 2008 policy plan, then VWS Minister Klink proposed addressing socio-economic health inequalities through policy that was integral and, most importantly, locally implemented.[47] It was for this reason that health policy was to extend across departmental boundaries. To this end, various elements of the policy areas and relevant budgets of other departments were linked together, representing the long-awaited response to the proposals of the Albeda commission.[48] Specific measures were aimed at reducing the number of early school-leavers, improving the integration of minorities, increasing participation, promoting healthy living environments and offering protection for people with low income. Reality unfortunately proved a tough customer, however, as demonstrated by RIVM research on these governmental measures. The conclusion was altogether disappointing. It was difficult to establish any correlation between the effects of the measures that had been taken and their role in reducing health deficits.[49] In hindsight, we can only conclude that the measures largely amounted to a bureaucratic exercise involving the unification of policies that had already been in existence in various departments under a single banner.

43 De Hollander et al. (2006).
44 The smoking-cessation programme was admitted to the basic package in 2011, only to be removed again in 2012. The exercise programme was never included.
45 Social and Economic Council (2009).
46 Ministry of Health, Welfare and Sport (2007).
47 The minister was supported by an advisory report commissioned from the Council for Public Health and Health Care (RVZ), the Education Council (OR) and the Council for Public Administration (ROB). (2009).
48 The minister admitted that, although the cabinet had been in agreement with the recommendations of the SEGV (SEHD) II Commission at that time, it had never managed to create a policy plan.
49 Schrijvers & Storm (2009).

2010-2012: Individual responsibility and making healthy choices easier

The first Rutte government (2010-2012) released a policy memorandum entitled 'Health Close By' [*Gezondheid dichtbij*],[50] in which the newly-appointed VWS minister Schippers called for efforts to realize the paradigm shift from 'living healthier' to 'making healthy choices more accessible', which had been espoused by her predecessor. Schippers nevertheless warned that the budget for such efforts should be lowered. The cabinet did not support the inclusion of lifestyle interventions as part of basic insurance policies under the Health Insurance Act. In 2012, Minister Schippers then took decisive action by removing the smoking-cessation programme that had been included in 2011 at the instigation of her predecessor. The evaluative response by the Council for Public Health and Health Care was clear: 'Prevention policy has been given a raw deal'.[51] The Council pointed out that the government was merely paying lip service to prevention policy, as compared to its health-protection policy (for combating infectious diseases, screening, vaccination), and relative to the costs of curative healthcare. The Council also pointed out that prevention offers major social advantages in terms of labour productivity and participation in society as well.

2012-2017: Integral, local and with an active role for citizens

The year 2014 saw the advent of the fifth prevention programme (National Prevention Programme, NPP),[52] the goals of which were intended to be achieved in part through statutory measures including changes to the Tobacco and Related Products Act [*Tabaks- en rookwarenwet*] and by initiating the social movement known as 'Everything is Health' [*Alles is Gezondheid*].[53] A prevention agreement was also viewed as an important instrument for combating smoking, obesity and problematic alcohol consumption.[54] To support a local, integrated approach, the national incentive programme entitled 'Healthy in…' [*Gezond in…*] was set up in 164 municipalities given the 'GIDS' (*Gezond in de Stad*, or 'Healthy in the City') label, with support from Pharos in conjunction with Platform 31. In a letter to the House of Representatives, State Secretary Van Rijn gave assurances that the programme would continue until the end of 2021.[55] He further stated that he was convinced of the impact of the GIDS approach and of the creativity that it inspired within the municipal authorities. Although it is not entirely clear exactly what it was about the approach that convinced Van Rijn,[56] there was no shortage of enthusiasm for the approach, either at Pharos or in the various municipal authorities.

50 Ministry of Health, Welfare and Sport (2011).

51 Council for Health and Health Care (*Raad voor Volksgezondheid en Zorg*, RVZ) (2011).

52 The objectives of the programme are to reduce the increasing number of people with chronic illnesses and to reduce the major health disparities between those with low and high levels of education. The programme focuses on alcohol, smoking, depression, diabetes, obesity and exercise.

53 'Everything is Health' is the sub-section of the NPP in which parties agree to undertake joint actions aimed at starting a social movement leading towards a healthier country.

54 The Prevention Agreement was eagerly pursued by Secretary Blokhuis (https://www.rijksoverheid.nl/onderwerpen/gezondheid-en preventie/documenten/kamerstukken 2018/04/20/kamerbrief-over-voortgang-nationaal-preventieakkoord-en-algemeen-overleg-17-mei-2018).

55 Ministry of Health, Welfare and Sport (2017).

56 The letter revealed that data had been collected 'merely' by making inquiries in the GIDS municipalities. Research conducted elsewhere on the reduction of socio-economic health inequalities is not reassuring in this respect. An evaluation of 13 years of intensive UK government policy aimed at reducing health inequalities proved highly disappointing, thereby prompting Mackenbach to bemoan the fact that 'reducing health inequalities is currently beyond our means. That is the sad but inevitable conclusion from the story of the English strategy to reduce health inequalities' (Mackenbach 2010).

The Netherlands National Institute for Public Health and the Environment (RIVM) manages an extensive database containing hundreds of behavioural interventions aimed at the main policy focus areas (smoking, excess alcohol consumption, obesity). Examination of this database (entitled *Gezond en Actief Leven*, or 'A Healthy and Active Life'), however, reveals that relatively little is known about specific effective interventions for reducing health disparities. This is not surprising, as effectiveness has never been systematically monitored. The Ministry of VWS did express its belief in the importance of monitoring in order to gain a better understanding of the integrated municipal approach, specifically through an annual survey and the four-yearly Health Monitor by the municipal health service (GGD). In 2017, initial monitoring steps were taken through zone indicators on a website entitled 'How does your municipality rate?' (*waarstaatjegemeente.nl*).[57] The NPP objectives will be included in the Public Health Forecast Studies starting in 2018, with RIVM bearing responsibility for monitoring. An impetus for a pilot was issued as well, in order to 'improve understanding of policy quality and its effect on society within a working context. It is important for the VWS policy cycle to include evaluations, in order to facilitate active learning from the results amongst all stakeholders.'[58]

In summary, the policy aimed at preventing and reducing socio-economic health inequalities was given a major push at the local level. Given the significant diversity, however, it is difficult to obtain a clear overview of all issues that are at play and their impact. Against this backdrop, it is remarkable that the presidents of the Association of Netherlands Municipalities (VNG) and the Association of Dutch Health Insurers (ZN) noted the difficulty encountered by municipal authorities and health insurers in the joint organization of and investment in prevention activities. This observation prompted an agenda for administrative collaboration covering several facets, including increased opportunities for joint and other prevention activities.[59] A review of the collaboration in July 2017 revealed that, although both parties felt good about working together, implementation continued to pose a struggle.[60]

57 The 14 indicators cover such aspects as the use of healthcare services, health disparities, education, housing and living environment, and public order and safety.

58 https://www.rijksoverheid.nl/documenten/kamerstukken/2017/09/14/kamerbrief-over-pilot-beleidsevaluaties-vws. The policy instruments entitled *Alles is Gezondheid* ['Everything is Health'] and *Aanpak overgewicht jeugd* ['Youth Obesity Strategy'] and others will be evaluated.

59 Collaboration Agenda letter, Association of Netherlands Municipalities (VNG) and Association of Dutch Health Insurers (ZN), 19 April 2016 (https://www.zn.nl/338067458? newsitemid=1099857920).

60 *Factsheet samenwerking gemeenten en zorgverzekeraar rondom preventie voor risicogroepen schetst huidige stand van zake*n [Factsheet on collaboration between municipalities and health insurers concerning prevention for risk groups outlines current status] (https://www.rivm.nl/Documenten_en_publicaties/Algemeen_Actueel/ Nieuwsberichten/2017/Factsheet_Samenwerking_gemeenten_en_zorgverzekeraar_rondom_ preventie_voor_risicogroepen_schetst_huidige_stand_van_zaken).

Conclusion

As shown in this overview, successive cabinets over the past 35 years have maintained a clear focus on prevention in order to reduce socio-economic health disparities. Continuity has been lacking, however, and many minor shifts in emphasis have occurred. Although the Ginjaar and Albeda commissions noted the need to address health inequalities within a broad context in the late 1990s, the various cabinets concentrated mainly on lifestyle interventions, with an emphasis on the personal responsibility of individual citizens. Because the government was well aware of its own responsibility in terms of making healthy choices accessible, however, the focus on policy since 2008 has been on links between behaviour and social/physical environment, predominantly at the local level. Obesity, smoking, and alcohol and drug abuse are currently being addressed in an integrated manner in municipalities and neighbourhoods, with support from government programmes. The effectiveness of this approach nevertheless remains uncertain.

6 PROPORTIONAL UNIVERSALISM IN PRACTICE

Translating proportional universalism into practical policy requires an understanding of the effectiveness of policy and interventions amongst groups with the greatest health potential. This is no simple matter, for various reasons. First, health effects are dependent on many individual and social determinants, making it difficult to determine the effectiveness of policies or interventions.[61] Second, the effectiveness of policies and interventions is significantly influenced by the contexts in which they are implemented. Third, health effects often become manifest only in the long term, thus making it difficult to attribute changes in health to any specific policy or intervention. Fourth, high-quality evidence is lacking on the effectiveness of policy and interventions in action. Although the concept of proportional universalism has been discussed extensively in the literature in recent years, there is no consensus on how it should be translated concretely into practice.[62]

Due to the lack of evidence, this policy brief also considers the notion of 'plausibility', or the relative likelihood that a policy measure or intervention will have effect on the health of children 18 years of age and younger from lower socio-economic backgrounds. Such measures or interventions can be implemented in order to fulfil the 'proportional' component of policy based on proportional universalism. We draw heavily on the available overview studies, including the recent publication by Beenackers and colleagues.[63]

In general, a programmatic approach that includes a mix of measures (targeting both individual behaviour and social determinants) is expected to result in the greatest health gains. Questions remain, however, with regard to the combinations of measures that will contribute the most. The available literature suggests a number of effective

61 Exworthy et al. (2006); Van den Berg and Schoenmaker (2010); Lorenc et al. (2013); Lenthe and Beenackers (2017).
62 Carey, Crammond and De Leeuw (2015).
63 Beenackers et al. (2015).

measures that could be applied (or focused on). These are listed in Figure 6.1. Given the focus on early intervention, we concentrate primarily on four stages in life: preconception, pregnancy, children 0-4 years of age and children of school age.

Universal policy

Universal policy is often aimed at entire populations. It can also target specific subgroups of a population (e.g. all children younger than six years of age or all residents living in a particular area), however, leaving aside such factors as income, education or ethnicity. One advantage of universal policy is that it does not stigmatize low socio-economic groups,[64] and it is apparently more effective in reaching these groups than specific lifestyle interventions are.

Proportional universal policy calls for investing greater effort (in terms of intensity and scale) in the most disadvantaged groups. The potential of proportional universal policy enjoys wide support, in terms of both health gains and fairness.[65] In practice, proportional universalism entails combining tailored interventions with a universal approach.[66] This combination is aimed at distributing health across the entire socio-economic gradient through policy, with the objective of levelling the gradient to some extent. Although the distinction between universal policy and proportional universal policy is not always easy to clarify in practice, we provide several examples of proportional universal policy below.[67]

Universal policy can target both individual behaviour and social determinants. One frequently cited and effective strategy for including proportional elements in universal policy targeted at behaviour is the use of financial incentives. Although such incentives work across the population, their effect is particularly marked in lower socio-economic groups, who have proven more receptive to financially appealing measures. Such measures can serve multiple purposes during the various stages of life. During pregnancy, financial incentives appear to be effective in reducing smoking. At later stages, financial rewards could be used to encourage healthy behaviour or to make healthy food less expensive.[68,69]

The prevention of smoking, alcohol consumption and obesity are important aspects with regard to school-aged youth. Effective measures during this phase include pricing measures, limiting points of sale (for smoking and alcohol), raising the minimum consumption age and interventions that take advantage of social norms.[70]

Universal policy can also target social determinants.[71] Many studies have underscored the importance of structural measures targeting early development, schooling and poverty in order to address the physical (and, to a large extent, mental) health of

64 Van der Wel et al. (2016).
65 Marmot and Bell (2012).
66 Carey, Crammond and De Leeuw (2015).
67 Storm et al. (2011); Newman et al. (2015); Storm et al. (2016).
68 Mantzari et al. (2015).
69 De Sa and Lock (2008).
70 Beenackers et al. (2015); Kuipers et al. (2015); Kuipers et al. (2017); Brown et al. (2014); Kunst (2017); Kuipers et al. (2016), Anderson et al. (2009).
71 Marmot et al. (2012).

children from lower socio-economic groups.[72,73,74,75] Based on the available research in this regard, the greatest health gains would seem to be achievable through universal policy aimed at unemployment and poverty.[76] From a lifespan perspective, universal policy should be aimed at current or expecting parents through such means as linking medical and social domains during preconception and pregnancy.[77] The effects of poverty and adverse circumstances on perinatal health are substantial.[78]

Education is another key social determinant,[79] and the Education Inspectorate is concerned about the widening equality gap between students. Children of well-educated parents receive higher recommendations for secondary school than do children of parents with less education, despite comparable results on the Cito exam (a general standardized test administered at the end of primary school in the Netherlands). It is essential for children to acquire fundamental cognitive, motor and health/other competencies, and for these competencies to be reflected in their recommendations for secondary school. Three of every 10 Dutch adults experience problems finding, understanding, evaluating and integrating health information,[80] and lower socio-economic groups are overrepresented amongst those who experience such difficulties. Although some health skills can be taught, knowledge concerning the effectiveness of relevant interventions is lacking in the Netherlands.[81]

Lifestyle interventions and lifespan

Analogous to universal policy, many individual lifestyle interventions are also aimed at promoting healthy behaviour. Overview studies have indicated that the effects of such interventions are often relatively modest and short-lived, especially amongst low socio-economic groups.[82] There is reason to suppose that universal policy would have a greater overall impact than would individual lifestyle interventions amongst lower socio-economic groups, partly because these groups are more difficult to reach through specific interventions.[83] Nevertheless, several effective lifestyle interventions are available for this group.

Interventions aimed at the phase prior to pregnancy are important in terms of long-term health potential. In the Netherlands, poor pregnancy outcomes are more common in disadvantaged areas. In cities like Rotterdam, perinatal mortality and disease rates in some neighbourhoods are two to three times higher than the national average.[84]

72 Diderichsen et al. (2011); Frank et al. (2015); Marmot et al. (2012); Pillas et al. (2014); Smith and Kandlik Eltanani (2015); Moore et al. (2015), Netherlands Youth Institute (2015); Social and Economic Council (SER) (2017); Netherlands Institute for Social Research (SCP) (2016); Gupta et al. (2007); Saunders et al. (2017).
73 Yoshikawa (2012).
74 Droomers et al. (2015).
75 Steegers (2017).
76 Droomers et al. (2015).
77 Steegers (2017).
78 Steegers et al. (2013).
79 Education Inspectorate (2017, 2014).
80 Rademakers (2014).
81 Rademakers (2014).
82 Lenthe and Beenackers (2017); Beenackers et al. (2015); Jepson et al. (2010).
83 Lorenc et al. (2013); McGill et al. (2015); Oldroydet al. (2008).
84 Steegers (2017).

Improved accessibility to preconception consultations and awareness of the importance thereof amongst prospective parents are key aspects.[85] In addition, ample scientific evidence is available demonstrating that in addition to having a positive effect on pregnancy outcomes, preconception care is cost-effective and can even reduce costs.[86]

The positive effect on pregnancy outcomes is greatest when unhealthy lifestyle habits are reduced prior to pregnancy.[87] Pregnancy is viewed as a 'window of opportunity', in part because pregnancy augments risk perception.[88] This provides opportunities for realizing health gains amongst pregnant women with lower SES by reducing smoking and alcohol consumption, with ancillary effects for the health of the child. With regard to smoking, counselling and feedback seem to be effective measures when combined either with each other or with other interventions. Other effective strategies include training midwives to refer expectant mothers to smoking-cessation programmes, flexible home visits and intensive treatment sessions. The provision of personal feedback to pregnant women with regard to alcohol consumption can have a positive impact on drinking behaviour.

Many individual lifestyle interventions for children 0-4 years of age focus on preventing obesity.[89] The identification of and provision of support for children who are at increased risk of obesity seem to be elements of a successful strategy for reducing obesity or affecting the key determinants that play a role amongst lower socio-economic groups. Programmes in which trained mothers from the 'peer group' make house calls can have a positive impact on children's diets. Programmes that provide support to young families at home and that are aimed in part at teaching parenting and other skills (e.g. healthy cooking) apparently have a positive effect on preventing obesity. Important factors to consider as children grow older include alcohol and smoking. Some studies conclude that school interventions that combine education with parental involvement are more successful at lower school levels, although the details are unclear. Short, intensive feedback interventions in face-to-face settings seem to be more effective at reducing alcohol consumption in low socio-economic groups than do those conducted online or by text message, although definitive conclusions will require additional research.

An approach based on a combination of universal policy supplemented by individual interventions would seem to be effective in promoting mental health in children.[90] The greatest gains could be expected from a combination of individual (behavioural/lifestyle) interventions aimed at the child and universal policy targeting the material and psychosocial circumstances in which the child is raised.[91]

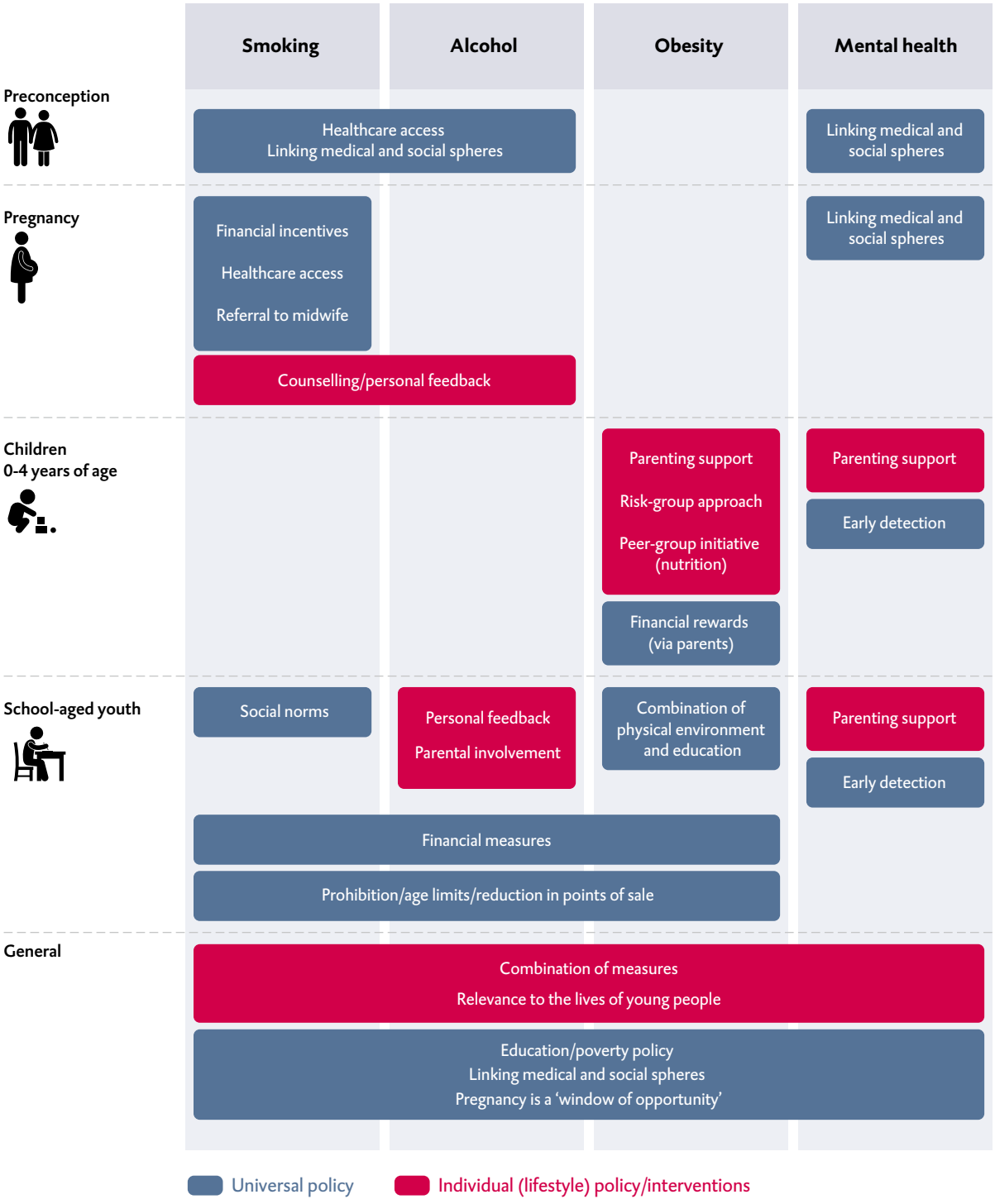
School screening is another effective method for the early identification of children who are at increased risk of mental health issues.[92]

85 Poels et al. (2017).
86 Health Council of the Netherlands (2007).
87 Poels et al. (2017); Waelput et al. (2016).
88 McBride et al. (2003).
89 Waters et al. (2011).
90 Welsh et al. (2015).
91 Reiss (2013); Kurtze et al. (2013).
92 Rasing (2017); Omlo (2016); Candy et al. (2007).

Integrated approach

An overview of the strategies discussed above is provided in Figure 6.1. Based on the research literature, it seems plausible that measures consisting of a combination of various elements (as listed in the visualization below) should have an impact.

Figure 6.1 **Visualization of effective lifelong strategies**



One relevant question obviously concerns how universal policy should be combined with individual lifestyle interventions in order to achieve the greatest gains. There is no single clear answer. What is clear is that any effective strategy aimed at increasing health potential amongst lower socio-economic groups will entail a combination of multiple measures, rather than being limited to a single element. This is because it is precisely amongst these groups that compounded health problems and social determinants are often interrelated, thus requiring an integrated approach.

Obesity is a good example, which would require a combination of changes to the physical surroundings, including neighbourhoods or schools (e.g. safer bike paths, fewer soft-drink vending machines); the normalization of healthy behaviours in an environment that usually encourages unhealthy behaviour; poverty policy; lowering the price of healthy foods; and providing information to the public. One key point to consider is that any approach should be relevant to the lives of people in lower socio-economic groups and the problems that they are likely to experience.

More data

In addition to the effective implementation of strategies that are most likely to increase health potential, it is also essential to invest in research on and experience with the following blind spots:

- There is a lack of systematic policy and intervention evaluation amongst groups with potential for health gains (e.g. low socio-economic groups). In recent years, emphasis has been placed on the implementation of policy and interventions, and not on monitoring the effects and evaluation of the various behavioural and other interventions. This approach produces little specialized data, thus making it impossible to adapt the policy and interventions as they are being implemented.
- The effects of policy and interventions aimed at boosting health potential are very long-range. The identification of realistic and relevant procedural and health objectives for the short and long term is necessary in order to monitor progress and change course if needed. The literature encourages an 'adaptive' policy that facilitates learning capacity, thereby enabling spontaneous changes,[93] possibly including short-cycle monitoring, evaluation and adjustments that enable the continued development of policy and interventions during implementation. It is also important to identify the prerequisites that are crucial to ensuring effective policy and interventions (e.g. an adequate administrative support base).

Different population groups possess different knowledge, health skills and cultural capital – all elements that can influence preventive health behaviours.[94] People from backgrounds of migration are one example, although other lower socio-economic groups also demand a focus on cultural capital. Preventive interventions designed to encourage healthy behaviours that run counter to the group's status quo (in some cases, drastically) are likely to be less effective. To date, knowledge is lacking with regard to the dynamics between cultural capital, health behaviours and health (and

93 Carey et al. (2015).
94 Groeniger Oude and Kamphuis (2017); Jansen (2017).

the intergenerational transfer thereof). Another important factor is the inclusion of the target group in the development and evaluation of policy and interventions.[95]

A better understanding of this process could help to customize policy and interventions to the perceptions and realities of target groups that demonstrate the greatest health potential, thereby increasing their effectiveness. This is yet another reason to develop a data-collection policy with a broad scope, aimed at augmenting potential health gains.

7 CONCLUSIONS AND POLICY RECOMMENDATIONS

In the decades following the Second World War, socio-economic health inequalities received hardly any consideration as part of health policy. There was an implicit belief that the continued growth of the welfare state and the opportunities for emancipation that were being offered to the lower classes would automatically take care of any disparity.

In the late 1970s and early 1980s, however, several Dutch and international publications were released, containing evidence of the continued existence of inequalities in health. These differences intuitively feel unfair: why should those who are already better off reap the greatest benefits from the welfare state, rather than lower socio-economic groups? The resulting outrage received widespread political support and, from that moment on, socio-economic health inequalities emerged as a policy focus. The WHO set an objective for the year 2000, stating that 'the actual differences in health status between nations and between groups within countries should be reduced by at least 25%, by improving the level of health of disadvantaged nations and groups'.[96] The Netherlands adopted more or less the same target. Now, 35 years later, we know that, even though lower socio-economic groups have made considerable progress, the gap between their health status and that of the higher socio-economic groups has not narrowed.

As clearly revealed in this brief historical sketch, the desire to reduce socio-economic health disparities is deeply rooted in more general notions of socio-economic equity, redistribution and fairness. Conditions relating to lifestyle and weight were far less common during the final decades of the previous century. Although more people smoked, the population of smokers was more evenly distributed across all levels of society. A connection was therefore expressly established between health inequalities and general issues of (undesirable) socio-economic inequality and (desirable) redistribution of resources. *This may well be the crux of the matter*, as it implies an evaluation framework that may not be appropriate, all things considered. Money can be redistributed, allowing interventions on either side of the gap: more money for the poor and less for the rich, facilitated by transfer payments. This scenario is a classic *zero-sum game*, and one that does not apply to health. In fact, quite the opposite is true:

95 O'Mara-Eves et al. (2015).
96 WHO (1984).

any efforts to raise those at the bottom of the ladder a few rungs upward will only push those further up the ladder even higher– perhaps to an even greater extent. Rather than being a zero-sum game, general prevention policy more closely resembles a *positive-sum game*.

In summary, a moral ideal linked to the distribution of a valuable *transferable* commodity is being mapped onto the distribution of a valuable *non-transferable* commodity. Sadly, this has proven to be a recipe for disappointment. Ambitions and ideals are obviously not only intended to be realized in a literal sense; they also serve as a source of inspiration (which may even be their primary purpose). The desire to reduce preventable disparities – including those in health – is an ideal that has served (and still serves) to kindle enthusiasm and mobilize potential. The ideal is capable of unleashing a mass of energy that can be channelled productively, and it has resulted in major advances over the past 35 years. The pursuit of equality in health outcomes is problematic, however, if it becomes a millstone that leads to despondency and the complaint that 'nothing works'. Does it then kindle the same enthusiasm? Does it still energize people? In such situations, it is useful to point out the aforementioned incongruence between the problem and the framework of health disparities. On closer inspection, non-transferable commodities call for a different framework – one that concentrates on the available potential and that strives to benefit everyone, especially those who have the least, as outlined in the sections above.

Whether this paradigm shift will usher in changes to policy will obviously depend on the details of its interpretation, particularly with regard to the chosen balance between universal and specific policy. Our recommendations are formulated briefly below.

Universal policy as the foundation...

The need to combat smoking, excess alcohol consumption and obesity throughout society remains unchanged. As mentioned above, the earlier the intervention, the greater the health potential.

First and foremost, this means that it will be important to continue the anti-smoking strategy that has already been set in motion. Measures from recent years have already significantly reduced the number of smokers. The government is now considering additional measures to discourage smoking even further. These developments are assisted by the fact that the social norm has now changed, and smoking has lost some of its status – even amongst young people. Although this is cause for hope, there is no reason to lower its priority as yet. The massive health risks associated with smoking and the fact that there are always new cohorts to reach mean that it will be absolutely essential to persist with and intensify the use of a programmatic approach. Pricing measures have proven effective in this regard, and increasing excise duties can serve as a deterrent to reduce the number of smokers even further. The additional income generated in this manner should be invested in additional policies that provide support to those who find quitting difficult or in public programmes aimed at combating poverty or improving the physical environment.

To date, the approach taken to alcohol and, in particular, obesity has not been quite as successful. Products that contain large amounts of hidden fat, salt or sugar offer considerable potential in this regard. Consumers often have trouble understanding exactly what products contain, and much advertising and packaging information is blatantly misleading. In its approach to obesity, the government is dependent on other parties, including supermarkets, canteens/cafeterias and food manufacturers.

True change will require making healthy choices easier and discouraging unhealthy choices (e.g. by improving choice architecture).[97] Opportunities for using a pricing mechanism to discourage excessive consumption of fat, salt and sugar should also be investigated further. Sales agreements have been made regarding permissible quantities of certain substances in foods that are high in fat, salt and sugar (whether obvious or hidden). If government and industry cannot reach agreement voluntarily, prohibition will become a more tangible option. Any effective strategy for increasing health potential will also require a focus on social determinants, in turn calling for an integrated approach. Structural measures aimed at combating poverty, improving the physical environment and similar aspects are therefore necessary as well.

... supplemented by specific policy

In order to be effective in tapping into the available health potential, it will be necessary to supplement the universal approach outlined above with additional elements focusing specifically on reaching lower socio-economic groups. Unfortunately, such efforts are currently thwarted by a lack of knowledge regarding the likelihood of success and failure for interventions targeting these specific groups. The review of the available research presented in Section 6 nevertheless allows us to draw three general conclusions.

Specific interventions are more useful if:

- They are geared towards the local and cultural context: Although robust local networks and data structures have been established in recent years, we believe that the local approach entails too broad a scope, especially in light of the limited available resources. Local professionals and their knowledge infrastructures should focus more on young people, in order to take full advantage of the available potential. In many municipalities, 'local context' also implies 'cultural context'. Acknowledging subcultures and cultural/language differences may be important for local policy to take full advantage.
- They are accessible both practically and financially: Otherwise, the very existence of a policy or programme would be pointless. In some cases, intensive promotion is needed in order to raise awareness of both the programme (e.g. preconception care) and its importance, and this may require the elimination of financial obstacles (e.g. to preconception care and sometimes pregnancy consultations). Language and illiteracy can also pose major barriers.
- They are embedded within social structures: Although policy is always determined from the 'top down' to a certain extent, research has shown that success rates increase as people feel more supported by peer groups, and as they retain some control over the process.

97 WRR (2014, 2017).

Few good-quality studies are available on the effects of interventions at all, let alone studies that differentiate between different socio-economic groups. Investments in research and monitoring are therefore necessary (but without the need to pursue a rigid, costly system). This will require shrewd triangulation between research, policy and implementing bodies, with a focus on fostering learning capacity (i.e. searching for indicators of process and effectiveness in both the short and long term).

Research and monitoring can also aid the effective deployment of resources. Especially now, when municipalities are creating their own policies, our aim should be to pinpoint the strategies that do work and those that definitely do not, in addition to identifying where further research is required.

Inclusion of mental health

We also wish to highlight the need for increased attention to mental health in general, and for research in particular. We acknowledge that these types of conditions are certainly less concrete than smoking, drinking and obesity, and they are harder to discuss in terms of 'lifestyles' that require intervention. Based on the available figures, however, mental health conditions (e.g. depression and anxiety) represent a major proportion of the disease burden, especially when added to existing risk factors, including smoking, excessive alcohol consumption and obesity. These conditions therefore represent major potential health gains (or prevention of health losses). Additional research is required on the extent to which psychological conditions can be influenced or prevented.

Roles and responsibilities

The proposed changes also have an impact on the roles and responsibilities of several parties. As part of the proposed Prevention Agreement, the third Rutte government drew up a long list of relevant parties, including patient organizations, care providers, health insurers, municipal authorities, sports associations, businesses and civil society organizations.

Although this policy brief does not address all relevant actors, we do identify three parties who are poised to make a difference through policymaking: the national government, local authorities and the private sector.

Let us begin with the national government. The Ministry of Health, Welfare and Sport might be regarded as the 'protector' of public health, which thus has an essential part to play. Maximizing health potential will require setting national priorities, which can then be interpreted locally in various ways. The decision to 'leave people to their own devices' will result in a multitude of haphazard and conflicting approaches. The national government can use legislation and/or frameworks to prohibit unhelpful practices, to set age limits, to regulate advertising and to impose geographic restrictions. As explained above, it is also necessary for the national government to direct monitoring and research, mainly to prevent the fragmentation of knowledge and to save municipalities from having to reinvent the wheel.[98]

98 Faasse and Koens (2017).

The Ministry of Health, Welfare and Sport (VWS) also has an important interdepartmental part to play. Some matters of considerable importance to public health can be addressed only by other departments. The general adage that 'other policy areas are relevant to health' is not enough. One good example is the approach taken to debt management and the creation of improved conditions to bring about lifestyle change, which is run by the Ministry of Social Affairs and Employment.

The Ministry of VWS is expected to take action whenever specific initiatives that are dependent on particular line ministries fail to take hold. For example, interventions relating to the built environment (e.g. the spread of fast-food chains, cannabis cafés or snack bars) are governed by the section of the Environment and Planning Act, which falls under the responsibility of the Ministry of the Interior and Kingdom Relations.

To guarantee the ultimate effectiveness of such interventions, the national government must monitor continuity more closely, in addition to ensuring a long-term vision. The need for continuity is at odds with the current governmental practice of setting new priorities with each successive cabinet. The required long-range approach extends beyond cabinet limits.

As a second actor, local authorities have an important pro-active and coordinating role. In order to be effective, priorities that are defined at the national level must be embedded within local professional, residential and civil society networks. Creative and unorthodox measures can often be taken locally that cannot even be conceived – let alone described – at national level. Local authorities also face the challenge of developing a system of effectiveness research that is not top-heavy, but that generates sufficient learning capacity. They must do so as part of the administrative coordination process (i.e. in conjunction with the Ministry of Health, Welfare and Sport and research institutes). Careful monitoring of a limited number of priorities will enable those involved in implementation to continue or fine-tune certain measures that prove effective, or to discontinue measures if the goals are not achieved (e.g. based on process or interim outcomes).

The final actor that we consider is the private sector. Many private parties are in a position to help improve health. Here, we consider two such parties: food manufacturers and supermarkets, and health insurers. Both of these parties can be expected to invest more effort than is currently the case. Food manufacturers and supermarkets have a major influence on our consumption of food, in both a positive and a negative sense. Hidden sugars, fat and salt, and misleading advertising mean there is much room for improvement with regard to the production of and information on healthy products. Although substantial freedom has been granted in exchange for the promise of self-regulation, deadlines and targets are necessary in order to make a real difference in terms of health potential, and the option of government regulation must become far more prominent. Health insurers have an important part to play with regard to prevention, in collaboration with municipal authorities. They are well aware of this fact, but they are simply not making any progress with actual implementation.

Concluding remarks

The Dutch welfare state has undergone a metamorphosis in past decades. Slowly but surely, the traditional welfare state of old has made way for what scholars are calling the 'social investment state',[99] which revolves by definition around investments in human capital, preferably those that are made as early as possible.

This policy brief can be viewed as an updated preventive healthcare framework that is in line with the broader movement towards a social investment state. Keeping the idea of investment in mind, our recommendation is to invest widely in the development of the potential present throughout the population, with particular attention to early intervention. This approach will benefit the health and prosperity of both individuals and society as a whole. At the same time, however, we also argue for *additional* support for groups who have the greatest health deficit, and therefore the greatest need. This is not only because these groups represent the greatest potential gains, but also – and perhaps precisely – because it is only fair to do so.

99 Hemerijck (2017).

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