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Learning from our Neighbours

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

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PREFACE

The Netherlands is renowned for its ability to look beyond its borders and proactively embark on international collaboration and the exchange of people, ideas and goods. Like other nations, we like looking at other countries to see how we are performing, also in the area of public health. Our assumption is that the Netherlands is doing very well in every area and is one of the top five countries in the world.

Although the level of health in the Netherlands can be considered fairly good, there are several alarming problems that require action. In previous Public Health Status and Forecast Reports (PHSF), the National Institute for Public Health and the Environment (RIVM) observed that the increase in life expectancy in the Netherlands was stagnating compared with other countries, and later that the Netherlands was no longer one of the top countries in the area of health care. In addition, the PHSF reports show that Dutch citizens with a low education or a low income experience fewer years of good health and live shorter than citizens WHO have a higher social status. The majority of Dutch unhealthiness could be prevented by a better individual and collective lifestyle. This is a painful conclusion. It is not a consolation but rather a stimulus to act.

International comparisons can shed light on the status of our health care and help set objectives for our national ambitions. For the benchmark, internationally comparable data on health status are important, as is information about epidemiologic causes (risk factors) and health care (costs, quantity). The PHSF reports give these issues ample attention.

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

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

The Ministry of Health, Welfare and Sport asked the RIVM to provide an international overview of policy developments in the area of public health, or in other words national health. A number of important spearheads have been selected from the national prevention policy, which are elaborated in separate chapters: smoking, alcohol, overweight, depression, health inequalities, youth and screening. This report is the result of intensive collaboration between the RIVM, policy officers of the Ministry of Health, Welfare and Sport and experts in the field.

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



Hans de Goeij
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KEY MESSAGES

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

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

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

Key findings

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

Unhealthy behaviour, health inequalities and disease are not only characteristics of individuals, but are also determined to a large extent by the social and physical environment in which people are born, raised and live. This is why public health policy requires a thorough and integrated approach: a combination of instruments that are not only aimed at the individual, but that also take into account the complex relationship between the different areas both within and without the public health area. Such an integrated approach has since proven to be effective in the Netherlands in the area of tobacco use and road safety and also has potential for alcohol abuse and obesity. Other countries have found more and better ways of applying integrated health policy to improve health, among other things by reducing (socio-economic) health inequalities.

- England and Sweden appear to be reaping the benefits of basing the systematic application of an integrated health policy for youth and health differences on their national strategy.
- An intersectoral approach to a healthy environment facilitates individual healthy behaviour (smoking, alcohol, obesity) and can also affect socio-economic health differences (SEHD) and the health of young people.

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

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

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

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

Policymaking for public health can conflict with other values and interests

Each policy sector focuses on a different interest. These interests can run in parallel to the public health interest, but they can also conflict with them. This can create conflicts within and between governments, between economic and public health policies, but also between long-term and short-term objectives. The interests of the government, the market and the citizens can, for example, conflict in terms of how tobacco prices are regulated and how screening self-tests are offered. At the individual level there is a paradox between health as an important value and the choice for or the continuation of unhealthy behaviour. In short, the value of (public) health does not seem to have the same importance for everyone.

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

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

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

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

- Scientific studies and health policies applied in other countries clearly show that a lot of policies (including integrated health policy) can be more effective.

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

INSPIRATIONS AND OBSERVATIONS

- DID YOU KNOW THAT...?

Smoking

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

Alcohol

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

Obesity

- Since 1980, obesity among children and adults in Western countries (including the Netherlands) has increased threefold.
- Many countries have developed numerous policies on obesity, but not one country has as yet reported any successes.
- A good policy on obesity can only be developed if the roles of the market, government and individuals are carefully balanced.
- Many countries are developing new policies on obesity that goes further than the individual's own responsibility. The Netherlands can learn from this.
- Sometimes the market thwarts policy (in the US, for example, industry gave the Lithuanian government a dressing down for forbidding soft drinks in schools) and sometimes it creates opportunities (for example, 'Victory Camps' for obese children).
- Regulating the supply (subsidies/taxes) and marketing of obesogenic foodstuffs are policy instruments that are still rarely used.
- The prevention of and fight against obesity would benefit from a European approach.

Depression

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

Health inequalities

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

Youth

- The Dutch youth are predominately healthy, but suitable preventive care is needed to ensure today's healthy youth remain healthy.
- In recent years, a number of countries have had a clearer national direction on preventive youth (health) care than the Netherlands.
- In the Netherlands (and Germany), few schools have a school health policy, while all of the schools in England and Scotland must become Healthy Schools soon.
- An integrated approach, with attention for mental health, healthy food and physical activity has proven to be an effective way of promoting health at school.
- Other countries have interesting variations of the Dutch Youth and Family centres (Centra voor Jeugd en Gezin): 'Sure Start Children's Centre' and 'Children's Trust' (England), Integrated Youth Services (Integrale Jeugdhulp), Child & Family (Kind en Gezin), and Centres for Pupils Counselling (Flanders), and the 'Socialtjänst' and 'Family Welfare Centres' in Sweden.
- Other countries put a strong emphasis on a positive approach (England, Sweden and Flanders) and on an integrated and intersectoral approach to their youth policy.

Screening

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

1 INTRODUCTION

1.1 Background

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

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

Learning from our neighbours

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

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

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

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

1.2.1 What is public health?

In the Netherlands, the terms 'public health', 'national health', 'basic health care', 'public health care' or 'collective prevention' are usually used interchangeably and all refer pretty much to the same thing. At the

same time, the internationally used term 'public health' appears to have a number of interpretations. The literal Dutch translation of public health, *publieke gezondheid*, has been in vogue for a few years – the Ministry of Health, Welfare and Sport have a Public Health Director - but this term, too, appears to have several meanings.

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

Text block 1.1: Definition of public health

'Public health is the science and the art of preventing disease, prolonging life and promoting physical and mental health and efficiency through organised community efforts for the sanitation of the environment, the control of community infections, the education of the individual in principles of personal hygiene, the organization of medical and nursing services for the early diagnosis and preventive treatment of disease, and the development of the social machinery which will ensure to every individual in the community a standard of living adequate for the maintenance of health'.

Source: Winslow, 1920

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

The objective of public health care is to protect and promote our health.'

This term 'public health care' is preferred by the Dutch Health Care Inspectorate (IGZ, 2005). The following tasks are also considered to be part of public health: the monitoring of Dutch public health (e.g. the Health Inequalities Monitor (*Monitor Gezondheidsachterstanden*)), the reports on the status of public health (e.g. RIVM's PHSF reports), health and care counselling (by, for example, the Health Council of the Netherlands and the Advisory Council on Health Research), the planning and evaluation of different public health activities (e.g. within the framework of the Netherlands Organisation for Health Research and Development (*ZonMw Preventieprogramma*)), and the necessary background research by, among others, universities. This organizational description of public health overlaps with a more subject-specific subdivision of prevention in health protection, health promotion and disease prevention. This report mainly focuses on the last two.

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

1.2.2 What is public health policy?

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

Sometimes, the definition of PH policy is limited to specific policy formulations, for example, the contents of national programmes or well-described priorities and activities in health or prevention memoranda.

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

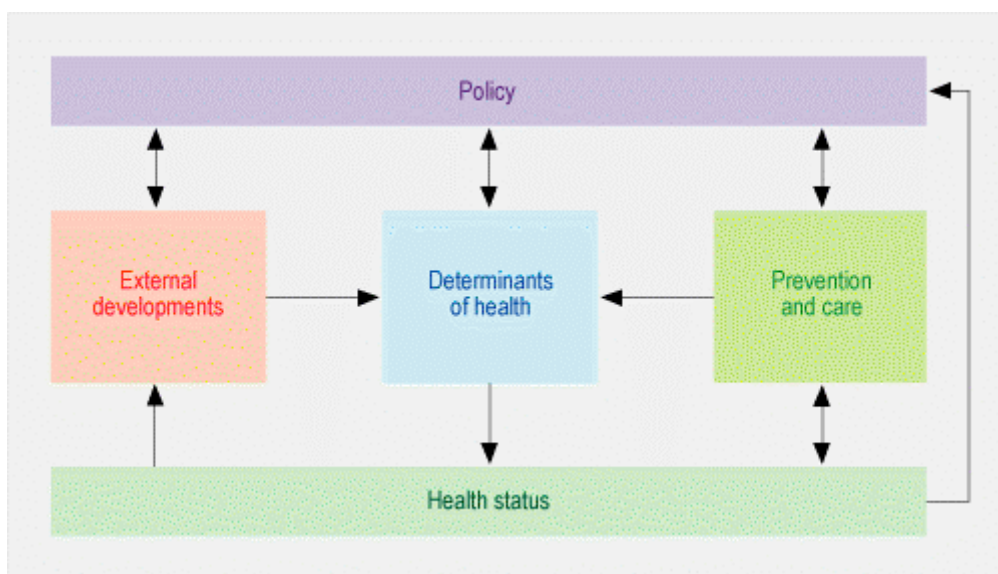


Figure 1-1 The conceptual model of public health (De Hollander et al., 2006)

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

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

1.2.3 Learning from our neighbours?

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

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

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

1.3 Methods and procedures

1.3.1 Selecting the themes for the individual chapters

Public health policy covers a number of different topics, which is why choices had to be made for this report. The themes were selected according to a number of criteria, such as spearheads and policy priorities in the prevention memorandum and the meaning of the 'problem area' according to PHSF 2006.

International developments that were potentially interesting for the Netherlands were also a criterion. The selected themes, which are interesting for Dutch public health policy in several ways, are:

- Smoking
- Alcohol

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

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

1.3.2 Selecting the countries

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

1.3.3 Collecting information and sources that were used

Different methods were used to find information, namely:

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

Although the search was extensive, it cannot be guaranteed that all of the relevant literature was found. Because the problem areas can be very different, the corresponding thematic chapters also differ in the way they were created and in their contents. The chapter on screening is based on discussions with a number of experts at RIVM, while other chapters are mainly based on literature research and the study of policy documents.

1.4 Outline of the report

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

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

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

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

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

Chapter 8 follows yet another approach; it is dedicated to a means or a strategy, namely screening, meaning the detection of diseases and disorders at an early stage. This subject is different from the previous subjects in a number of ways. But because both the technological and social developments in this area are taking place so quickly, it makes sense in this international exploratory report to look 'abroad' for initiatives and developments in this area, too.

References

- Allin S, Mossialos E, McKee M, Holland W. Making decisions on public health. A review of eight countries. Copenhagen: European Observatory on Health Care Systems and Policies, 2004.
- Banta HD, Hatziandreu E, Dauben HP, Forde OH, Laebli Loud M, Isacson SO et al. Health Promotion and disease prevention as a complement to community health indicators. *Int J Technol Assessment Health Care* 2002;18(2):238-272.
- Claassen R. Het eeuwig tekort: een filosofie van de schaarste. Amsterdam: Ambo, 2004.
- Drewes JBJ. Het preventieconcert. Signalement over internationale vergelijking van publieke gezondheid. Signalementen RVZ. Zoetermeer: RVZ, 2005.
- Hollander AEM de, Hoeymans N, Melse JM, Oers JAM van, Polder JJ (eindred.). Zorg voor gezondheid. Volksgezondheid Toekomst Verkenning 2006 [English: Care for health. The 2006 Dutch Public Health Status and Forecasts Report. RIVM report 270061003]. RIVM-rapportnr. 270061003. Houten: Bohn Stafleu Van Loghum, 2006.
- IGZ, Inspectie voor de Gezondheidszorg. Staat van de Gezondheidszorg 2005. Openbare gezondheidszorg: hoe houden we het volk gezond? The Hague: IGZ, 2005.
- McKee M, Delnoij D, Brand H. Prevention and public health in social health insurance systems. In: Saltmann RB, Busse R, Fihueras J (eds.). Social health insurance systems in western Europe. Berkshire: Open University Press, 2004.
- VWS, Ministry of Health, Welfare and Sport. Preventienota Opting for a healthy life. Brief van de minister aan de Tweede Kamer [Dutch House of Representatives] (PG/OGZ/2.720.104). The Hague: VWS, 2006.
- Winslow C-EA. The Untilled Field of Public Health. *Science* 1920;(51):23-33.

SMOKING

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

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

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

Several effective policies are available that various countries have already implemented:

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

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

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



2 SMOKING

Eveline van der Wilk

2.1 Introduction

2.1.1 Adverse effects of smoking

2.1.2 International perspective on smoking

2.2 Anti-smoking policy in an international context

2.3 Policy implementation concerning smoking

2.3.1 Effectiveness of anti-smoking policy

2.3.2 Anti-smoking policy in the Netherlands

2.3.3 Anti-smoking policy comparison among countries

2.4 Discussion and conclusions

References

2.1 Introduction

Long before the Europeans went to the Americas, Native Americans were already using tobacco primarily for its alleged medicinal powers (www.sigaar.nl). The English colonists who returned to their mother country attracted attention because they smoked tobacco from pipes. This quickly became a popular practice; however, the high cost of tobacco meant that smoking was only reserved for the rich.

The cigar reached Western Europe around 1800, yet many more years passed before cigarettes made their debut. Cigarettes were probably invented by soldiers because they occasionally smoked tobacco in scraps of paper. During the First and Second World Wars, soldiers distributed cigarettes, and the general public quickly became acquainted with these.

Popes introduced the first no-smoking rule

Smoking attracted opponents early on in its history. Various popes in the past issued a no-smoking edict. The physical enjoyment of smoking was considered to be something demonic. King James I of England (1603-1625) penned a treatise entitled 'A Counterblaste to Tobacco', in which he expresses himself as a misocapnic – a hater of tobacco smoke. He denied there being any medicinal powers in tobacco and claimed that smoking posed a danger to England. His subjects, however, did not want to listen and continued to smoke. James I was succeeded by Charles I, who headed a money-devouring royal household. To pay for this expense he taxed tobacco heavily, and allowed the English to smoke as much as they wanted. This made Charles I the inventor of the national excise duty on tobacco (www.sigaar.nl).

Sociocultural and political powers promote tobacco consumption

The frequency of smoking increased in America and Europe for various reasons, among which the addictive effect of one of tobacco's substances, nicotine. In addition, an extensive tobacco industry along with sales outlets developed in which many people found, and still find, their income and source of work. Sociocultural factors also play a significant role in smoking. The smoker's social image, including what he smokes (cigar, pipe, rolling tobacco), can correspond with desired social roles that almost require a person to smoke to belong to these groups. Finally, smoking also became a significant source of revenue for national governments through levying excise taxes. There were, and still are, strong sociocultural and political forces that promote tobacco sales and do not support the discouragement of smoking.

Insight into the damaging health impacts leads to the formation of anti-smoking policy

The first epidemiological studies that indicated a positive correlation between the number of cigarettes smoked and the risk for lung cancer appeared in 1950 (Wynder & Graham, 1950; Doll & Hill, 1950). An increase in the frequency of smoking led to a strong increase in the magnitude of the detrimental health effects, which subsequently led to the formulation of an anti-smoking policy in various countries. In the meantime, most countries have implemented, often extensive, policies to discourage smoking and in Europe this has in part been realized by European legislation collectively agreed upon by the EU Member States.

Overview of this chapter

After this section, the adverse effects of smoking will first be addressed in more detail and smoking trends in the Netherlands and Europe will be compared. In the following section, international policies and recommendations, such as those formulated at the supranational level by the World Health Organization (WHO) and the European Union (EU) will be described. Policy implementation is then compared in greater detail. Evidence of the effectiveness of a number of anti-smoking policies is first of all briefly summarized. Policy in the Netherlands is then discussed, followed by a comparison of policies using several examples from other countries. The discussion and conclusions consider what this information means for Dutch

policy. Which countries' policies should we look at to draw up the most effective policy possible and what is the current smoking trend in the Netherlands?

2.1.1 Adverse effects of smoking

A landmark study by Doll and Hill followed the study mentioned earlier (Wynder & Graham, 1950; Doll & Hill, 1950) which showed a correlation between smoking and lung cancer. A cohort of approximately 35,000 doctors in the United Kingdom was followed for 50 years to study the correlation between smoking and lung cancer (Doll & Hill, 1964; Doll et al., 2004). The most significant conclusion from this study was that men born between 1900 and 1930, who had smoked, died an average of ten years earlier than men who had never smoked. Further studies have found correlations, which were sometimes strong correlations, between smoking and other diseases.

Smoking the most important cause of premature death

Smoking is currently the most significant single cause of premature death. Smoking not only considerably increases the risk of lung cancer, but also the risk of asthma, COPD, coronary heart disease and stroke. It contributes to a low birthweight and is also associated with an increased risk of various cancers other than lung cancer. Approximately 21% of years of life lost and 13% of the entire disease burden of disease in the Netherlands is attributed to smoking (De Hollander et al., 2006). Passive smoking also has negative health impacts. This causes a 20% increase of the risk for lung cancer and a 20 to 30% risk for cardiovascular disease for non-smokers (GR, 2003).

Smoking-related premature death causes a considerable loss in labour productivity in many countries. At the same time, many medical costs, along with a relatively large number of years of life lost, are the result of diseases caused or accelerated by smoking. Smokers also have a higher average work absenteeism. There are considerable social and economic costs connected to smoking and the consequences of smoking (Analysis of the Science and Policy for European Control of Tobacco, 2004).

2.1.2 International perspective on smoking

The prevalence of smoking, defined as the percentage of daily smokers 15 years of age and older in the population, remains relatively high in the Netherlands. The prevalence of smoking was found to be 28% in 2004; this was under 30% for the first time. It has not decreased since then. The prevalence of smoking in the Netherlands was also 28% in 2005: 31% in men and 25% in women (The Dutch Foundation on Smoking and Health, 2005). In particular, the percentage of smokers has not decreased among women. The differences in the prevalence of smoking among education levels seem to have increased during the past ten years. The number of highly-educated smokers has slightly decreased while the number of low-educated smokers has increased. The latter applies to men in particular.

Percentage of smokers in the Netherlands is average in Europe

The percentage of adult smokers in the Netherlands is average compared to other European countries (Figure 2.1). In 2005, 28% of the Dutch population aged 15 years or older smoked (The Dutch Foundation on Smoking and Health, 2005; WHO-HFA, 2007). Greece (38%) and Germany (34%) are the EU countries with the most smokers (WHO-HFA, 2007). In general, men in Southern, Eastern and Central Europe smoke more than men in Northwest Europe. The most recent statistics for Greece (from 2000) show that 47% of men smoke, which is the same figure as in Latvia, whereas only 14% of men in Sweden smoke. More women smoke in Western and Northern Europe than in Southern Europe. Twenty-five percent of women smoke in the Netherlands and less than 10% of women smoke in Portugal. Compared to other EU countries, women in the Netherlands score quite unfavourably (WHO-HFA, 2007).

In most EU countries, the percentage of men who smoke decreased from 1980 to 2005. Just as in the rest of Europe, the differences between men and women in the Netherlands have continued to decrease during the

past decade. In Sweden, more women (18%) smoked than men (14%) in 2005 (WHO-HFA, 2007). Moreover, the most spectacular decrease in the percentage of smokers occurred in Sweden, from 32% of the population in 1980 to 16% in 2005. There is another form of tobacco consumption in Sweden, namely the use of an oral tobacco called 'Snus'. The body absorbs nicotine from this oral tobacco without the damage caused by the smoke itself. Even though using 'Snus' is probably associated with health risks as well, these are not in proportion to the risks associated with smoking.

Prevalence of smoking amongst Dutch teenagers average in EU

The prevalence of smoking among Dutch teenagers is average in the EU: 31% of 15- and 16-year-olds have recently smoked (Hibell et al., 2004). In 2003, Austria had the most 15- and 16-year-old smokers and Sweden the least. More than a quarter (27%) of Dutch adolescents say they have smoked more than 40 times. This percentage varies in Europe, from 18% in Portugal to 42% in Austria. More boys and girls smoke in the Baltic States and Poland. In most Northern and Western European countries girls smoke more than boys, yet boys start smoking at a younger age than girls (Hibell et al., 2004).

Low-educated children and adolescents smoke more, except in the southernmost part of Europe

In many EU countries, including the Netherlands, there have been reports of large socio-economic differences in smoking percentages since the 1950s. These differences among men are more closely correlated to education level than they are to income (Mackenbach et al., 2004). During the 1990s, the differences stabilized in most countries; they increased in a few countries. Because smokers with a low education, a low-level occupation or a low income stop smoking less frequently, and because young people from these socio-economic groups start smoking, the percentage of smokers in these groups is currently substantially higher (Mackenbach, 2006).

At the end of the 1980s, socio-economic differences in smoking prevalence existed among women, particularly in Northern Europe. In Southern Europe, there were no differences seen among women at the end of the 1980s or, in some cases, the converse in differences was seen, with highly-educated women smoking more. During the 1990s, however, the differences increased in most Northern European countries and differences developed in the south. This was the result of the favourable development in the prevalence of smoking among highly-educated women. Among the youngest generation of women, low-educated women smoke more than highly-educated women in almost all countries except in southernmost Europe. These developments follow the pattern in the so-called 'four-stage smoking epidemic model'. In this, highly-educated men start smoking first, followed by highly-educated women, after which smoking gradually becomes common practice among the low socio-economic status groups (Cavelaars et al., 2000) and the high socio-economic status groups stop smoking sooner. A north-south trend in the timing of this development exists within Europe (Mackenbach et al., 2004). These differences could be important for the implementation of a national anti-smoking policy.

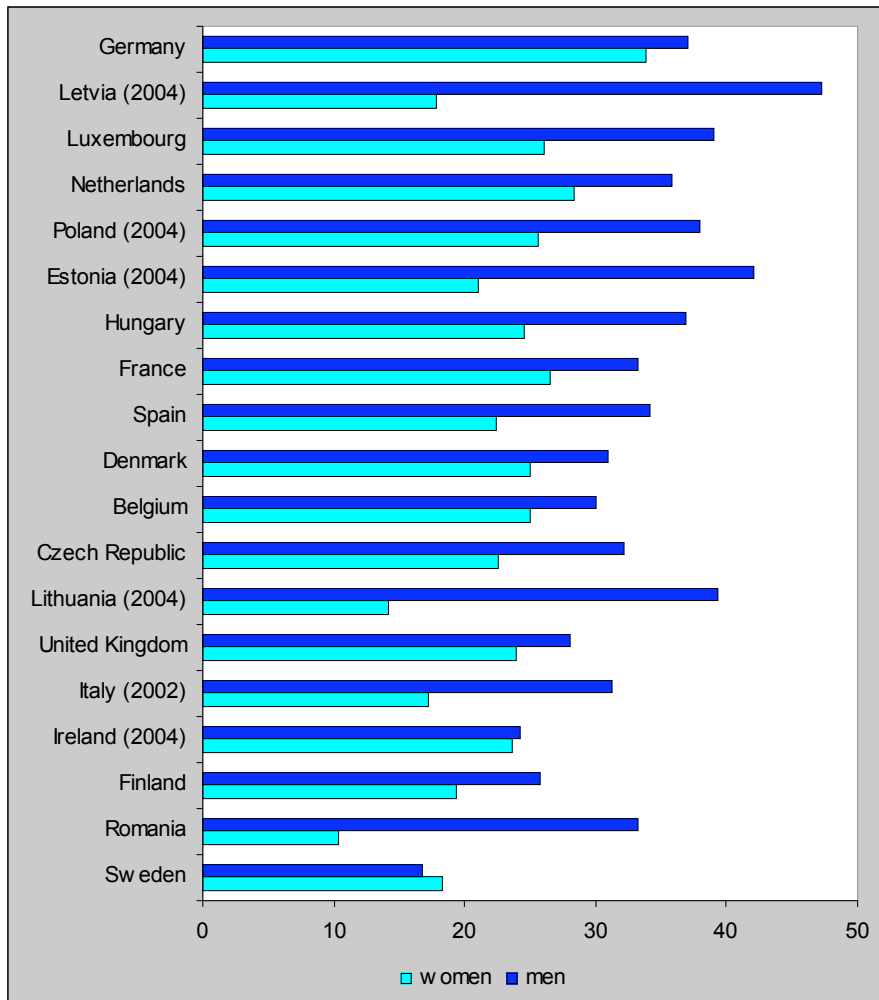


Figure 2-1: Percentage of daily smokers (15 year and older) in a number of EU-countries in 2003, unless stated otherwise (WHO-HFA, 2007)

2.2 Smoking policy in an international context

The EU tobacco control policy has its judicial basis in Articles 152 and 95 of the Treaty on European Union (Maastricht Treaty) concerning public health and the internal market. In line with these articles specific measures and agreements have been developed that shape tobacco discouragement policy.

Article 152 of the Treaty states that the EU must take measures to protect and promote public health via policy in all areas, as long as these measures supplement the policies of individual Member States. Consequently, the principle of tobacco control is, wherever possible, related to the objectives of other policy areas such as agriculture and excise tax. This can prove to be a considerable challenge as the interests of tobacco farmers, for example, do not always coincide with those of health promoters and initiatives in the area of excise taxes might interfere with the autonomy of the Member States. The Treaty is not binding in the area of tobacco discouragement.

Binding EU measures against smoking to avoid internal market disruption

The EU has far more extensive powers in the area of the internal market. For example, it can harmonize the legislation of different Member States with respect to the internal market by issuing binding directives,

regulations et cetera. The binding legislation on tobacco policy is predominantly based on legal considerations regarding the internal market; or better said, the disruption of the internal market due to legislative differences between Member States (Article 95, EU Treaty).

Examples of binding measures:

- ban on tobacco advertisement in printed media, radio broadcasting and in information society services
- tobacco companies may not sponsor events or radio broadcasting
- ban on tobacco advertisement on television
- the EU sets limits on certain ingredients, issues guidelines for the formulation of warnings on cigarette packaging and forbids the use of terms such as ‘mild’ and ‘light’
- Member States must levy a certain minimum excise tax on tobacco products to reduce price differences between Member States

Since the late 1980s, several of the recommendations and conclusions in the area of tobacco control from the Council of the European Union (Council of Ministers) have been implemented. The most recent Council recommendation was published on 2 December 2002 and concerned the prevention of smoking and initiatives to improve tobacco control (2003/54/EC). It included the advice to reduce the supply of tobacco products to children and adolescents, and it addresses issues not regulated at the EU level, such as the minimum age for buying tobacco products.

The European Union is actively developing a comprehensive tobacco control policy, which is characterized by a four-stage approach:

- legislative measures
- support for Europe-wide smoking prevention and cessation activities
- mainstreaming tobacco control into a range of other EU policies
- ensuring that the pioneering role of the EU in many tobacco control areas produces an impact beyond the frontiers of the European Union, and establishing the EU as a major player in tobacco control at a global level

EU implements and supports various anti-smoking initiatives

This four-fold strategy is reflected in the activities implemented and supported by the EU. The first attempts to reduce the smoking problem in the EU date back to 1987, when the ‘Europe Against Cancer’ programme was launched. This programme consisted of actions in the fields of prevention, data collection and public health care information, training for health care personnel, and cancer research, which served to support anti-smoking campaigns. Subsequent anti-smoking actions were funded via cancer control programmes until 2003. After this they were incorporated into the broader ‘EU Public Health Action Programme 2003-2008’.

The ‘Community Tobacco Fund’ was established in 1992. As a result of a levy imposed on subsidies for the discontinuation of the subsidized cultivation of tobacco in the EU, revenue became available to set up public information projects about the harmful effects of smoking. The funds also finance projects that allow tobacco growers to switch to alternative crops or activities.

On 1 March 2005, Markos Kyprianou, the EU Health Commissioner, launched a new anti-smoking campaign, ‘HELP – For a Life Without Tobacco’. This campaign was implemented at the EU level, and further built upon the experiences from the first campaign: ‘Feel Free to Say No’. The HELP campaign, which runs until 2008, promoted a smoke-free lifestyle among adolescents, 15 to 18 years old, and young adults, 18 to 30 years old. The dangers of passive smoking are emphasized and the campaign supports striving towards smoke-free public spaces. The campaign has a budget of 72 million Euros and consists of a roadshow, a public relations campaign, and an advertisement campaign. Since May 2005, there has also been a website with advice on how to stop smoking (www.Help-eu.com).

At the beginning of 2007, the European Commission published a ‘Green Paper’, which launched a broad consultation process concerning the best way to proceed with tackling passive smoking in the European Union (EC, 2007). A few years earlier, the Commission had committed itself to the Environment and Health Action Plan (2004-2010) to “develop work on improving indoor air quality, in particular by encouraging the restriction of smoking in all workplaces by exploring both legal mechanisms and health promotion initiatives at both European and Member State level” (EC, 2004).

In the 1990s, action programmes by the EU indirectly led to the establishment of a number of international knowledge centres in Europe. Some of these centres developed into autonomous non-profit organizations. An example of this is the ‘European Network for Smoking Prevention’ (ENSP) whose objective is to create a greater degree of coherency between smoking prevention activities and to promote anti-smoking policy at national and European levels. Another EU-financed network is the ‘European Network for Young People and Tobacco’ (ENYPAT). ENYPAT’s objective is to reduce smoking among young people by promoting collaboration among health workers, experts and researchers. It is also a knowledge centre in the area of smoking, smoking prevention programmes and questions about smoking policy: the ENYPAT’s activities are particularly focused on youth. These European networks assemble a great deal of expertise and ‘good practice’. They have also published a number of significant international comparative studies (Analysis of the Science and Policy for European Control of Tobacco, 2004; Joossens, 2004).

Text block 2.1: Framework Convention on Tobacco Control

The first 10 statements in the preamble of the Convention:

The Parties to this Convention,

1. Determined to give priority to their right to protect public health,
2. Recognizing that the spread of the tobacco epidemic is a global problem with serious consequences for public health that calls for the widest possible international cooperation and the participation of all countries in an effective, appropriate and comprehensive international response,
3. Reflecting the concern of the international community about the devastating worldwide health, social, economic and environmental consequences of tobacco consumption and exposure to tobacco smoke,
4. Seriously concerned about the increase in the worldwide consumption and production of cigarettes and other tobacco products, particularly in developing countries, as well as about the burden this places on families, on the poor, and on national health systems,
5. Recognizing that scientific evidence has unequivocally established that tobacco consumption and exposure to tobacco smoke cause death, disease and disability, and that there is a time lag between the exposure to smoking and the other uses of tobacco products and the onset of tobacco-related diseases,
6. Recognizing also that cigarettes and some other products containing tobacco are highly engineered so as to create and maintain dependence, and that many of the compounds they contain and the smoke they produce are pharmacologically active, toxic, mutagenic and carcinogenic, and that tobacco dependence is separately classified as a disorder in major international classifications of diseases,
7. Acknowledging that there is clear scientific evidence that prenatal exposure to tobacco smoke causes adverse health and developmental conditions for children,
8. Deeply concerned about the escalation in smoking and other forms of tobacco consumption by children and adolescents worldwide, particularly smoking at increasingly early ages,
9. Alarmed by the increase in smoking and other forms of tobacco consumption by women and young girls worldwide and keeping in mind the need for full participation of women at all levels of policy-making and implementation and the need for gender-specific tobacco control strategies,
10. Deeply concerned about the high levels of smoking and other forms of tobacco consumption by indigenous peoples,

The core demand reduction provisions in the WHO FCTC are contained in articles 6-14:

- Price and tax measures to reduce the demand for tobacco, and
- Non-price measures to reduce the demand for tobacco, namely:
 - Protection from exposure to tobacco smoke;
 - Regulation of the contents of tobacco products;
 - Regulation of tobacco product disclosures;
 - Packaging and labelling of tobacco products;
 - Education, communication, training and public awareness;
 - Tobacco advertising, promotion and sponsorship; and,
 - Demand reduction measures concerning tobacco dependence and cessation.

The core supply reduction provisions in the WHO FCTC are contained in articles 15-17:

- Illicit trade in tobacco products;
- Sales to and by minors; and,
- Provision of support for economically viable alternative activities.

Another novel feature of the Convention is the inclusion of a provision that addresses liability. Mechanisms for scientific and technical cooperation and exchange of information are set out in Articles 20-22.

Source: WHO, 2003

The WHO Framework Convention on Tobacco Control obligates countries to discourage tobacco

The activities of the World Health Organization (WHO) have for a long time been limited to the exchange of knowledge and providing recommendations. In 2003, under the auspices of WHO, a binding treaty was created in the field of tobacco control; the WHO 'Framework Convention on Tobacco Control' (FCTC). This Framework Treaty in the area of tobacco control is the first global treaty in the field of public health. The aim is to reduce the percentage of tobacco users and the exposure to environmental tobacco smoke (WHO, 2003; Text block 2.1). The treaty needed ratification from at least 40 Member States to be implemented.

Norway was the first country in the world to ratify this treaty. The Netherlands ratified the Framework Convention on Tobacco Control on 27 January 2005. The treaty became effective on 27 February 2005. In principle, the countries that joined this treaty – now more than 140 – assemble annually in a so-called 'Conference of the Parties'. During this conference issues are addressed, such as the manner in which the parties fulfil their treaty obligations and the further development of the treaty. As this is a framework treaty, the further development can be realized through an amendment to the treaty text or through the development of binding protocols.

Currently, protocols in the area of cross-border tobacco advertisement, anti-contraband, and product regulation are being worked on within the framework of this treaty. In addition, the Conference of the Parties also establishes non-binding directives in regard to certain articles. National implementation is closely monitored by the European Network on Smoking Prevention (ENSP).

2.3 Policy implementation concerning smoking

This section starts with a summary of the effectiveness of anti-smoking measures and anti-smoking policies in the world, and then addresses a framework for the comparison of international tobacco policies. Subsequently, Dutch policy and the policies in other countries are considered.

2.3.1 Effectiveness of anti-smoking policy

A number of extensive studies have recently been performed, which describe the anti-smoking policies of countries and assess the effectiveness of the measures. The World Bank published the fact sheet 'Tobacco control at a glance' in 2003. This document describes six cost-effective interventions to reduce disease and death that result from smoking (World Bank, 2003).

These measures are:

- higher excise taxes on tobacco products
- banning smoking in public buildings and workplace
- banning advertising and sponsoring for tobacco products
- better consumer information concerning health aspects (including addiction), stopping with smoking (advantages and possibilities) and the strategic operations of the tobacco industry (for example, via counter- advertising)
- large, direct labels on cigarette packaging and other tobacco products
- help for smokers who want to stop, including access to Nicotine Replacement (NRT) and other cessation therapies

The best results are achieved when an extensive package of coherent measures are implemented. In 2004, the report, 'Tackling inequalities in smoking' (Mackenbach et al., 2004) was published. With the exception of the large warning labels on cigarette packaging and better consumer information, there are five anti-smoking measures that were identified as being effective in low socio-economic groups; four of which concur with those of the World Bank. The fifth one, which was explicitly mentioned as being effective, is the availability of telephone help lines. This report summarizes the developments in this policy in six countries between 1985 to 2000. However, no European country has fully seized this potential to date. Although most countries have implemented at least some potentially relevant tobacco control measures, these measures have often been implemented partially and not fully to the benefit of lower socio-economic groups. Additionally, in some cases the measures were implemented in such a way that only the high socio-economic groups benefited from them. This points to the fact that there is still room for making anti-smoking policy more effective, certainly for groups with a low socio-economic status.

Comparison of effective anti-smoking policy among countries

Levy, Chaloupka and Gitchell described the effects of an anti-smoking policy on smoking statistics and developed a scorecard for smoking policies (Tobacco Control Scorecard'; Levy et al., 2003). A substantial tax increase (price) and the implementation of stricter laws for smoking in public were found to constitute the most important measures for successfully reducing the prevalence of smoking. Both measures could lead to a reduction in the prevalence of smoking of 10% or more.

In 2004, Joossens provided an overview of effective anti-smoking policies and also quantified the policies in European countries (Joossens, 2004). The European Network on Smoking Prevention (ENSP) assembled a panel of international researchers and policy experts to reach a consensus regarding the allocation of scorecard points to measures proven to be effective. The components of a good anti-smoking policy are:

- price/tax policy (30 points)
- ban on smoking in the workplace/public space (22 points)
- raising the smoking policy budget (15 points)
- banning advertisement (13 points)
- health warnings and labelling (10 points)
- treatment to help dependent smokers stop (10 points)

With this scale, countries receive a certain score for each component which in turn provides an impression as to whether a country has developed an active or a less active anti-smoking policy. The maximum number of points is 100. The objective is not to condemn a national smoking policy, but rather to encourage policymakers to analyze their countries' scores and to improve on the weaker points. For example, as a result of the study Belgium (19th of the 28 countries) had a parliamentary debate about

subsidies, prices and stopping with smoking. This also expressed Belgium's desire to return to the top of Europe (Burgeon, 2004). Denmark also reviewed its policies as a result of the score it received (Falk, 2004).

Various countries have a more active anti-smoking policy than the Netherlands

In 2005, the policies from 30 countries were again compared so that the results from more than one year previously could be compared using what has since been termed the 'Tobacco Control Scale' (Joossens & Raw, 2006). The four countries with the highest 'Tobacco Control Score', and thus the most extensive policies are Ireland, the United Kingdom, Norway and Iceland. Along with these countries, there are five more countries with a higher score than the Netherlands. All of these countries have a lower prevalence of smoking than the Netherlands, which has a prevalence of 28%. The Netherlands has dropped from seventh to tenth place since the previous measurement because various countries have further refined their policies.

2.3.2 Anti-smoking policy in the Netherlands

In the Dutch National Tobacco Control Programme 2006-2010, the government declares that it wants to reduce the percentage of smokers from 28% in 2004 to 20% by 2010 (VWS, 2006). An annual action plan based on this programme has been compiled by the parties involved: the Dutch Cancer Society (KWF), the Dutch Asthma Foundation, the Dutch Heart Foundation and the Ministry of Health, Welfare and Sport (VWS). These action plans consist of the specific activities the parties shall implement in the following year.

Parts of Dutch legislation, regulation and policy in the area of smoking are directly derived from obligations under international law. Various organizations are involved in non-smoking activities. The Ministry of Health, Welfare and Sport bears primary responsibility for the Tobacco Act. The Food and Consumer Product Safety Authority (VWA) supervises compliance with this (enforcement). The most important national prevention organization in the area of smoking is the Dutch Foundation on Smoking and Health (STIVORO). This tobacco knowledge centre manages, for example, mass media campaigns and information about stopping with smoking.

The Tobacco Act amended in 2002

The Tobacco Act was amended in 2002. This Act contains regulations for the tobacco industry, tobacco sellers, employers and managers of public buildings and public transport, such as train and bus systems.

The Act contains decrees outlined as follows:

- a virtually all-encompassing ban on tobacco advertisement and tobacco sponsoring
- a ban on selling tobacco products to young people under the age of 16
- the right to a smoke-free workplace and smoke-free public transport
- administrative penalties imposed upon infringement

Smoke-free sport and a smoke-free hospitality industry in the future

The Ministry of Health, Welfare and Sport commissioned the Netherlands Olympic Committee * Netherlands Sports Confederation (NOC*NSF) and the Dutch Foundation on Smoking and Health to begin with the 'Smoke-free Sport project'. In 2003, an inventory of the state of affairs in all sport establishments began, followed by an information campaign aimed at sports associations in 2004. This is an attempt to achieve self-regulation within sports associations so that they establish rules within their own regulations. The aim was to have a virtually smoke-free sport sector in 2006 (STIVORO, 2005). It is unclear if this has been successful. Hospitality industry employers were also encouraged to make the hospitality industry smoke-free. They have developed a procedure based on self-regulation for this purpose. This plan runs until the end of 2008, but according to an evaluation by the Dutch Institute for Public Opinion and Market Research (TNS NIPO), restaurants, cafés and discotheques had not reached the target figures for 2005 (TNS NIPO, 2006).

Different types of individualized advice about stopping with smoking

Smokers have been able to receive 'Individualized Advice' since 1988. After filling in a questionnaire on the Internet (www.stopeffectief.nl), smokers receive personalized recommendations about stopping with smoking sent to their home. Since 1999, telephone counselling has also been available to help smokers with their attempts to stop in six sessions with counsellors. Finally, smokers can participate in stopping-with-smoking courses which have existed since 1967 and are frequently offered by the municipal health services or home care organizations. The 'Smoking, no thank you' campaign that began in 1994 is specifically aimed at immigrants (Turkish, Moroccan, and Surinamese). They receive information about smoking and stopping with smoking in their own languages.

Various prevention activities in the area of smoking in schools and the workplace

The 'Healthy School and Drugs' project was developed to reduce smoking in primary and secondary schools (Paulussen, 2002; also see the chapter on Youth). In addition, teachers use lesson plans to educate students about smoking. Furthermore, students in their first and second year of secondary education have been able to participate in 'Actie Tegengif' ('Antidote Action') since 1999. This is the Dutch version of a school-based European smoking prevention project, the 'Smokefree Class Competition', in which students make agreements with each other not to smoke or to quit smoking. Finally, since 1997, the 'Smoke-free school' project has existed for primary and secondary education and one of its objectives is the creation of a smoke-free environment in schools.

For a smoke-free workplace, the Dutch Foundation on Smoking and Health developed a method implemented in a number of products concerning advice: a manual for the implementation of a smoking policy, a website, telephone advice and the non-smoking programme for the workplace. For example, the 'Smoke-free at work' folder describes how to set up a health policy regarding smoking at a company in seven steps.

Costs for smoking prevention decreased between 2003 and 2005

Costs of smoking prevention measures in the Netherlands amounted to 22 million euros in 2003 out of a total of 12.5 billion euros dedicated to disease prevention (De Bekker-Grob et al., 2006). This amount of 22 million Euros in 2003 was so high because of the implementation of the Werner motion (Dutch Senate, 2002). After the Dutch Senate and the Dutch House of Representatives had approved the new Tobacco Act in 2002, the Christian Democratic Union (CDA) senator Jos Werner proposed a motion for the Minister of Health, Welfare and Sport to release 15 million Euros for prevention measures. Ultimately, a one-off amount of 10 million euros was made available.

Werner was surprised that the budget would provide just 6 million euros for smoking prevention when the government collects billions from excise taxes on tobacco products. Of these 22 million euros, 16.1 million euros was spent on health promotion measures (mass media campaigns, The Healthy School and Stimulants project, 1.7 million euros on protective measures (inspections by the Food and Consumer Product Safety Authority (VWA)) and 3.7 million euros on disease prevention (nicotine patches, nicotine tablets, and nicotine gum). An extra 5 million euros was made available in 2004.

Tobacco control policy in the Netherlands is cost effective

The tobacco control policy in the Netherlands was evaluated for cost-effectiveness by the National Institute for Public Health and the Environment (RIVM) (Feenstra et al., 2006). This study proved that mass media campaigns, excise tax increases as well as individual help for stopping with smoking, costs less than 10,000 euros per Quality-Adjusted Life Year (QALY) gained. These are cost-saving interventions when the other care costs in the life years gained are not included in the calculation. It should be noted that the potential advantages people gain from smoking (enjoyment, relaxation, etc.) were not included in this study.

2.3.3 Anti-smoking policy comparison among countries

Anti-smoking policies in most EU countries have become increasingly stricter. Tobacco legislation in the Netherlands was difficult to initiate in the 1980s, but it has become more stringent since 2004. How strict Dutch policy is compared to other EU countries is discussed using an international comparative scale. Which countries have taken which specific measures and reports concerning the effectiveness of these is also considered.

Price increases resulted in fewer smokers in many countries

According to the World Bank, price increase is the most cost-effective measure, particularly for young people and people with a lower income. A price increase of 10% leads to a 4% reduction of consumption in rich countries. When France implemented a 31% price increase in 2003 for Marlboro, which is the most popular cigarette brand with the greatest market share worldwide, its sales dropped by 13.5%. The percentage of smokers in France decreased from 35% in 1999 to 30% in 2003. This boils down to two million fewer smokers. Furthermore, in 2003, 66% of the smokers in France indicated that they wanted to stop smoking, compared with 58% in 1999. The most important reason for this was the price of cigarettes, which was the third most important reason in 1999 (Joossens & Raw, 2006). In the United States, the state of California had already increased the tobacco excise tax in 1988 by 25 US dollar cents and 20% of this increase was spent on tobacco prevention (California Department of Health Services, 2006). The percentage of smokers in California decreased from approximately 23% in 1988 to 14% in 2005 (California Department of Health Services, 2006). Other countries such as New Zealand and Australia have also acquired experience by earmarking a portion of the excise tax revenues (dedicated tax) for prevention policy.

The Netherlands increased the price of a pack of Marlboro by 18% (90 euro cents) in February 2004. Subsequently, during 2004, sales dropped by 12.8% and the number of smokers decreased by approximately 7%: from 3,950,000 in 2003 to 3,690,000 in 2004. Despite this price increase, the price of a pack of cigarettes in the Netherlands is low compared to that of many other countries such as the United Kingdom, Ireland, Germany and France. A price comparison in July 2003 by the European Network on Smoking Prevention (ENSP) indicated that the price of a pack of cigarettes in the United Kingdom was more than twice as high, and in Ireland almost twice as high, as in the Netherlands (Joossens, 2004).

Ban on smoking in hospitality venues is effective in various countries

The European Commission argues for a general ban on smoking in public spaces. Smoke-free workplaces and public buildings protect not only the non-smoker, but they also encourage smokers to reduce or stop smoking. A review of 26 studies on this measure concluded that an entirely smoke-free workplace leads to a decrease of 4% in smoking prevalence. The following European countries have a ban on smoking in the workplace and in hospitality venues: Ireland (March 2004), Norway (June 2004), Italy (January 2005), Malta (April 2005), Sweden (June 2005) and Scotland (March 2006). France implemented a general smoking ban in hospitality venues in October 2006. A ban on smoking in hospitality venues in the United Kingdom was enforced in July 2007.

The sale of cigarettes in Ireland decreased by 15% following the ban: the percentage of smokers was reduced from 25.5% in March 2004 to 23.6% in August 2005. In this respect, Ireland can be considered a success story. Initially, there was a lot of scepticism about the smoking ban plans in a land where smoking and drinking is a part of the culture. In June 2003, the Irish Cancer Society, the Irish Action on Smoking and Health (ASH) and the Irish Heart Foundation joined forces and collectively became a lobby group. This allowed for a counterbalance against the continuously strengthening opposition, such as the Licensed Vintners Association (LVA).

In Italy, the sale of cigarettes was reduced by 9% after a smoking ban in hospitality venues in January 2005. The ban turned out to be a success here as well. Despite the common Italian expression 'fatta la legge, trovato l'igiano' (every law has its loophole), even the hospitality venue managers in Italy seem to

be satisfied with the effect of the smoking ban (Dobson, 2005). In addition, 10% of the Italians questioned indicate that they go out more frequently since the smoking ban has been enforced.

A more noticeable effect was seen in addition to the decrease in the sale of cigarettes. Since the implementation of the smoking ban at hospitality venues in Italy, there has been a significant reduction in hospital admissions for acute myocardial infarctions (AMI) in the Northern Italian region of Piemonte (Barone-Adesi et al., 2006). The non-smokers in particular would benefit from the general smoking ban. From February 2004 to June 2004, there were 922 patients with a heart infarct admitted to hospital in Italy. After the introduction of the smoking ban on 10 January 2005, there were 832 AMI admissions observed from February 2005 to June 2005. Researchers attribute this decrease of more than 10% to the introduction of the smoking ban. There was a constant increase in the number of AMI during years before the ban. The smoking ban would have immediately had an effect because smoking can directly lead to blood clots that could cause AMI. Nothing is known yet about the long-term consequences for cardiovascular disease and lung cancer, for example.

Fewer than 20% of the hospitality venues in the Netherlands have a smoke-free zone

The Netherlands has a law for a smoke-free workplace and a smoking ban in public spaces. The hospitality industry is the only exception to this in the Netherlands. The Minister made agreements with the hospitality industry about a gradual development of a policy with which clients were not allowed to smoke at all or only in specified areas. The so-called step-by-step plan was introduced in 2005 and will last until 1 January 2009. An interim evaluation by the Dutch Institute for Public Opinion and Market Research reveals that cafés, restaurants and discotheques have not sufficiently kept to the agreements made so far (Dutch House of Representatives, 2006). They had promised that a smoke-free zone would be available in 25% of the businesses. However, this occurred in only 11% of the cafés and in 20% of the restaurants. Merely 11% of the discotheques have a smoke-free zone.

Increased investment in tobacco discouragement diminishes smoking

The experiences from the United States and Australia show that higher investment in interventions for smoking cessation (campaigns, treatment and other measures) reduce smoking. In the United States, different states have invested in large-scale anti-smoking programmes such as media campaigns and school programmes as well as interventions such as telephone assistance programmes, in addition to having strengthened smoking restrictions. In the United States, increased investment in anti-smoking policy is invariably linked with decreasing sales figures for cigarettes, but it turns out that the effectiveness of mass media campaigns depend on the scale and duration of the campaigns. The American Centre for Disease Control (CDC) has estimated that states must spend between 1 and 3 US dollars per capita each year for a period of 3 years to be effective (The Centre for Disease Control, 1999).

Within the EU, only the United Kingdom spends more than 2 euros per capita on [tobacco discouragement](#). [Just](#) as the Centre for Disease Control in America, the Analysis of the Science and Policy for European Control of Tobacco (ASPECT) organization recommended that the EU Member States spend 1 to 3 euros per capita each year on tobacco discouragement (ASPECT, 2004). Iceland, which is not an EU Member State, has effected legislation that the government spends at least 0.9% of the excise tax revenues on tobacco discouragement (Hakala & Waller, 2003). Currently, 2.27 euros per capita is spent each year. The German government, for example, provided 0.01 euros per capita each year in 2004 for tobacco discouragement as a result of a five-year contract that of Ministry of Health concluded with the tobacco industry (Simpson, 2003).

Indirect advertisement in most of the EU countries is still not banned

A complete ban on advertising applying to all media and all forms of direct and indirect advertisement reduces tobacco use. Furthermore, it turns out that a partial ban has little or no effect. Smoking could be reduced by 6% with the most extensive limitations (Saffer & Chaloupka, 2000).

There has been virtually an entire ban on sponsor and advertisement activities in the Netherlands since 2002. Within Europe, only Denmark, Finland, France, Iceland, Norway and Portugal have a complete ban on all forms of indirect advertisement. There is no tobacco advertisement via international television anywhere in Europe. In most EU countries there are limitations enforced on tobacco sales outlets and tobacco may not be sold to people under the age of 16 years. However a minimum age of 18 years applies in Finland, Iceland, Norway, Sweden and Switzerland.

Warnings on tobacco products in most EU countries is a fact

In almost all EU countries there are warning texts on the packaging of tobacco products that clearly inform tobacco users about the health risks of smoking. These warnings are laid down in a European directive. The warning on the front side of the package must take up at least 30% of the surface. The warning text on the rear side must take up at least 40% of the package. Research has proven that these warnings are effective in informing smokers about the dangers of smoking, in encouraging them to stop and discouraging non-smokers from beginning (World Bank, 2003; Willemsen, 2005).

Smokers in Canada have been confronted with images of black lungs and dying people on tobacco packages since December 2000. The inside of the package contains more extensive information about the harmfulness of smoking and also tips on how to stop smoking. A review that compared the United Kingdom, Canada, the United States and Australia, revealed that the graphical warnings are a good method for making smokers aware of the dangers of smoking and they are cost effective (Hammond et al., 2006). Partially because of these positive reports, the European Commission decided to make a series of 42 graphic warnings available in accordance with Directive 2001/37/EC. Belgium was the first Member State to make use of this option. The Netherlands will follow later, but the images used in the Netherlands will probably be less confrontational than those in Belgium.

Evaluations of smokers, people who have stopped and people who want to stop show that the colour photographs are effective and motivate people to stop; particularly low-educated people. A year after the introduction of the graphic images in Canada, 19% of the smokers indicated that they were going to smoke less as a result of the illustrations (Hammond et al., 2004). Researchers do not agree about the effects of the images, specifically the more terrifying images. Some researchers argue that research on the efficacy of this approach would mostly measure the smokers' intention at the time of questioning and that the frightening images have a counterproductive effect (Ruiter & Kok, 2005). A recent report, however, concluded that there were only indications that smokers actually stop as a result of the images, but that this had not been demonstrated unequivocally (see www.researchvoorbeleid.nl: Kleurenfoto's op tabaksverpakkingen 'Colour photographs on tobacco packages').

Remuneration for treatment of nicotine addiction to increase the number of quitters

Many smokers who want to stop smoking have benefited from help with the assistance of behavioural support, such as telephone help lines and medication. Advocates of these measures think that they should be made available on a broader scale, because even though the effect on prevalence is not so great, they could help the more severely-addicted smokers. These people have the greatest difficulty with stopping and comprise the largest burden on health care. Such treatments are currently available for all smokers in the United Kingdom. Smokers do not have to pay for treatment, which is covered by the tax-paid 'National Health Service' (NHS) (McNeill et al., 2005). Stopping with smoking is a core element of the tobacco discouragement policy in the United Kingdom since the White paper 'Smoking Kills'. The importance of smoking cessation is also emphasized in guidelines for the NHS and health care staff (see www.nice.org.uk). Goals are formulated for treating smokers who want to quit and also for the reduction of

the percentage of smokers in every Primary Care Trust, which is the most important level of financing and preventive care within the NHS (Irish Action on Smoking and Health, 2006).

The decision as to whether or not nicotine replacement therapies should be remunerated in the Netherlands is left to the health insurers, even though research in the Netherlands has demonstrated that the remuneration of effective support for stopping with smoking is a suitable cost-effective instrument, not only for the use of support, but also to increase the number of attempts to stop and decrease the prevalence in the Netherlands (Kaper et al., 2003).

The 'Partnership Stop Smoking' (www.partnershipstopmetroken.nl) was launched in 2002. Various public and private parties from the health care sector are united in this partnership. Their participation helps to reduce the percentage of smokers and they contribute to the policy of the Ministry of Health, Welfare and Sport (VWS) through various activities. In addition, the partnership would like to achieve the following:

- smoking is recognized as addiction
- a structurally embedded support for smoking cessation in the health care sector
- making smokers and non-smokers aware of the addictive effect of tobacco and the presence of effective support for stopping

2.4 Discussion and conclusions

Smoking policy in the Netherlands is moderately restrictive compared to other countries

Despite the introduction of substantial measures that have achieved some success in recent years, smoking policy in the Netherlands is not very restrictive compared to other European countries, Canada or certain states in the United States, and California in particular. Cigarette prices in the Netherlands are around the average for Europe, a slow start has been made with a complete smoking ban in public venues and tobacco sales to young people are not monitored carefully enough. The agreements in the step-by-step plan that was established with the hospitality industry have not been lived up to. Yet at the same time an increasing number of other EU countries are already introducing a general smoking ban and their experiences with this have been unexpectedly positive. The important role of the EU should be noted, bearing in mind that anti-smoking legislation in the Netherlands is in part directly taken from European legislation in this area.

The Netherlands is certainly not a leader in terms of budgeting for tobacco discouragement policy either. There is a considerable difference between what the government collects on tobacco excise taxes – approximately 1.8 billion euros annually – and the budget made available for prevention. Earmarking several percent of the excise tax revenues for funding smoking prevention in the Netherlands is controversial, but there are certainly advantages of such a dedicated or earmarked taxation that are worth mentioning. Firstly, increasing the price of cigarettes is an effective means of reducing smoking. This is expected to be particularly effective in population groups that need this the most, such as young people and low socio-economic groups (Feenstra et al., 2006). Secondly, a system with a 'fair' budget allocation has the support of the general public (Phipps, 2003). Thirdly, a budget return quickly develops to improve the health care sector.

Other countries are also more active within their health care systems when it comes to reducing smoking. There was an experiment involving remuneration for treatment of smoking cessation in the Netherlands, and it has now been left to the insurers to decide whether or not remuneration will take place. In the United Kingdom these remunerations are covered under the National Health Service (NHS) and they also prove to be working. The difference between the United Kingdom's health care system and that of the Netherlands possibly plays a role in this. The PHSF-2006 established that there is a relatively large gap between care and prevention in the Netherlands compared to the NHS in the United Kingdom.

Quick changes in smoking policy prove to be possible in other countries

Recently, the most revolutionary changes in public health care policy, and especially smoking policy, within the EU have probably taken place in Ireland. Ireland scores very high on the Tobacco Control Scale and has actively implemented effective policies against smoking in various ways, as evidenced by the fall in the number of smokers. In a country where the ministry of public health is the same as the ministry for children (Department of Health and Children), the policy is naturally focused on young people. Young people under the age of 18 are not allowed to buy cigarettes. This is not just a paper exercise, as sellers who repeatedly fail to comply with this law may no longer sell any tobacco. Strict enforcement is therefore important. An example of such a strict supervisory and compliance policy exists in California, where undercover agents on the street monitor if store owners ask cigarette buyers for proof of age and check this.

Benefit to be gained by focusing policy on low socio-economic groups

The difference in smoking prevalence between high and low socio-economic groups is evident in many Northern and Western European countries, including the Netherlands. This fact and the underlying causes are still largely ignored in the new National Tobacco Discouragement programme (Mackenbach, 2006). Less advantageous living circumstances and a social standard that regards smoking as positive, play important roles in starting to smoke and they make stopping more difficult. Furthermore, the degree of nicotine dependence is frequently higher among the low socio-economic groups. This is partially caused by starting to smoke at an earlier age, which makes stopping even more difficult (Mackenbach, 2006). Not all tobacco discouragement measures are as effective with low socio-economic groups as they are with high socio-economic groups. Informational activities in particular are generally more effective in the high socio-economic groups (Mackenbach, 2006). Of the measures addressed in this chapter, a cigarette price increase was mentioned as being more effective for low income groups. Also the advantages of a general smoking ban (including the hospitality industry) would substantially benefit people in the low socio-economic groups who proportionally smoke more and are more often employed in the hospitality industry.

The action programme in the United Kingdom from 2002, 'Tackling health inequalities: A Programme for Action', focused a broad strategy to reduce health inequalities between socio-economic groups (Department of Health, 2003). A number of strategies in this programme aim to reduce smoking in certain groups such as low socio-economic groups and pregnant women. Chapter 6, Health Inequalities, describes the policy in the United Kingdom as being effective.

Solid basis for evidence-based anti-smoking policy is available

The Netherlands shares the public health problem of smoking with many other European countries. Many policy initiatives and legislative measures to discourage smoking have been introduced through international collaboration in association with WHO and the EU. International networks and organizations, including various EU networks, contribute and have contributed to the comparison and analysis of anti-smoking policies and their efficacy to a significant degree. This has since formed a solid basis for evidence-based anti-smoking policies. Among the effective measures are: higher excise taxes on tobacco products, smoking ban in public buildings and in the workplace, advertisement and sponsoring ban for tobacco products, better consumer information concerning health aspects (including addiction) as well as the advantages and possibilities for stopping with smoking, information about the trade methods (counter-advertising) used by the tobacco industry, large straightforward labels on cigarette packages and tobacco products, and assistance for smokers who want to stop, which includes the availability of nicotine replacements and other treatments to stop smoking.

In view of the experiences with policies in other countries, it is not only desirable, but probably also very possible that smoking in the Netherlands could be reduced quickly. To achieve that, the Netherlands would have to refine its smoking policy on a number of aspects. Similar stricter policies have recently had evident effect in other countries like Ireland and Italy, for example. In addition, more efforts would have to be made for measures that reduce smoking in low socio-economic groups because the smoking problem here –

in practically all countries – is by far the most persistent. At the very least, existing policy should be better enforced.

From an international perspective, we can draw the following conclusions in closing:

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

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

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

Several effective policies are available that various countries have already implemented:

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

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

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

References

- ASH. UK Tobacco Control Policy and Expenditure - An Overview. <http://www.ash.org.uk/html/factsheets/pdfs/uKtobaccocontrolpolicyexpenditure.pdf> (last visited 13 december 2006), 2006.
- ASPECT. Tobacco or health in the European union. PAST, PRESENT AND FuTuRE. Brussels: European Commission, Directorate-General for Health and Consumer Protection, 2004.
- Barone-Adesi F, vizzini L, Merletti F, Richiardi L. Short-term effects of Italian smoking regulation on rates of hospital admission for acute myocardial infarction. *European Heart Journal* 2006;27(20):2468-2472.
- Bekker-Grob EW de, Polder JJ, Witte K, Mackenbach JP, Meerding WJ. Kosten van preventie in Nederland 2003: Zorg voor euro's -4. RIVM-rapportnr. 270751011. Bilthoven/ Rotterdam: RIVM/Erasmus MC, 2006.
- Burgeon C, Chambre 2e session de la 51 E législature, CRIv 51, 10-6-2004, p.7.
- California DHS, Department of Health Services. Tobacco Control Section, <http://www.dhs.ca.gov/tobacco> (last visited 8 december 2006), March 2006.
- Cavelaars AEJM, Kunst AE, Geurts JJM, et al. Educational differences in smoking: an international comparison. *BMJ* 2000;320:1 102-1107.
- CDC, Centers for Disease Control and Prevention. Best practices of comprehensive tobacco control programs. Atlanta, Georgia: CDC, 1999.
- DH, Department of Health. Tackling Health Inequalities. A Programme for Action. Londen: DH, 2003.
- Dobson R. Italy's smoking ban has led to an 8% drop in tobacco consumption. *BMJ* 2005;331:1159. doi:10.1136/bmj.331.7526.1159-a.
- Doll R, Hill AB. Smoking and carcinoma of the lung. *Br Med J* 1950;2:739-748.
- Doll R, Hill AB. Mortality in relation to smoking: ten years observations of British doctors. *BMJ* 1964;1:1399-1410.
- Doll R, Peto R, Boreham J, Sutherland I. Mortality in relation to smoking: 50 years' observations on male British doctors. *BMJ* 2004 Jun 26;328(7455):1519.
- EC, Europese Commissie. Technical Annexes to the Communication of the Commission on the European Environment and Health Action Plan 2004-2010; Annex I. COM (2004) 416 final. Brussels: EC, 2004.
- EC, Europese Commissie. Green Paper; Towards a Europe free from tobacco smoke: policy options at Eu level. COM (2007) 27 final. Brussels: EC, 2007.
- Eerste Kamer. vergaderstuk: 26472, nr 59e; vergaderjaar 2001-2002. The Hague, 2002. Falk J, Danish National Board of Health, personal communication, 31-8-2004.
- Feenstra TL, Baal PHM van, Hoogenveen RT, vijgen SMC, Stolk E, Bemelmans WJE. Costeffectiveness of interventions to reduce tobacco smoking in the Netherlands. An application of the RIVM Chronic Disease Model. RIVM-reportnr. 260601003/2005. Bilthoven: RIVM, 2006.
- Fong GT, Cummings KM, Borland R, Hastings G, Hyland A, Giovino GA, et al. The conceptual framework of the International Tobacco Control (ITC) Policy Evaluation Project. *Tob Control* 2006;15:3-11.
- GR, The Health Council of the Netherlands. volksgezondheidsschade door passief roken. GR-publicatiennr. 2003/21. The Hague: GR, 2003.
- Hakala K, Waller M. Nordic tobacco control - towards smokefree societies. Copenhagen: Nordic Council of Ministers, 2003.
- Hammond D, Fong G T, McNeill A, Borland R, Cummings K M. Effectiveness of cigarette warning labels in informing smokers about the risks of smoking: findings from the International Tobacco Control (ITC) Four Country Survey. *Tobacco Control* 2006;15(Suppl III):iii19-iii25. doi: 10.1136/tc.2005.012294.

- Hammond D, Fong GT, McDonald PW, Brown KS, Cameron R. Graphic Canadian cigarette warning labels and adverse outcomes: evidence from Canadian smokers. *Am J Public Health* 2004;94(8):1442-1445.
- Hibell B, Andersson B, Bjarnason T, Ahlström S, Balakireva O, Kokkevi A, et al. The ESPAD Report 2003; Alcohol and Other Drug use Among Students in 35 European Countries. Stockholm: The Swedish Council for Information on Alcohol and Other Drugs (CAN) and the Pompidou Group at the Council of Europe, 2004.
- Joossens L, Raw M. The Tobacco Control Scale: a new scale to measure country activity. *Tob Control* 2006;15:247-253. doi: 10.1136/ tc.2005.015347.
- Joossens L. Effective tobacco control policies in 28 European countries. ENSP, 2004.
- Kaper J, Wagena EJ, Schayck CP van. Het effect van het vergoeden van ondersteuning voor stoppen met roken: resultaten van een gerandomiseerd experiment. Maastricht: universiteit Maastricht, 2003.
- Knol K, Hilvering C, Wagener DJT, Willemsen MC (red.). *Tabaksgebruik: gevolgen en bestrijding*. utrecht: Lemma Bv, 2005.
- Levy D, J Gitchell J, Chaloupka F. The effects of tobacco control policies on smoking rates: A tobacco control scorecard. PIRE Working Paper. Calverton: MD, 2003.
- Mackenbach JP, et al. Tackling socio-economic inequalities in smoking in the European union, Final Technical Report. Brussels: ENSP, 2004.
- Mackenbach JP. Antirookbeleid moet anders. *Medisch Contact* 2006;13:512-514.
- McNeill A, Raw M, Whybrow J, Bailey P. A national strategy for smoking cessation treatment in England. *Addiction* 2005 Apr;100 Suppl 2:1-11.
- Nemery B, Joossens L, Bartsch P, et al. Tactics of the tobacco industry in Belgium. *www. bmj.com Rapid Responses for Fleck*, 330(7487)325, 11 April 2005.
- Paulussen Th. voeren scholen een gezondheidsbeleid? In: Jansen J, Schuit AJ, Lucht F van der (red.). *Tijd voor gezond gedrag. Bevordering van gezond gedrag bij specifieke groepen*. RIVM-rapportnr. 270555004. Houten: Bohn Stafleu van Loghum, 2002; 134-141.
- Phipps R (BC Health Promotion Coalition). Report on the 3rd meeting of the international network of health promotions foundations. Budapest, Hungary. April 28-30, 2003.
- Prins GJJ, Willemsen MC. Tabakswetgeving in Nederland. *Hart Bulletin* 2004;35(4):85-87.
- Ruiter RAC, Kok G. Saying is not (always) doing: cigarette warning labels are useless. *European Journal of Public Health* 2005;15(3):329-330.
- Saffer H, Chaloupka F. The effect of tobacco advertising bans on tobacco consumption. *J Health Econ* 2000;19:1117-1137.
- Simpson D. Germany: still sleeping with the enemy. *Tob Control* 2003;12:343-344.
- STIVORO, Stichting volksgezondheid en Roken. Jaarverslag 2004. The Hague: STIVORO, 2005.
- TNS NIPO. Zelfregulering roken in de horeca en podia. Onderzoek naar rookbeleid van horecagelegenheden en podia (E3089/ E4383). Amsterdam: TNS NIPO, 2006.
- Tweede Kamer [Dutch House of Representatives]. Brief ministerie VWS: vGP/ADT 2695128, dd 5 July, 2006.
- Vijgen SMC, Gelder BM van, Baal PHM van, Zutphen M van, Hoogenveen RT, Feenstra TL. Kosten en effecten van een pakket maatregelen voor tabaksontmoediging. (In voorbereiding).
- VWS, Ministry of Health, Welfare and Sport. Het Nationaal Programma Tabaksontmoediging 2006-2010. http://www.minvws.nl/images/vgp-2646769b.doc_tcm19-98351.pdf (last visited 18 February 2007). The Hague: VWS, 2006.
- WHO, World Health Organization. Framework Convention on Tobacco Control. Geneva: WHO, 2003.
- WHO, World Health Organization. Framework Convention on Tobacco Control. Geneva. Switzerland. 2003, updated reprint 2004, 2005.
- WHO-HFA, World Health Organization. Health For All Database <http://www.who.dk/country/country.htm>, 2006 en 2007.

Willemsen MC. The new Eu cigarette health warnings benefit smokers who want to quit the habit: results from the Dutch Continuous Survey of Smoking Habits. *Eur J Public Health* 2005;15:389-392.

Worldbank. Tobacco pack information at a glance. www.worldbank.org/tobacco. Washington DC: Worldbank, June 2003.

Wynder EL, Graham EA. Tobacco smoking as a possible etiologic factor in bronchiogenic carcinoma. *J*

ALCOHOL

Effective measures can be taken to decrease the supply of alcohol, for example decreasing its availability and increasing its price, to reduce alcohol consumption among young people in the Netherlands

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

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

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

Alcohol policy in the Netherlands would benefit from the Netherlands taking a more proactive approach towards EU policies with relevance for alcohol

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



3 ALCOHOL

Peter Achterberg

3.1 Introduction

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References

3.1 Introduction

In most countries, alcohol is a legally accepted product that can have beneficial as well as harmful effects. Since time immemorial, alcohol has been used as a ‘social stimulant’ and was also used in medicine because of the stimulating and medicinal effects that were attributed to it. In Western countries, alcohol played and still plays a central role in certain rituals, such as sacramental wine, and at official gatherings and festivities. Besides socially desirable effects alcohol also has positive health effects, including the protective effect on the development of cardiovascular diseases in certain groups.

Alcohol: an economically important product with negative side effects

Historically, alcohol production is an activity that has been strongly linked to the agricultural sector because alcoholic beverages are made from fruit, chiefly from grapes, but also from grains, corn or potatoes. Hence alcohol production has always been a source of income for agrarian populations. Consequently, in many countries the alcohol-producing sector, agriculture and industry, is a very important and extensive employer. Many countries levy excise taxes on alcohol, which also can create an important source of revenues for the governments concerned. The sale of alcohol is a source of income for hotels, restaurant and cafes, and it can also be a lucrative business for sport clubs and sociocultural organizations, for example, during sport events. There are therefore extensive socio-economic interests at play with the production and distribution of alcohol.

However, there are also many adverse effects from harmful alcoholic consumption and alcohol addiction. Later in this chapter, we will address these in more detail. Here it is sufficient to mention detrimental health effects, including accidents, adverse social consequences and effects such as work absenteeism, disability and the costs associated with these.

Various factors affect the actual alcohol consumption by individuals in a country and its negative effects. We mention: price and availability, type of alcoholic drink (high-proof, mild), social traditions around alcohol, social peer pressure, existing health information and advertisements as well as legal measures. Many countries have already implemented policies to reduce the negative consequences of alcohol consumption. However, the differences between these policies can be considerable.

Overview of this chapter

This chapter examines national policy in the area of alcohol in the Netherlands compared with the policies in other countries and with the policies proposed by international organizations such as the European Union (EU) and the World Health Organization (WHO). What can we learn from others? What do we do differently from other countries? What could we and should we still do? What is the role of the European Union in this?

This introduction will first delve into the necessity for an alcohol policy by outlining the adverse effects of alcohol consumption. Subsequently, an international comparative description of alcohol consumption in the Netherlands and Europe is outlined, followed by a brief description of international policies. This chapter then details policy practice in the Netherlands and in other countries, including what is known about the effectiveness of policy practice. This chapter ends with a Discussion and conclusions section.

3.1.1 Adverse effects of alcohol consumption

Alcohol consumption increases the risk for diseases and accidents

One of the most important reasons for the implementation of an alcohol policy is the fact that alcohol – along with its addictive action – increases the risk for a number of diseases and accidents (Anderson &

Baumberg, 2006). Among the health risks are a some forms of cancer, such as cancer of the mouth, throat and oesophagus, liver cancer and breast cancer. In addition, excessive use of alcohol, is accompanied by increased risks for cardiovascular diseases, such as coronary and ischaemic heart diseases, heart failure, stroke and heart rhythm disorders, as well as increased risks for diabetes and mental health problems, such as alcohol addiction, epilepsy and unipolar depression. Moreover, there is an increased chance of gastrointestinal disorders, such as pancreatitis, liver cirrhosis and gall stones, as well as an increased chance of organ damage of the brain, liver and pancreas. Furthermore, alcohol can harm the unborn child by causing Foetal Alcohol Syndrome, low birthweight and spontaneous abortion. The effects of alcohol on an unborn child and neonate consequently lead to neurological, behavioural and learning problems. A very important negative health impact from alcohol is that it increases the chance of an accident. This concerns traffic accidents to a significant degree, but it also involves drowning, falling and alcohol poisoning. Moderate drinking on the other hand can have a positive effect on cardiovascular diseases in certain population groups (WHO, 2004a).

Social and economic costs of alcohol are extensive

Alcohol can contribute to domestic violence, to a family breaking up and is sometimes related to crime. Discharge from work or falling out of the job market and loss of social contacts are negative social costs of alcohol. These social costs are not always mentioned in policy reports and are quantified even less frequently than that, possibly because it is difficult to estimate such costs properly. The direct costs are the health care costs and the indirect costs are the above-mentioned alcohol-related social problems, diseases and accidents through which increases in work absenteeism, disability and production loss collectively contribute to the economic costs.

Various studies reveal that the economic costs of excessive alcohol consumption are considerable. A recent study for the European Union (Anderson & Baumberg, 2006) concluded that the alcohol-related costs in EU countries averaged out to 1.3% of the gross domestic product (GDP). A recent analysis by the Netherlands Bureau for Economic Policy Analysis (CPB) (Cnossen, 2006) once more showed that in practically all EU countries, these costs are several times higher than the revenues from alcohol excise taxes. Before that analysis, the social cost caused by alcohol for the Netherlands were estimated to be 0.5 to 0.7% of the GDP (KPMG, 2001), which is also much more than the excise tax revenues in the Netherlands.

3.1.2 Alcohol consumption in international perspective

Patterns in alcohol consumption differ within Europe, but are converging

From a global perspective, all Europeans drink a lot. There are differences – culturally determined differences in some cases – within and among countries; and there are also differences in the degree of and the type of alcohol problems. In some countries, such as the Scandinavian countries ‘acute intoxication’ is predominant; in other countries, it is continuously drinking a lot, such as in France and in Mediterranean countries. However, the patterns of alcohol consumption in most Western countries have been changing in recent decades. Since 1990, the total alcohol consumption – expressed in litres per capita – has decreased slightly in almost all European countries. Alcohol consumption has only increased in Ireland and the United Kingdom. Alcohol consumption in Finland has increased since 2003, following an earlier decrease. This coincides with changes in the predominant type of alcohol (beer, wine and spirits) that is being drunk. In the 1980s, there was a declining trend in beer consumption in the traditionally beer-drinking countries such as Belgium, Germany and the Netherlands. Since the 1990s, beer consumption in these countries has levelled off. Alcohol consumption in all traditionally wine-drinking countries has decreased with the exception of Greece. France and Italy recently showed the largest decrease. Beer consumption in Greece, Italy, Portugal and Spain has increased since the 1950s and the use of wine is increasing in the Netherlands. In summary, there is a convergence of drinking patterns within the EU.

The number of problem drinkers in the Netherlands is high

The total alcohol consumption per capita in the Netherlands stabilized in the 1990s after a decrease in the 1980s. The number of adult problematic drinkers in the Netherlands has not changed much recently, but it is still considerable and relatively high within the EU. In the Netherlands, alcohol consumption still causes a considerable health burden and many social and economic costs.

The average person in the Netherlands does not drink very much

Compared to many other Europeans, the average person in the Netherlands does not drink very much. Of the residents in the EU-25 in 2002, the average Dutch individual only drank more than people in Sweden, Norway and Malta, and drank approximately as much as people in Belgium, Italy and Greece. The people that drink by far the most live in Hungary, Letland, the Czech Republic, and Lithuania, directly followed by Ireland, Luxemburg, Slovakia, France, Estonia and Denmark (Anderson & Baumberg, 2006). These figures have been corrected to add justifiable estimates for export and unrecorded consumption to the national data, for example, home-distilled alcohol.

High alcohol consumption in Central and Eastern Europe lowers life expectancy

The high alcohol consumption in Central and Eastern Europe probably contributes significantly to the high premature death from cardiovascular diseases and liver cirrhosis, resulting in a low life expectancy in those countries. This is in contrast to the Mediterranean countries, such as France, where death from cardiovascular diseases is low. A possible explanation lies in the type of drinking behaviour, such as the fact that people chiefly drink during their healthy Mediterranean meals. In Central and Eastern European countries, a considerable quantity of spirits is frequently drunk on one single occasion, which is called binge drinking. In addition, more alcohol is distilled at home in Central and Eastern European countries compared to Western European countries. The amount of alcohol in home-distilled alcohol products is higher than in regular alcohol products.

Adverse European drinking trends have adverse health impacts

Men in Europe still drink more than women and more frequently. However, in the case of young people, it seems that girls drink more often and begin at an earlier age than was the case in the past. Throughout Europe the alcohol consumption among young people has increased considerably in recent years. In Scotland and England, the trend in adverse health impacts from alcohol consumption is very unfavourable, as evidenced by a recently strong increase in deaths from liver cirrhosis. This trend is particularly alarming in Scotland (Leon & McCambridge, 2006). Within the current EU-27, – with the Baltic states included – Hungary has a particularly high death rate from liver cirrhosis, which is ten to fifteen times as high than in the Netherlands.

Alcohol consumption among young people is problematic in many countries

Dutch young people belong to the leading group of frequent alcohol drinkers in Europe, and alcohol consumption among the Dutch youth still seems to be on the rise. A quarter of 15- and 16-year-old students in the Netherlands drink alcohol ten times or more per month. Moreover, students in the Netherlands (28%) together with their counterparts in Ireland (32%) and the United Kingdom (27%) are in the top three of countries with the highest percentage of binge drinkers among young people. Binge drinking is defined here as drinking five or more drinks containing alcohol during one occasion (Currie et al., 2004; Hibell et al., 2004). The increasing trend in binge drinking by young people is considered to be exceptionally problematic in many European countries. In various countries, including the Netherlands, these trends translate into a changing alcohol policy that focuses more strongly on the youth.

Significance of alcohol consumption in health inequalities

Alcohol is a factor that explains health differences that exists among and within the EU countries. The health burden caused by alcohol in the relatively poor new Eastern European Member States of the EU, for instance, is on average twice as high as the burden in the EU-15. Within countries, there are occasional

reports of large socio-economic differences in certain alcohol consumption-related conditions (Anderson & Baumberg, 2006; Kunst et al., 1998).

3.2 Alcohol policies in an international context

International organizations can inspire and harmonize national alcohol policies. In addition, WHO as well as the EU play an important role for the Netherlands. Other international organizations, such as the World Bank, also pay attention to alcohol. The recent World Development Report 2007 (World Bank, 2006) indicates that alcohol threatens to be a worldwide problem among young people and that price increases (excise taxes), advertisement bans, age limitations for the sale of alcohol and clearly visible health warnings on products containing alcohol seem to be appropriate measures. The following paragraphs address the activities of WHO and the European Commission (EC) regarding alcohol policies in more detail.

The role of WHO: the first plans in 1991

WHO has had alcohol policy on its agenda for a long time. In 1991, the reduction of alcohol consumption was one of the subgoals of the 'Health for All' strategy (Target 17: about alcohol and drugs). In 1993, the 'European Alcohol Action Plan' was accepted, which included the goal to reduce alcohol consumption by 25% by 2000 compared with 1980. One of the results of this action plan was a European Ministerial Conference on alcohol (1995), which adopted the unanimous 'European Charter on Alcohol'. Next, the 'European Alcohol Action Plan 2000-2005' was approved in 1999. This plan consisted of broader and more concrete actions and goals, among which actions to ensure that no alcohol advertisement will be addressed to young people. In February 2001, during the Second European Ministerial Conference on Alcohol, the 'The Declaration on Alcohol and Youth' was adopted. Even though the ministers, who are the competent authorities, have repeatedly adopted these WHO plans, the objectives of WHO programmes are still not always explicitly integrated into national policy plans.

The WHO Framework for Alcohol Policy provides ten strategies

During the 'World Health Assembly' in 2004, WHO had once again indicated the potential detrimental health effects in the world caused by alcohol (WHO, 2005a), and subsequently, the 'Framework for Alcohol Policy in the WHO European Region' was established in Bucharest in 2005, (WHO, 2005b).

WHO recommends ten strategies in the framework:

- informing the general public
- counteracting negative effects of alcohol in daily life
- establishing laws and regulations
- controlling prices and availability of alcohol
- restricting alcohol advertising
- improving the accessibility to effective care for people with alcohol problems
- fostering the awareness of responsibility in producers and providers
- enhancing the effective capacity of people in our society (education, social welfare, judiciary)
- supporting relevant organizations and networks
- formulating broad-based, national programmes which include examining relevant indicators of outcomes and their periodical evaluation

WHO has set up a website for the European region in which all sorts of policies in the European Member States can be compared systematically: the 'Alcohol Control Database' (WHO, 2006). A comparable database of the elements of national alcohol policies, albeit broader in terms of geographical spread, is that of the International Centre for Alcohol Policies (ICAP), one of the institutes financed by the alcohol industry (ICAP, 2007).

The role of the European Union: public health versus free market

As the European Union became larger and acquired more mandates in the area of health protection via the Maastricht Treaty and the Amsterdam Treaty, it became more involved in public health. This also increased the opportunity for a common European alcohol policy. However, the historic main focus of the EU has been aimed at the economy (markets) and agriculture. Collective agricultural politics is still an important element of EU policies. Grants were and are provided for agriculture, specifically, to the European vintners, but even tobacco growers still receive grants in the EU (see chapter on Smoking). The systematic discontinuation of grants to vintners began in 2006. At present, the EU still indirectly stimulates the availability of alcohol in Europe through the vintner grants.

Scandinavian countries see negative health impacts by joining the EU

New Member States in the 1990s, specifically Sweden and Finland, experienced the further expansion of the free market politics, a core strategy of the EU, as a threat to their national alcohol policy right after they joined the EU. These countries have traditionally had state monopolies for alcohol. After joining the EU, the monopolies in the Scandinavian countries were contested in several lawsuits. Finland and Sweden subsequently dispensed with their monopolies in the production, import, export and wholesale of alcohol in January 1995; Iceland and Norway followed these examples later. However, the sale of alcohol to consumers by the state-led chains has remained partially intact as monopolies, because of their specific organizational structures. Systembolaget in Sweden and Alko Oy in Finland would be two examples of this. These monopolistic systems for the sale of alcohol may remain in existence within the EU, but they might perish in future trade negotiations with the World Trade Organization (WTO), where the free market is addressed on a global scale.

After joining the EU, Finland implemented an excise tax and this led to major changes in the sale and import of alcohol from, among others, the Baltic countries. In Finland, this led to a clear increase in alcohol consumption, and more recently, this was followed by an increase in alcohol-related health effects (Tigerstedt et al., 2006). In 2006, alcohol-related death became the most significant cause of death in men in Finland, and the second most significant cause of death in women between the ages of 15 and 65 (Statistics Finland, 2006).

EU gradually develops a more active alcohol policy

Economic and market-oriented activities were the main origins of the EU. However, the Maastricht Treaty from 1992 also gave explicit attention to public health. From 1985 onwards, a few research programmes were started, even before the Maastricht Treaty; for example, research on AIDS, cardiovascular disease and cancer. The Amsterdam Treaty of 1998 gave more attention to public health and led to a new Directorate-General at the European Commission and to an EU Commissioner for public health. The subsequent action programmes for public health offer possibilities for collaboration in the EU and for exchanging best practices in many public health areas, including the area of alcohol.

In 2001, the European Commission made a recommendation about children and adolescents drinking alcohol, which started the development of a broad-based alcohol strategy for the EU. In the meantime there was also a European Directive, the so-called 'Television Without Borders' Directive, regarding the restriction of advertisement: 89/552/EEC, which was also formally implemented in many countries. This Directive was implemented in the Netherlands by means of a self-regulating code.

In recent years, the European Commission has commissioned a number of policy preparation reports. In 2003, this led to the publication of an EU report entitled, 'Alcohol policies in EU Member States and Norway. A collection of country reports' (Österberg & Karlsson, 2002). Subsequently at the request of the European Commission, the RAND Corporation published a report in 2006 (Hurlings & Scoggins, 2006) entitled, 'An ex ante assessment of the economic impacts of EU alcohol policies'. This RAND report compared four different policy strategies for the EU. The best strategy proved to be an integrated approach in which different policy instruments would be simultaneously implemented: legal instruments, self-

regulation, information campaigns, exchange of good practices and the involvement of all relevant parties. All of these points should address all policy domains: internal market, excise duties and taxes, transport and traffic, education, research and consumer policy. The emphasis should be on alcohol in traffic, coordinated campaigns, protecting third parties, advertisement, information for the consumer and the availability and prices of alcohol products.

Later in 2006, a major European alcohol report appeared (Anderson & Baumberg, 2006), and shortly thereafter, a new alcohol strategy was presented by the EU.

Not all of the earlier plans for EU policies have been realized

The European Commission announced a new alcohol strategy in an ‘Announcement by the Commission’ in October 2006 (Text block 3.1). The Commission would like to stimulate the exchange of best practices at an EU level, and set the minimum age for alcohol consumption at eighteen.

Text block 3.1: New strategy to support Member States in reducing alcohol related harm

The Commission has identified the following five priority themes, which are relevant in all Member States and for which Community action in complement to national policies and coordination of national actions has an added value:

- Protect young people, children and the unborn child;
- Reduce injuries and death from alcohol-related road accidents;
- Prevent alcohol-related harm among adults and reduce the negative impact on the workplace;
- Inform, educate and raise awareness on the impact of harmful and hazardous alcohol consumption, and on appropriate consumption patterns;
- Develop and maintain a common evidence base at EU level.

These themes cut across EU, national and local level, and call for multi-stakeholder and multi-sector action. The present strategy therefore proposes to highlight what the Commission and Member States have already done, and further action or continuation of existing actions by the Commission. It also presents good practices implemented in Member States, and which could inspire similar actions and synergies at national level.

Source: EC, 2006

The announcement by the Commission appeals to the industry to be more self-regulatory and to make use of responsible advertisement and marketing practices. In the new strategy, no further restrictions on alcohol advertisement were proposed and no proposals were implemented for EU-wide warning labels against alcohol abuse. In earlier draft versions of the new EU strategy, there were proposals for advertisement restrictions and the introduction of warning labels.

These earlier proposals disappeared a short time after a report by the collective European breweries appeared (Weinberg Group, 2006). This report put into question a number of the scientifically-formulated basic assumptions that substantiated a stricter, broad-based European alcohol policy. In this way the alcohol-producing sector seems to have thwarted a stricter European policy. This can be seen as a victory for free market policy and as a defeat for public health policy. There is now talk of a first, reasonably clear, and in any case, official EU strategy on alcohol. The strong influence of the European alcohol sector on European alcohol policy will probably continue. Nevertheless, a European forum has now been established in which the alcohol industry will also have a seat, that is, if they are prepared to play an active role in tackling the alcohol problem.

3.3 Policy practice on alcohol

We will first briefly address the possible focus areas for alcohol policy and then outline the general policy differences between countries. After a brief summary of what is known about the effectiveness of alcohol policies and interventions, the Dutch alcohol policy is addressed. This is followed by a more detailed country comparison of alcohol policies.

Alcohol policy can focus on supply, demand and harmfulness

The main features of alcohol policies focus on the triad of: supply reduction, demand reduction, and harm reduction (Garretsen & Van de Goor, 2004). We see measures for supply reduction, such as age restrictions, price and excise tax increases as well as measures that restrict the number of sales outlets or limit their business hours. For demand reduction, parental education and information focusing on norms and values with regard to alcohol use are important instruments. Harm reduction focuses on alcohol-related harm, such as using alcohol when driving.

The most prevalent national policy interventions can be subdivided into: fiscal measures (excise taxes), legislation (age limitations, regulating sales), drinking while driving, safer drinking environments, advertisement restrictions, education and information, problem reduction and dealing with problem drinkers.

Multiple factors determine variations in national alcohol policies

It is clear that the implementation of a comprehensive and effective alcohol policy is a complex task that requires collaboration between various policy areas, i.e. an integrated policy. In different countries, this complex approach has inevitably led to different policy interpretations. Not only because the patterns of alcohol use vary between countries, but also because the social and economic interests related to alcohol differ, and because there are considerable national differences in the cultural-historical context in which alcohol is used.

A recent international policy comparison, consisting mainly of policies from English-speaking countries and countries that have presented their policy in English documents, has shown that differences in alcohol policy are chiefly found in areas such as levy taxes (excise taxes), policies with regard to alcohol and traffic, different approaches to the drinking environment and high-risk groups (Crombie et al., 2007).

National alcohol policy can differ within countries

The different basic assumptions, emphases and approaches of national alcohol policy mentioned above can also change over the course of time. Furthermore, at times, there are regional variations in alcohol policies within some countries. The recommended amount of alcohol per day by the autonomous Basque authorities is three to four times as high as the amount recommended by the Spanish ministry of health, and the recommendation by the autonomous Catalonian authorities lies somewhere in between. Provinces in federal countries, such as Quebec and Ontario in Canada, develop their own alcohol policies (Crombie et al., 2005).

Organization and presentation of alcohol policies vary greatly

There are strong differences between countries in the degree to which the policy is made explicit by reports and programmes or in how the policies are implemented – through national programmes or commissions and dedicated organizations. Even though policies in many countries predominantly address the same aspects, there are considerable differences in the level of detail.

Many countries emphasize the importance of involving all relevant parties in developing and implementing policies but, in general, few details are provided about their implementation. Some countries specify the amount of money that can be spent on their alcohol policy. Moreover, those investments are always much

lower than the direct and indirect costs of alcohol-related harmfulness from alcohol consumption (Cnossen, 2006).

Sometimes countries use international comparisons focusing on alcohol and prevention policies when developing their own policies (Sewel et al., 2002; Crombie et al., 2005). The comparative policy information that is relevant for this approach is being compiled and made available by WHO and various other organizations, such as the International Centre for Alcohol Policies (ICAP) and Alcohol Policy Information System (APIS) as well as by EU projects, such as the European School Survey Project on Alcohol and Other Drugs (ESPAD), the European Comparative Alcohol Study (ECAS) and the Eurocare project. National policy frequently looks to the international policy context and recommendations by WHO or the EU, which we will address in more detail later in this chapter.

National alcohol policy goals vary greatly

Usually, policy is not only implemented to reduce the supply, but also to reduce the demand through advertisement restrictions and information. Minimizing alcohol-related harm in individuals, their families and society as a whole is frequently the most prominent policy goal. Prevention of alcohol-related problems, such as negative health effects, traffic accidents, crime and productivity loss are important subgoals in practically all countries. Some countries, such as New Zealand and Australia, have formulated alcohol policies in considerable detail, and in New Zealand this is coordinated by the Alcohol Advisory Council (ALAC). It is interesting that ALAC is financed from alcohol excise taxes. In the preparatory phase of policymaking, many countries are paying more and more attention to the implementation of evidence-based measures, that is to say, measures that have turned out to be effective in other countries (Crombie et al., 2005).

There are also differences in target groups, action areas and focus areas

Countries differ in how they structure the framework of their policy strategy. The Australian strategy distinguishes eleven action areas, among which, information, young people and other high-risk groups, legislation and regulation as well as the enforcement thereof, price and excise tax policy, drinking environment and ‘alcohol promotion’.

It would appear that the Australian model attributes equal importance to all of these areas. Denmark and Japan concentrate their policies on the reduction of alcohol consumption by heavy drinkers, children and young people. New Zealand distinguishes control of alcohol supply, demand reduction and problem-reducing strategies. The strategy in the United Kingdom has four focus areas: education and communication, improvement of institutions for health and trade, counteracting crime, counteracting misconduct and collaborating with the alcohol industry (Crombie et al., 2005).

Sweden, Denmark, Ireland and New Zealand want their national policies to enforce the highest possible level of excise taxes. Australia and New Zealand have proposed to subsidize non-alcoholic beverages and beverages with low alcohol content (Crombie et al., 2005).

Here we conclude that the formulation of policy, the visibility of the policy and the degree to which there is an integrated approach to alcohol policymaking may differ significantly between countries. We address the comparison of specific components of alcohol policies in European countries in more detail later in this chapter.

3.3.1 Effectiveness of alcohol policies

Several large, international comparative reports have summarized the evidence-base for the existing policy interventions that focus on alcohol (Österberg & Karlsson, 2002; Ludbrook et al., 2002; Rehn et al., 2001; WHO, 2004a). This has been extensively summarized again in a recent report for the European Commission (Anderson & Baumberg, 2006). Before that, a number of syntheses of the then existing

evidence-base had appeared (Klingemann et al., 1993; Holder & Edwards, 1995; Babor, 2002; Babor et al., 2003). In 2004, the Health Evidence Network (HEN) of WHO-Europe published a report from the series HEN Synthesis Reports (WHO, 2004b), in which the evidence-base for alcohol policy was reviewed once again. One important conclusion (WHO, 2004a) was that, compared to the past, policymakers were better able to make informed policy choices with the strength of all the scientific evidence present at the time. On the whole, the reports mentioned above also draw the same conclusions:

- The alcohol problems in a country are strongly correlated with the per capita alcohol consumption and the reduction of this alcohol consumption per capita reduces the national alcohol problems.
- Most evidence regarding the influence of governmental policy has been compiled in the area of the price elasticity of the demand for alcoholic beverages. The demand for alcohol is sensitive to price changes, so that when the price increases, the demand decreases and vice versa. The HEN report by WHO makes a note that the effect is dependent on the existing level of the excise taxes, the existing alcohol culture in a country and the public support for a stricter alcohol policy. However, there are clear effects on the harm caused by alcohol and the costs are low, which turns this into a cost-effective form of policy.
- For heavy drinkers, it was demonstrated that they can be influenced by policies that regulate the price and availability as well as through other regulations.
- Alcohol policies that can influence drinking patterns through restricting the availability and that discourage drinking under the legal age limit will probably reduce the harmful effects associated with certain drinking patterns. Approaches that are aimed more at the individual (prevention programmes at schools) have, however, usually had less effect on drinking patterns and the related problems. Broad-based population-focused strategies that influence the drinking environment and restrict the availability of alcohol have more effect.
- Legal measures against using alcohol while driving, the increase of the legal age at which one may drink and the reduction of sales outlets have turned out to be effective in reducing alcohol-related problems, at least when properly enforced.

Supply reduction is most effective

There is very strong evidence for the effectiveness of policies that reduce the supply side of the market through regulations and therefore limit harm from alcohol, particularly policies aimed at certain groups such as young people.

The regulation of alcohol advertisement by way of supply reduction or through adjusting the content of the advertisement would probably also limit alcohol-related harm. From an international perspective, self-regulation in this area has not yet proven to be effective; Australia evaluated self-regulation as being ineffective (NCRAA, 2003).

According to most researchers, the effect of policies that aim at informing, educating, training and raising awareness of alcohol problems by the general public is not great. Mass media campaigns are probably necessary to broadly increase the awareness that alcohol causes many problems. This can make the introduction of later, specific interventions easier. In principle, the target range of education lessons at schools is considerable. However, the limited or lacking effectiveness of this education may cause that the total effect will be minor (WHO, 2004b).

Policy against driving under the influence is effective when properly enforced

Very effective policies exist that can reduce driving under the influence. Unlimited and random breath tests, further reduction of legal blood alcohol levels (BAL) and lower legal blood alcohol levels for young drivers have turned out to be effective in many countries.

There is increasing evidence that measures in social venues can have effect, but their effectiveness is dependent on local implementation and enforcement. Smaller interventions in health care, for example, primary care doctors, can also be effective (Shand et al., 2003). A recent report by the National Institute for

Public Health and the Environment (RIVM) (Meijer et al., 2006) about prevention of alcohol dependence showed, among other things, that several effective group-oriented prevention programmes have been developed in the Netherlands.

The alcohol sector questions the effectiveness of restrictive alcohol policies

The broadly supported scientific conclusions about effective alcohol policies mentioned above have been criticized repeatedly. That occurs in reports for which the alcohol sector provided financial support, for example the reports by ‘The Amsterdam Group’ (Naert et al., 2001) or the ‘Weinberg Group’ (Weinberg Group, 2006). The messages from these reports are: price or excise tax increases are restrictive and not sufficiently effective. That means: no governmental intervention, no EU regulations, no collective EU policy, but rather, self-regulation. Self-regulation is, however, not known to be effective and has already been subject to much criticism in several countries, for example Australia and Ireland.

3.3.2 Alcohol policy in the Netherlands

When Els Borst was Minister of Health, Welfare and Sport, the Dutch Cabinet presented the ‘Alcohol Policy Memorandum 2001-2003’, which contained a relatively broad and integrated description of the alcohol problems. In one of the succeeding cabinets, Minister Hoogervorst sent an alcohol policy memorandum to the Dutch House of Representatives, which concentrated mainly on alcohol and young people (Dutch House of Representatives, 2005). A succinct summary of the Dutch alcohol policy in 2006 (Ministry of Health, Welfare and Sport (VWS), 2006a) proposed the following:

The Ministry of Health, Welfare and Sport (VWS) strives to limit harmful alcohol consumption. Harmful alcohol consumption would include alcohol addiction, alcohol consumption among young people under 16 years of age, alcohol consumption while driving or alcohol problems in the workplace. Additionally, the goals are that:

- children will not start drinking until they are older than is the case now, preferably older than sixteen years of age
- young people will drink less
- fewer people become addicted to alcohol
- the harmful consequences of alcohol consumption in specific situations will be reduced, that is in the family, at work, while driving and while at social venues

According to the Ministry of Health, Welfare and Sport, the Dutch alcohol policy has a coherent package of measures that includes legislation, self-regulation, health care and support, education as well as policies focused on specific situations. Special attention is given to young people and problem drinkers.

Various ministries in the Netherlands are involved in the preparation, implementation and enforcement of alcohol policies. The Ministry of Health, Welfare and Sport is responsible for alcohol prevention, that is, information and legislation, and treatment for alcoholism; the Department of Justice is in charge of criminal enforcement; the Ministry of Transport, Public Works and Water Management (V&W) addresses the policy concerning driving under the influence; the Ministry of Finance (MvF) handles excise taxes on alcoholic beverages.

Organization of the Dutch alcohol policy distributed over various organizations

In the Netherlands a number of different organizations are involved in the preparation and implementation of components of the alcohol policy and alcohol-related research: The Trimbos Institute – National Institute of Mental Health and Addiction, the National Institute for Health Promotion and Disease Prevention (NIGZ) and the National Foundation for Alcohol Prevention (STAP). It appears that the cooperation between these organizations has not always been optimal (Dekker et al., 2006). In addition to this, on behalf of the alcohol industry, the Dutch Foundation for the Responsible Use of Alcohol (STIVA) presents itself in the field as an educational organization on behalf of the collective alcohol industry, and the Institute for Road Safety Research (SWOV) performs research in the area of alcohol and traffic safety.

The implementation of the alcohol policy for several important issues is decentralized in the Netherlands, because a part of the responsibility for enforcement and detection lies with local authorities. This also largely conceals the implementation of the policies. There are, however, considerable differences between local authorities in the enforcement of the Alcohol and Catering Act (DHW). A mere minority of the local authorities carry out an effective local alcohol policy (Dekker et al., 2006). There is an absence of a uniform set of actions and measures at the local authority level that could lead to a univocal and effective national policy, resulting in the local authorities developing a wide range of policies. Subsequently, it can be concluded that there is fragmentation of policy at the national level.

There is a relatively large gap between prevention and health care within the Dutch health care system (De Hollander et al., 2006) and this may create an additional obstacle for realising an effective, integrated alcohol policy in which prevention and treatment accompany each other. A potentially good initiative to deal with this obstacle could be the recently established Partnership on Early Identification of Problem Drinking (PVA), which is a collaboration between organizations and professional associations from the prevention sector and the health care sector.

A few organizations compile and integrate data that could be of importance for Dutch alcohol policies. We mention the National Drug Monitor (Van Laar et al., 2004) and the National Public Health Compass (www.nationaalkompas.nl). The data on alcohol consumption that are being collected is, however, not unequivocally linked to specific policy objectives. Therefore it is not clear whether the available data provides a sufficient basis to evaluate components of the policy. A broader analysis of the wider detrimental health effects caused by alcohol is only performed occasionally.

The last Public Health Status and Forecasts Report (De Hollander et al., 2006) stated that the message of Dutch alcohol prevention hobbles along on two different thoughts (Text block 3.2).

Limiting harmful alcohol consumption is the spearhead of Dutch prevention policy

Limiting harmful alcohol consumption is one of the spearheads in the Ministry of Health, Welfare and Sport Prevention Memorandum 'Opting for a healthy life' from 2006. This memorandum indicates that young people in particular, drink too much and that parents have become too tolerant of this behaviour. It refers to the potential harmful consequences, such as the burden of ill health caused by various diseases as well as accidents. It also refers to the adverse social consequences, such as aggression, crime, disturbance of public order and traffic safety as well as the related financial costs (VWS, 2006b).

This memorandum aims to reduce the use of alcohol by young people under the age of sixteen to the 1992 level, and to reduce the number of adult problem drinkers from 10.3% to 7.5% by 2010. A national approach is proposed to meet this goal with the 'Alcohol and Parenting' project by the Trimbos Institute – National Institute of Mental Health and Addiction - in collaboration with the National Institute for Health Promotion and Disease Prevention (NIGZ). Furthermore, there is reference to the importance of a local authority approach in dealing with the problem. It proposes strengthening the role of the mayors by appointing them as the competent authority in regard to granting Alcohol and Catering Act permits. This would include the possibility to suspend Alcohol and Catering Act permits and, at sometime in the future, to appoint inspectors. The local authorities have the assistance of a directive for local authority alcohol policy, to which the earlier mentioned Partnership on Early Identification of Problem Drinking (PVA) would contribute by providing support for an integrated approach to early identification (Ministry of Health, Welfare and Sport (VWS), 2006b).

Dutch politics does not always opt for proven effective policies

In 2006, the Dutch House of Representatives made a motion in which the following was proposed: establishing that the policy effort by the government in regard to prevention mainly focuses on more control and repression, such as bans, injunctions, reducing sales outlets, increasing excise taxes for specific

stimulants and other matters that threaten public health in the eyes of the government. and. are of the opinion that this is not the proper way of promoting public health and welfare in a balanced and effective manner.’

In a follow-up of this motion, the House appealed to the Minister to implement policy geared to a more focused, preventive approach that strengthens people’s individual responsibility and capability. Part of the cited text from the motion is against too much governmental interference and is also seems to contain an implicit recommendation to ban policies that international research has demonstrated as being effective to reduce alcohol-related harm.

After this motion by the Dutch House of Representatives, the alcohol producers, who are the interested parties from business, appealed to the Ministry of Health, Welfare and Sport in 2006 through a letter from the Dutch Foundation for the Responsible Use of Alcohol, requesting the Ministry to ban the use of the familiar manual (Babor et al., 2003) as the basis for Dutch policymaking on alcohol. This manual is innumerable cited by scientific researchers as a significant source for scientific analyses on the effectiveness of alcohol policies. This manual, just like a number of other large synthesis reports and publications (see Section 3.3.1), draws the conclusion that both a price increase through excise taxes and sales restrictions could be effective policies to reduce alcohol-related harm.

That the Dutch government would appear to want to refrain from effective, evidence-based health care policies is surprising to say the very least. There was no absence of policy ambition by the Ministry of Health, Welfare and Sport, but a lack of political will or courage.

Text block 3.2: Message, Dutch alcohol prevention hobbles along on two notions

Moderate alcohol consumption is the social norm in many circles in the Netherlands and moreover, reduces the risk for certain diseases. However, excessive alcohol consumption and alcohol consumption while driving harm health and are therefore much less socially acceptable. That double message makes implementation of an unequivocal alcohol policy difficult. Although different instruments are used simultaneously in the Netherlands to counteract excessive alcohol consumption (education, legislation and regulation, levying excise taxes and self-regulation by the hospitality industry) an unequivocal, cohesive and transparent approach is, however, lacking. According to the policy formulated, important target groups are young people and problem drinkers; that is, excessive drinkers with alcohol-related physical, social or mental problems.

Prevention of excessive alcohol consumption in young people in the Netherlands is focused on the prevention of binge drinking – drinking more than five glasses of alcoholic beverages during one occasion – and the development of a responsible drinking pattern for later in life. The young people are reached through parents, schools and mass media by way of different prevention interventions, but none of these have already been proven effective, albeit that some seem to have a high chance of success (Meijer et al., 2006). The chance that a young person in the Netherlands can purchase spirits is nevertheless, 90% (Van Laar et al., 2004), and the price of alcoholic beverages in the Netherlands is still not very much higher than that of soft drinks.

In the Netherlands, a health gain can still be achieved through increasing excise taxes, advertisement restrictions, adjusting the Alcohol and Catering Act, a more active municipal permit policy and more strictly enforcing the ban on the sale of alcohol to young people under the age of sixteen. Finally, extra attention for excessive alcohol consumption by adults is desirable because the ageing process diminishes the body’s alcohol tolerance.

Source: De Hollander et al., 2006

3.3.3 Country comparison of alcohol policies

Below, we briefly discuss the international differences within the EU regarding several elements of alcohol policy such as restrictions on advertisements, driving under the influence, and age limits for the sale of alcohol to young people. Finally, we pay attention to the general differences and trends in alcohol policies in EU countries and to the question of the extent to which the Netherlands has strict or mild alcohol policies compared to other countries. There are no clear-cut model countries with effective alcohol policies. Still, certain countries have introduced specific interesting policy elements, such as the broad-based national alcohol policy programme that New Zealand has established.

Large differences in alcohol prices and excise taxes among EU countries

The considerably different prices, excise taxes and taxes on alcohol that continue to exist among the EU countries will not be described in detail here. The traditional wine countries, such as Germany, France and other Mediterranean EU countries still do not levy excise taxes on wine, but they do so for other alcoholic beverages. For details about the effects that such differences can have on alcohol consumption, we refer to a recent study by the Netherlands Bureau for Economic Policy Analysis (CPB) (Cnossen, 2006). This study indicates, for example, that the differences in excise taxes and prices in the EU must be reduced to make the cross-border purchase of alcohol less attractive. Increasing the excise taxes on ‘premixed beverages’, also-called breezers, as Germany, Switzerland, France and Denmark have done, could reduce the drinking behaviour among young people. Excise tax increases could compensate more for the economic costs of harmful alcohol consumption compared to the current situation. However, this would require a more progressive European harmonization of alcohol excise taxes, which is currently not the case.

Advertisement restrictions vary considerably

The marketing and advertisement regulations for alcohol and the associated implementation frameworks are very complex and differ strongly between the EU countries. A 460-page report by Canadean (2005) provides a comparative overview of this. The earlier mentioned WHO Alcohol Control Database provides a more simplified overview. From this database, it can be concluded that there are alcohol advertisement restrictions in a number of countries in different media, such as television, radio, newspapers, advertisement billboards and films. Restrictions on the content of television advertisement for alcoholic beverages as laid down in the earlier-mentioned EU directive ‘Television Without Borders’ are of course the same across Europe. However, there are differences in how these regulations are implemented and enforced.

France, Norway and Switzerland have the most advertisement restrictions

Norway, Switzerland, and from the EU-25 countries, France, have complete advertisement restrictions for beer, wine and spirits on national television as well as on commercial cable television. Denmark, Norway and Switzerland have a complete restriction on radio advertisements for beer, wine and spirits. Slovenia and Norway have a complete ban on alcohol advertisement on billboards, and Estonia, France and Norway have a complete ban on cinema advertisement for alcohol. A number of countries such as Austria, Belgium, Finland, Poland, Slovenia, Spain, France and Switzerland have ‘partial restrictions’ for a number of media mainly on radio, printed material (newspapers) and billboards. It is striking that the two countries in this European comparison that are not official members of the EU – Norway and Switzerland – have strong advertisement restrictions and the actual EU Member States, with the exception of France, do not. There are some interesting exceptions to the advertisement regulations within the EU that seem to be inspired by socio-economic forces, such as legal restrictions on beer advertisements in Greece and on those for spirits in Italy: both countries are traditional wine countries (Canadean, 2005).

France: model country for advertisement restrictions with the Loi Evin

In France, the so-called Loi Evin from 1991 regulates direct and indirect advertising for all alcoholic beverages with an alcohol content greater than 1.2%. There are no alcohol advertisements on French television or in cinemas. In all other French media, advertising is possible on the condition of a substantial number of restrictions regarding content, timing and location, and only if provided with an educational

message about alcohol. The Netherlands has no formal legal regulations concerning television advertising for alcoholic beverages. There is self-regulation, which therefore includes – as already explained – the regulations that are based on the EU directive ‘Television Without Borders’. Germany, Ireland and the United Kingdom are a few of the other countries with much self-regulation, but Denmark and Belgium also follow this strategy in a few advertisement areas. Norway has the most complete restrictions – seven of the eight differentiated media areas – with Switzerland and France in second place each with three complete restrictions.

More frequent self-regulation, but the effect is still unclear

All in all, there is a trend in Europe towards the intensification of self-regulation or co-regulation, without there being any evidence that is effective in terms of successfully limiting harmful alcohol consumption. Overviews of these developments in European self-regulation, which are usually produced by the alcohol sector (Canadian, 2005), do not yet pay any attention to the effects of self-regulation on harmful alcohol consumption.

Blood alcohol levels (BAL) while driving are strongly comparable in the EU

As there is proven effectiveness, most of the countries in the European Union enforce an 0.5 alcohol permillage (BAL values) in traffic, with the exception of Norway and Sweden where the permillage is 0.2. In Ireland and the United Kingdom, the permillage limit is 0.8, which is the same as in Canada, New Zealand and most of the states in the United States. Australia introduced random breath tests (non-selective tests) in 1989, which was found to be a great success due to a combination of the increased chance of being caught and strict punishment, together with a strong positive effect on health harm caused by traffic accidents.

In the mid-1990s, the number of ‘young’ drivers in Austria in possession of a driving licence for less than five years who were involved in an alcohol-related accident decreased by more than 16% after a BAL value of 0.1 permillage was introduced for them (Bartl et al., 1997). The European Transport Safety Council (ETSC, 1997) recommended that all EU countries should introduce this measure. Almost ten years later, on 1 January 2006, the Netherlands has enforced such a measure. However, it is enforced with a BAL level of 0.2 permillage. We do learn from other countries, but just not always as quickly as possible. This measure also applies until five years after having earned a driving licence in the Netherlands.

Intensified controls on driving under the influence have beneficial effect in the Netherlands

In an international comparative study (Steward, 2000), the Netherlands, Sweden, New Zealand, France and a few Australian states emerged as the countries where alcohol control in traffic occurs relatively often. Partially on the basis of a European recommendation, the Netherlands has tested drivers for alcohol consumption more frequently since 2000. The frequency with which the limit was exceeded during weekend nights has decreased from 4.2% to 2.8% in this period. The effect is limited to the last two BAL classes (BAL 0.5-0.8 permillage and BAL 0.80-1.3 permillage) while the share of the most serious offenders (BAL greater than 1.3 permillage) remains the same (Stipdonk et al., 2006). It seems that the more intensive Dutch policy therefore produces a favourable effect.

Age limits for the sale of alcohol to young people

Most of the countries in the EU-25 have a minimum age limit of eighteen for the sale of beer, wine or spirits in a bar or for purchase in a store. The age limit of eighteen years only applies to spirits in the Netherlands. The age limit for other alcoholic beverages in the Netherlands is still sixteen, which is an approach shared by Belgium, Austria, France, Germany, Italy and Portugal. Iceland is the only European country with an age limit of twenty and Greece has an age limit of seventeen. The age limit of sixteen years appears in many countries, but is certainly not present everywhere. There are tendencies to increase the age limits. However, enforcement and an effective control at the sales outlets are crucial with age limits. A restriction of sales outlets could occasionally be an alternative as well (WHO, 2004b).

Increases in personal, marketing and environment control, supply control decreases

The European Comparative Alcohol Study group (ECAS) has developed a point system to assess the strictness and comprehensiveness of a national alcohol policy. This system monitors the control on production, wholesale, distribution, marketing and also on personal and environment controls along with national public policy. The ECAS system gives a maximum of seven points for restrictions of alcohol distribution (the sale of beer, wine and spirits) and three points for restrictions on production and wholesale. Furthermore, there are three points for restrictions of personal use (age limits) and for environmental restrictions (BAL values while driving). There is a maximum of two points for advertisement restrictions and for specific government policies (national prevention programmes or institutes, national alcohol information programmes or institutes).

Table 3-1 Strictness and comprehensiveness of a national alcohol policy in the ECAS countries (1950-2000).

	1950	1960	1970	1980	1990	2000
Control of production and wholesale	1.2	1.3	1.3	1.3	1.3	0.9
Control on distribution	2.9	3.0	3.0	2.8	2.9	2.8
Personal control	1.3	1.5	1.4	1.7	1.8	1.8
Control of marketing	0.3	0.4	0.8	1.3	1.7	1.7
Social and environmental controls	0.6	0.9	1.2	2.0	2.3	2.7
Public policy	0.5	0.7	1.0	1.1	1.4	1.5

The ECAS approach (Table 3.1) shows that alcohol policy in the former EU-15 and Norway has gradually changed over the past fifty years. The control of distribution was never optimal in this period, with an average of three of seven points on the ECAS scale, and it has not increased either. Effort is increasingly often put into personal control, marketing control as well as social and environmental control, while recently, control on production and wholesale has strongly decreased because of the discontinuance of the alcohol monopolies in the Scandinavian countries. Marketing control increased between 1970 and 1990, but has recently stabilized. Public policy has become more important over the years. The highest ECAS scores in 2000 were found in Norway, Sweden and Finland. The United Kingdom, Italy, the Netherlands and France followed.

Around 1950, countries could roughly be categorized as wine countries, beer countries or spirits countries, the Netherlands falling under the latter. Policies were stricter in the spirits countries, followed by beer and wine countries. The situation had become more complex by the year 2000. On the one hand, countries had become more difficult to classify as a 'beer country' or a 'spirits country' because of the current converging alcohol usage, whereas on the other hand, policy in France for example, has become stricter in certain areas such as drinking while driving (Österberg & Karlsson, 2002).

Still clear differences, but there is a converging trend in alcohol policy in the EU

Between 2000 and 2005, no great shifts in the ECAS ranking of strictness of alcohol policies has occurred (Anderson & Baumberg, 2006). In a nutshell, it can be said that there are similarities as well as differences in alcohol policies in the ECAS countries and at the same time, as was pointed out earlier in this chapter, the degree of coherency – integrated approach – may vary to a large extent. Driving under the influence (BAL values) is dealt with in a reasonably comparable manner, as are the systems for granting permits and minimum ages for the purchase of alcohol in bars; practically all schools everywhere provide alcohol education. There are considerable differences within the EU concerning the enforcement of alcohol restrictions while driving and the age at which young people may purchase alcohol in stores (Anderson & Baumberg, 2006).

During the second half of the twentieth century there was a marked decrease in the restrictions on the supply side. The excise taxes, compared to the actual prices, are lower in Europe than in the rest of the world. In general, it can be said that alcohol policies within the EU have converged over the past fifty years (Anderson & Baumberg, 2006), which has resulted in policies that more often address the demand rather than the supply.

What is significant in these international comparisons of alcohol policies, however, is the persistent question as to how well policies are supported by effective enforcement, something which the ECAS scale generally does not address.

3.4 Discussion and conclusions

Restricting alcohol consumption by young people is a priority in EU countries

Alcohol-related deaths have recently increased in several EU countries. There are reports of a strongly increasing death rate from liver diseases in England and Scotland, and in Finland, alcohol-related death is now the number one cause of death among people aged 15 to 65 years old. These are countries with a drinking pattern comparable to the Netherlands.

European youths drink a lot of alcohol; young people in the Netherlands are among the front-runners. This excessive drinking at an early age and the pattern of binge drinking associated with it is a shared problem of EU countries, which indicates the necessity for an EU-based alcohol policy.

The recent figures of alcohol consumption by young people in the Netherlands seem to indicate that Dutch policy has been limited in its effectiveness. A French international comparative report (Jourdain-Menninger & Lignot-Leloup, 2003) that involved a few other countries and regions (Quebec, Finland, United Kingdom) concluded that alcohol policy focused on young people is failing there.

International inspiration, opposing forces and chances

At the supranational level within Europe, there is inspiration from policies originating from WHO-Europe by means of the Framework for Alcohol Policy. Many European countries, including the Netherlands, can still refine their policies by following the recommendations in the European Alcohol Action Plan by WHO in its entirety.

There are opposing forces from the European Union at work on national alcohol policies. First of all, there are influences from the EU by means of agricultural grants to grape growers. In addition to this, there are still large differences in excise duties and taxes within the EU and there are leading free market principles in the EU that make national restrictions on the sale of alcohol difficult or occasionally even impossible. This is why the Scandinavian countries have had to liberalize their restrictive alcohol policies; this seems to have led to problems in Finland.

Meanwhile, an alcohol strategy has been formulated for the EU with various recommendations to the Member States and there are European regulations in the area of alcohol regarding the content of television advertisement. The Netherlands has already introduced various recommendations and the regulations concerning television advertisement are implemented in the self-regulation.

However, the development of international policy frameworks, that can support national policies, have been frustrated at the EU level through strong oppositional forces from the alcohol-producing sector, which rejects restrictive measures in the supply area.

Proactive Dutch stance in the EU would be desirable

Phased introduction of the recommendations from the recent European alcohol report (Anderson & Baumberg, 2006) would be a possibility for intensified common EU policies that the Member States could collectively put into action. In addition, new EU proposals for deregulation and harmonization in the new services directives, among others, must be critically examined for the possibility that alcohol sales will take place across borders – for example, over the Internet – and would therefore disrupt national alcohol control policies.

What seems to be needed therefore is a watchful, participating and proactive attitude by the Netherlands in the various EU policy committees in the areas of agricultural politics, market operations and regulation as well as public health. Consequently, it seems important that the EU Member States will closely collaborate in further alcohol policy development.

Alcohol consumption, detrimental health effects and costs: what can policy do?

Europeans drink relatively large quantities of alcohol and all EU countries bear, albeit to varying degrees, the negative consequences of excessive alcohol consumption. These negative consequences are health-related, social and economic. In some countries, such as Finland, England and Scotland, there is an emphasis on paying attention to the assessments of the health effects caused by alcohol, however, in most countries, including the Netherlands, this damage is not brought to the forefront on a regular basis.

The costs caused by alcohol are in most countries higher or much higher than the national excise tax revenues. The revenues from excise taxes do not even cover half the costs in the Netherlands. This indicates the need to increase the alcohol excise taxes in the Netherlands, for example, for premixed beverages that serve as ‘first-round drinks’ for many young people.

If the costs and problems resulting from alcohol within the EU countries do not decrease and if the apparent possibility of the increasing free market forces further curtail or negate components of national alcohol policies –which certainly seems possible – few policy options remain open to the governments other than detecting and treating heavy drinkers or increasing excise taxes along with mass media campaigns. The first option appears to be the most agreeable choice for the alcohol sector and the average drinker; however, it is by far the most expensive for the government and the health care insurers (Österberg & Karlsson, 2002).

Other countries, such as New Zealand or regions such as Quebec, have adopted the novel approach of linking the funding of alcohol policies to the alcohol excise taxes.

Information, research and monitoring can improve

Many countries have acknowledged the need to collect more evidence for the effectiveness of new interventions and to perform research in that area. An enormous range of potential interventions have already been identified. However, their implementation and effectiveness have often not been properly described or researched yet.

A systematic analysis of the research that would be needed to develop alcohol policies has hardly ever taken place. Even though virtually all countries make proposals to measure the dynamics of alcohol-related

health harm and policy effectiveness, the necessary conditions, specifically the monitoring of alcohol-related indicators, needed to measure these dynamics properly have usually not been met.

In many countries, the Netherlands included, information is not collected systematically enough to properly monitor alcohol policies or alcohol-related health effects. This also means that evaluating policy for the most important outcome measure, health gains, is not feasible.

Dutch alcohol policy is ‘moderately’ strict and somewhat irregularly organized

Dutch alcohol policy receives an average score on the international ECAS scale for strictness of alcohol policies. Also according to the alcohol field’s own assessment, the Netherlands has a somewhat moderate alcohol prevention policy (Dekker et al., 2006).

A number of different organizations in the Netherlands, such as the Trimbos Institute - National Institute of Mental Health and Addiction, the National Institute for Health Promotion and Disease Prevention (NIGZ) and the National Foundation for Alcohol Prevention (STAP) are involved in preparation and implementation of components of alcohol policy as well as in alcohol-related research. It would appear that cooperation between these organizations has not always been optimal (Dekker et al., 2006). The recently established Partnership on Early Identification of Problem Drinking (PVA) is a Dutch initiative that focuses on the improvement of this collaboration. In addition to this, on behalf of the alcohol industry, the Dutch Foundation for the Responsible Use of Alcohol (STIVA) presents itself as educational organization and research has been performed by the Institute for Road Safety Research (SWOV) in the area of alcohol and road safety.

Dutch alcohol policies appear to be fragmented and so there is a need for more central programming, direction and inspiration. An improved and recognizable responsibility for policy by one field organization can be a solution; however, a national alcohol programme could provide results as well.

In some other countries, a single organization or national commission is responsible for the national coordination of alcohol policy, often based on a national programme and with sufficient financial resources.

Alcohol policy and societal oppositional forces

In recent years, proposals have regularly been made in the Netherlands for larger and smaller alcohol policy changes that were supported by the public health field. However, these proposals were immediately rejected by the alcohol branch and consequently voted down in Dutch House of Representatives as well.

The Dutch government appeared to allow the job opportunities in the alcohol sector, the protection of the free market and individual freedom to weigh heavier than the collective interest of limiting alcohol related harm. In general, it seems that the least effective and most popular measures of education and self-regulation prevail in policy and politics while the most effective measures of increasing prices and excise taxes as well as the regulation of supply are the least popular (Garretsen & Goor, 2004).

In the meantime, as we saw earlier for the area of smoking policy, the influence of the alcohol sector on national policymaking has taken a similar road, specifically trying to deny or rule out the influence of scientific evidence and enticing government to do the same. This analogy with smoking policy has been noted before (Arora, 2006).

Integrated approach and chances for policy

The government has different interests with regard to alcohol consumption, such as a fiscal interest with excise taxes, an interest regarding public order and safety, an interest in the economic growth of the alcohol sector and a health interest, including reproductive health. The degree to which these interests play a role differs in each country. These interests are usually distributed among different ministries or departments

within national governments and deserve a broad-based and integrated approach merely because of the possibilities for synergy and the need for policy consistency.

There are various cost-effective interventions that have not yet been entirely or maximally introduced by the Netherlands. Excise tax increases, advertisement restrictions, adjustment of the Alcohol and Catering Act, a more active municipal permit policy and a more strict enforcement of age limits for the sale of alcohol are effective measures. A certain part of these measures demands a more active role of the national and local governments. Increases of excise tax or prices are proven cost-effective interventions that could compensate more for the societal costs of alcohol than they currently do.

Many countries indicate in their policy documents that more evaluation of existing policies and of new interventions is necessary, and that governments should also further stimulate scientific research for an effective alcohol policy.

A recent analysis performed by the RAND organization to identify the most favourable alcohol policies in European Member States demonstrated that a broad-based, integrated and intersectoral approach has the highest chance of successful outcomes (Horlings & Scoggins, 2006).

A summary of the international perspective on alcohol policies outlined above leads to a number of final conclusions:

Effective measures can be taken to decrease the supply of alcohol, for example decreasing its availability and increasing its price, to reduce alcohol consumption among young people in the Netherlands

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

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

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

Alcohol policy in the Netherlands would benefit from the Netherlands taking a more proactive approach towards EU policies with relevance for alcohol

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

References

- Anderson P, Baumberg B. Alcohol in Europe. A Public Health Perspective. A report for the European commission. http://ec.europa.eu/health-eu/news_alcoholineurope_en.htm (last visited June 2006). UK: Institute of Alcohol Studies, 2006.
- Arora M. Alcohol Advocacy. Lessons to be learned from tobacco. <http://www.ias.org.uk/resources/publications/theglobe/>. The Globe: 2005, Issue 3 en Issue 1, 2006.
- Babor TF, caetano R, casswell S, Edwards G, Giesbrecht N, Graham K, et al. Alcohol: No ordinary commodity. Research and Public Policy. oxford: oxford university Press, 2003.
- Babor TF. Linking science to policy. The role of international collaborative research. Alcohol Research and Health, 2002;26(1):66-74.
- Bartl G, Esberger R, Brandstätter c. unfallbilanz nach fünf jahren führerschein auf Probe. Zeitschrift für verkehrssicherheit 1997;42(9),317-321.
- Canadean. Responsible marketing of alcoholic beverages in Europe. Brussels: canadean, April 2005.
- Cnossen S. Alcohol Taxation and Regulation in the European union. cPB discussion Paper 76. (ook verschenen als: cESifo Working Paper No 1821: www.cesifo-group.de). The Hague: cPB, 2006.
- Crombie IK, Irvine L, Elliott L, Wallace H. Public Health Policy on Alcohol: an international perspective. A report to NHS Health Scotland. www.phis.org.uk/pdf.pl?file=pdf/Alcohol%20Report%20full.pdf. Public Health Institute of Scotland, 2005.
- Crombie IK, Irvine L, Elliott L, Wallace H. How do Public Health policies tackle alcoholrelated harm: a review of 12 developed countries. Alcohol & Alcoholism, 2007 (Epub ahead of print).
- Currie c, Roberts c, Morgan A, Smith R, Settertobulte W, Samdal o. Young people's health in context. Health Behaviour in School-aged children (HBSc) study: international report from the 2001/2002 survey. copenhagen: WHO-Europe, 2004.
- Dekker E, Dalen WE van, Kuunders MMAP, Mulder J. Beleid onder invloed. Alcoholpreventiebeleid in Nederland. utrecht: STAP, 2006.
- EC, Europese commissie. Mededeling van de commissie aan de Raad, het Europees Parlement, het Europees Economisch en Sociaal comité en het comité van de regio's. Een Eu-strategie ter ondersteuning van de lidstaten bij het beperken van aan alcohol gerelateerde schade. COM(2006) 625 definitief. Brussel: Ec, 2006.
- ETSC. European Transport Safety council. A strategic road safety plan for the European union. ETSC, Brussels, 1997.
- Garretsen HFL, Goor I van de. Towards evidence-based policy. In: Müller R, Klingemann H (eds.). From Science to Action? 100 Years Later - Alcohol policies revisited; pp 141- 151. Dordrecht, Boston, London: Kluwer Academic Publishers, 2004.
- Hibell B, Andersson B, Bjarnasson T, Ahlström S, Balakireva o, Kokkevi A, et al. The ESPAD report 2003: Alcohol and other Drug use Among Students in 35 European countries. Stockholm: cAN, 2004.
- Holder HD, Edwards G (eds.). Alcohol and Public Policy: Evidence and Issues. oxford: oxford university Press, 1995.
- Hollander AEM de, Hoeymans N, Melse JM, Oers JAM van, Polder JJ (eindred.). Zorg voor gezondheid. Volksgezondheid Toekomst Verkenning 2006 [English: Care for health. The 2006 Dutch Public Health Status and Forecasts Report. RIVM report 270061003]. RIVM-rapportnr. 270061003. Houten: Bohn Stafleu van Loghum, 2006.
- Horlings E, Scoggins A. An Ex Ante Assessment of the Economic Impacts of Eu Alcohol Policies. Prepared for the European commission. RAND technical report, RAND, 2006.
- ICAP, International center for Alcohol Policies. Policy Issues. <http://www.icap.org/Publication/IcAPReports/tabid/147/Default.aspx> (last visited 5 January 2007), 2007
- Jourdain-Menninger D, Lignot-Leloup M. comparaisons internationales sur la prevention sanitaire. IGAS-Rapportnr. 2003003. Paris: IGAS, 2003.
- Klingemann H, Holder HD, Gutzwiller F. Alcohol-related accidents and injuries. Addiction 1993;88(7),861-1016.

- KPMG. Excessive alcohol consumption in the Netherlands. Trends and social costs. Hoofddorp: KPMG, 2001.
- Kunst AE, Groenhof F, Mackenbach JP, and Eu Working Group on Socioeconomic inequalities in health. occupational class and cause specific mortality in middle aged men in 11 European countries. comparison of population based studies. *BMJ* 1998;316:1636-1642.
- Laar MW van, cruts AAN, verdurmen JEE. ooyen MME van. Nationale Drug Monitor. Jaarbericht 2004. utrecht: Trimbos-Instituut, 2004.
- Leon DA, Mccambridge J. Liver cirrhosis mortality rates in Britain from 1950 to 2002: an analysis of routine data. *Lancet* 2006;367(9504),52-56.
- Ludbrook A, Godfrey c, Wyness L, Parrott S, Haw S, Napper M, et al. Effective and cost-Effective Measures to Reduce Alcohol Misuse in Scotland: A Literature Review. <http://www.scotland.gov.uk/health/alcoholproblems/docs/lire-05.asp> (last visited 15 November 2006). Edinburgh, 2002.
- Meijer SA, Smit F, Schoemaker cG, cuijpers P. Gezond verstand: preventie van psychische stoornissen. RIVM-rapportnr. 270672001. Bilthoven/ utrecht: RIVM/ Trimbos-instituut, 2006.
- Naert P, Naert S, Maex D. The socio-economic impact of the European alcoholic beverages industry, in: the Amsterdam Group Report 2001: Alcoholic Beverages and European Society. TAG, 2001.
- NCRAA. National committee for the Review of Alcohol Advertising. Review of the selfregulatory system for alcohol advertising, report to the ministerial council of drug strategy. www.dhs.vic.gov.au/phd/publications/downloads/ncraareport.pdf (last visited 14 december 2006) victoria, Australia: DHS, 2003.
- Österberg E, Karlsson T (eds.). Alcohol Policies in Eu Member States and Norway. http://europa.eu.int/comm/health/ph_projects/1998/promotion/fp_promotion_1998_a01_27_en.pdf. Helsinki: STAKES, 2002.
- Rehn N, Room R, Edwards G. Alcohol in the European Region - consumption, harm and policies. WHO: copenhagen, 2001.
- Rescon, research & consultancy. De gezonde school en genotmiddelen 1995-1998. Eindevaluatie. Haarlem: Rescon, 1999.
- Sewel K. International Alcohol Policies. A selected literature review. <http://www.scotland.gov.uk/cru/kd01/red/iapl-00.asp> (last visited 12 mei 2006). Edinburgh: Scottish Executive central Research unit, 2002.
- Shand F, Gates J, Fawcett J, Mattick R. The treatment of alcohol problems. A review of the evidence. commonwealth Dept of Health and Ageing. canberra: NDARc, 2003.
- STAP. Stichting Alcohol Preventie. Factsheet; Nederlands alcoholbeleid. utrecht: STAP, 2005.
- Statistics Finland. http://www.stat.fi/til/ksyyt/2005/ksyyt_2005_2006-10-31_tie_001_en.html (last visited November 2006), 2006.
- Stewart K. Preventing impaired driving around the world: lessons learned. *Inj Prev* 2000;6:80-81.
- Stipdonk HL, Aarts LT, Schoon cc, Wesemann, P. De essentie van de daling in het aantal verkeersdoden. ontwikkelingen in 2004 en 2005, en nieuwe prognoses voor 2010 en 2020. Leidschendam: SWov, 2006.
- STIVA, Stichting verantwoord Alcoholgebruik. Brief aan VWS. http://projecten.drecomm.nl/fileadmin/stiva/brf_87-_IvE_mw_Bolhuis.pdf (last visited december 2006), 2006.
- Tigerstedt c, Karlsson T, Mäkelä, Österberg E, Tuominen I. Health in alcohol policies: the European union and its Nordic Member States. In: Stahl T, Wismar M, ollila E, Lahtinen E, Leppo K. Health in all policies. Porspects and potentials. Helsinki: SAH, 2006.
- Tweede Kamer [Dutch House of Representatives]. Alcoholbeleid. Brief van de minister van VWS, d.d. 24 March 2005. Tweede Kamer [Dutch House of Representatives], vergaderjaar 2004-2005: 27 565, nr. 29. The Hague, 2005.
- Tweede Kamer [Dutch House of Representatives]. Kamerstuk 22 894 nr. 94. Preventiebeleid voor de volksgezondheid. The Hague, 2006.
- Vogels T, Buitendijk SE, Bruil J, Dijkstra NS, Paulussen TGWM. Jongeren, seksualiteit, preventie en hulpverlening. Een verkenning van de situatie in 2002. TNO-rapport 2002.281. Leiden: TNO, 2002.

- VWS, Ministry of Health, Welfare and Sport. Dossier Alcohol. <http://www.minvws.nl/dossiers/alcohol> (last visited 11 mei 2007), 2006a.
- VWS, Ministry of Health, Welfare and Sport. Preventienota Opting for a healthy life. The Hague: VWS, 2006b.
- Weinberg Group. An independent review of issues related to alcohol consumption in Europe. Prepared for the brewers of Europe. Brussels: The Weinberg Group, June 2006.
- Worldbank. World Development Report 2007. Development and the Next Generation. Washington: Worldbank, 2006.
- WHO, World Health organization. Global Status Report: Alcohol Policy. http://www.who.int/substance_abuse/publications (last visited 12 August 2006). Geneve, 2004a.
- WHO, World Health organization. HEN synthesis report: What are the most effective and cost-effective interventions in alcohol control? copenhagen: WHO, February 2004b.
- WHO, World Health organization. Public health problems caused by alcohol. Report of the secretariat. Geneva: WHO, 2005a.
- WHO, World Health organization. Framework for Alcohol Policy in the WHO European Region. copenhagen: WHO-Europe, 2005b.
- WHO, World Health organization. Alcohol control Database. <http://data.euro.who.int/alcohol> (last visited October 2006), 2006.

OVERWEIGHT

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

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

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

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

The control and prevention of overweight will benefit from an EU-wide approach

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



4 OVERWEIGHT

Eveline van der Wilk and Peter Achterberg

4.1 Introduction

- 4.1.1 Undesired effects of overweight and obesity
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4.5 Discussion and conclusions

References

4.1 Introduction

Overweight and severe overweight (obesity) carry an increased risk for a whole range of chronic diseases. The prevalence of overweight has increased sharply in many countries over the last decade.

Overweight and obesity in epidemic proportions

The worldwide prevalence of overweight and obesity has recently taken on epidemic proportions. This has led to overweight becoming a hot issue in public health policy. Recently, Hans de Goeij, Director-General of the Netherlands Ministry of Health, Welfare and Sport (VWS), made the following statement: 'the obesity epidemic has the character of an assassin and the effect of a nuclear disaster'. Almost half of the Dutch population is now overweight and if this situation is allowed to continue, then for the first time in history, we will have a generation that outlives its children' (NRC, 2005).

Efforts to find satisfactory answers regarding the cause of the current high incidence of overweight and obesity often lead to a number of recent changes (particularly in Western and more affluent communities) being mentioned. These include an increase in the so-called 'car culture' and the increasingly intensive use of technology that requires either no physical activity at all or, for example watching television, invites less physical activity. In addition, there is a rise in the overconsumption of foodstuffs that are available in an increasingly varied assortment at consumer-friendly prices and stimulated by a culture dominated by persistent and continuous advertising. This coincides with a general behavioural change to eat more snacks in between meals. At the same time, less water and more soft drinks containing sugar are being drunk.

Small sustained positive energy balance most important cause of overweight

A small sustained positive energy balance can result in significant changes to body weight (Van den Berg et al., 2006). It is plausible that the high prevalence of overweight and obesity has been caused by a slow increase in people's lack of exercise combined with a marginal dietary overconsumption. Genetic factors also play a role in the onset of overweight, although the exact mechanisms involved in this process are not known.

Important influence of environmental factors

There are indications that factors in the physical, social and economic environment – the so-called obesogenic environment, encourage people to eat a lot and exercise little, therefore pointing them in the direction of an unhealthy lifestyle. Various studies have, for example, found a connection between the number of television hours watched and the development of overweight in children (Salmon et al., 2006; Vereecken et al., 2006).

The size of food and drink portions also plays a role in the quantities consumed by people. People eat more when they are offered larger portions, even though this is not a conscious decision.

Cinema-goers, for example, ate on average 53% more popcorn when they were given a bag containing 240 grams instead of the usual portion of half that amount. We can draw the conclusion from this and other experiments that enlarging the portion can lead to an increase in food consumption (Wansink & Park, 2001). This effect is seen not only with snacks but also regular meals, even when people do not actually prefer a particular food.

It would therefore appear that the explanation of overweight should not be sought simply in the phenomenon of eating more and exercising less, but that there is a complexity of emotional and other psychological processes as well as environmental stimuli that contribute to the problem. The higher obesity prevalence rate in population groups with a lower socio-economic status largely depends on environmental factors that prevent healthy behaviour from taking place (Van der Lucht & Picavet, 2006).

Policy that focuses on reducing the levels of overweight and obesity therefore needs to concentrate on both food and exercise as well as the social structures and changes taking place in the background. To this end, more information needs to be gained on how individuals encourage overweight by their own mechanisms and behaviour.

4.1.1 Undesired effects of overweight and obesity

The most common approach to determining the degree of overweight is measuring the body-mass index (BMI). For adults the criterion for obesity is a BMI of 30 kg/m² or more and for overweight a BMI between 25 and 30 kg/m² (WHO, 1997).¹

In its milder form, overweight is an important risk factor for bad health. In addition, obesity is increasingly considered a disease requiring medical treatment. This chapter will refer mainly to the term overweight, even when both overweight and obesity are actually meant.

Weight increase leads to a whole range of disorders

One important consequence of weight gain is the ensuing disruption in insulin activity. This plays a key role in the development of the metabolic syndrome characterized by various interrelated abnormalities, such as high blood pressure and excess fat (abdominal obesity) in the abdominal region. These abnormalities are underlying factors for the development of diabetes (type 2 diabetes mellitus).

Other health risks related to overweight and obesity are cardiovascular disease, certain forms of cancer, liver and biliary tract disorders, arthrosis, respiratory problems, psychological problems such as depression and negative self-image and infertility. Although the exact shape of the risk curve is still subject to discussion, we can say that in general, most research points to the conclusion that as overweight increases, the health risks become greater. Recent findings however, show that the risk of mortality as a result of moderate overweight is possibly not that high and that in some cases (such as fit people of middle age) is perhaps even smaller than in people of normal weight (Flegal et al., 2005).

Of the health risks concerned, the prevalence of diabetes (also in children) is the most alarming due to the many complications of the disease, the associated disorders and the costs of related health care. Overweight in children is a predictor for overweight, disease and mortality in adults (Wang et al., 2003). As overweight is very difficult to treat, its prevention at a young age can prevent many health problems from occurring.

Direct and indirect costs of overweight are high

In the Netherlands, the costs relating to overweight have been estimated at 2% of the total costs for health care, which converts to 77 US dollars per inhabitant (Van Baal et al., 2006). For the United States, the estimates range from 5.5% to 9.4 % of the total health care costs which converts to between 166 and 353 US dollars per inhabitant per year. These calculations include the direct medical costs and indirect costs that cover productivity losses. In the US, the direct costs have risen to 7% of the national costs for health care. Some researchers think that these estimates are on the cautious side because not all diseases related to obesity have been included in these studies (Colditz, 1999). The estimates for Australia, Canada, France and New Zealand, are lower than those of the United States. In these countries, the estimation of costs from overweight or obesity is between 2.0% and 3.2% of the total costs for health care. The indirect costs (resulting from sickness absence and occupational disability) in the Netherlands are estimated to be around 2 billion euro per year (RVZ, 2002).

¹ BMI is defined as the body weight (in kilograms) divided by the square of the body height (in metres). To determine overweight and obesity in young people, an age-adjusted cut-off BMI value should be used (Cole et al., 2000).

4.1.2 Overweight from an international perspective

In the Netherlands, as in many other countries, the number of people with overweight and obesity has steadily increased during the last few years. The increase in the Dutch population is comparable with that of many other countries of the European Union (EU) although the prevalence is still not as high as, for example, in the United Kingdom and Germany (Appendix 3. Table A3.1).

A recent study on the prevalence of self-reported data on overweight and obesity in the Netherlands (Schokker et al., 2006) indicates that between 1981 and 2004, overweight in men rose from 37% to 51%; for obesity the figures rose from 4% to 10%. In women, overweight rose from 30% in 1981 to 42% in 2004; obesity from 6% to 12% in the same period. If this trend continues, then by 2015 an estimated 15-20% of the total adult population in the Netherlands will be classed as obese.

In boys and girls, obesity prevalence doubled between 1980 and 1997, and then tripled between 2002 and 2004. For boys, the current prevalence is age-related and lies between 9.2% and 17.3% for overweight and between 2.5% and 4.3% for obesity (Schokker et al. 2006). For girls, the prevalence varies between 14.6% and 24.6% for overweight and between 2.3% and 6.5% for obesity. According to another estimate, the current prevalence of obesity for Dutch boys is an average of 2.9% and for girls 3.3% (Van den Hurk et al., 2006).

In the Netherlands, overweight and obesity are more prevalent in population groups with a lower educational level and in Turkish and Moroccan ethnic groups (GR, 2003). Moreover, overweight and obesity in the Netherlands are related to health inequalities – something that also applies to other countries (Pickett et al., 2005).

The prevalence of overweight in youth communities is high, especially in Southern European countries with the highest in Italy (36%) and Spain where the percentage of 6 and 7-year old children with overweight rose between 1985 and 1996 from 23% to 35%. In the UK as well, the problem of overweight children is a far more pressing issue than in the Netherlands (see Appendix 3, Table A3.2).

Thus, the Netherlands shares a growing problem of overweight with many other Western and European countries. International comparisons as well as the current trends in the Netherlands show that the Dutch epidemic (as it is known) could be much worse than it actually is at present.

Overview of this chapter

This chapter will first of all address the international frameworks that have been developed in connection with policies on overweight and obesity. Subsequently, the policy practices will be presented, starting with a summary of interventions proven to be effective for reducing problems of overweight. Then the Dutch policy and Dutch initiatives to reduce overweight will be discussed. Following this we will describe how, in a number of countries, action plans have been developed, covenants drawn up and proposals (whether controversial or not) or unusual initiatives put forward to tackle obesity. Special attention will be paid to Finland, the United States and France.

In addition, questions will be raised on where success has been achieved in the drive to reduce overweight, to stimulate physical activity or to encourage a healthier diet. The final section of this chapter (discussion and conclusions) will weigh up the balance of all these approaches in various countries and discuss how public health policy in the Netherlands can benefit from examples and developments taken from abroad.

4.2 International frameworks and policies on overweight and obesity

European Union has set up an action platform

Diet, physical activity and overweight are currently high priority items within the European Union. This subject has also been addressed in the EU Community action programme for public health that runs from 2003-2008. This action programme awards subsidies to various projects working on data collection, the exchange of best practices and bringing together international networks focussed on overweight. The European Commission also funds projects aimed at encouraging a healthy diet and physical activity such as Eurodiet (Nutrition and Diet for Healthy Lifestyles in Europe) and the Status Report on the European Commission's work in the field of nutrition 2002 (Eurodiet, 2002; EC, 2002).

In March 2005, the European Commission launched the EU Platform for Action on Diet, Physical Activity and Health. This platform stimulates all parties involved, including the business sector, consumer movement, health organizations and political leaders, to take up the battle against overweight in the European Union. This platform is also preparing plans for the development of a code of conduct to reduce the levels of marketing of unhealthy foods aimed at children. The committee emphasizes that the problem of overweight needs to receive due attention from other sectors. Examples are agricultural policy in which the production of milk fat is still subsidised, educational policy and the policy of the transport sector.

The EU platform operates under the leadership of the European Commission whose primary role is to ensure that the approach adopted is cooperative and action-oriented. The Commission also has to guarantee that the work activities of the platform are in harmony with those of the European Nutrition and Physical Activity Network and with discussions taking place in the European Council and the European Parliament. The purpose of the platform is to provide a forum for all interested parties at a European level. In this they will be able to explain their plans for the pursuit of healthy nutrition and physical activity and to discuss outcomes and experiences from relevant parties so that a list of best practices can eventually be compiled.

Given the complexity of the problem, most of the participants support a multisectoral approach that includes interaction and coherency between the various EU policy areas. Moreover, many of the parties involved propose paying special attention to children and young people, where the largest increase of overweight has been determined. Furthermore, there seems to be a high demand for improved consumer information on nutrition and especially that which points to clear and evidence-based information.

Various interest groups cooperating at EU level

The fact that many organizations have joined forces at EU level in this matter is seen as a great strength. These include the NGOs, consumer organizations, professional organizations in the public health sector, representatives of food producers, marketers, the catering trade and advertising. However, criticism has also been aired about the presumed and sometimes too big an influence that certain large companies exert in the platform compared to the influence of non-profit organizations. For example, it is not clear who decides which bodies can participate in the platform. Furthermore, hardly any funding is available for non-profit participants. They therefore have to rely on the generosity of others when it comes to buying in expertise, whereas the business sector usually has its own expertise on hand (O'Loughlin, 2006). Consequently it is hardly likely that equal input will be guaranteed from all sides. Moreover, participants from profit and non-profit organizations differ strongly on the importance of regulation.

Finally, in 2005 a Green Paper was published (EC, 2005). The main objective of this paper was to collect more information so that the problems of obesity can be tackled from a European perspective, which compliments, supports and coordinates measures already taken by the individual Member States. At the same time, the Commission wanted to promote the spread of good practical examples within Europe. The Green Paper initiated 260 answers from relevant parties from throughout Europe, including governments within the EU and from Iceland, Norway and Switzerland, the public health community, the food industry, universities and the general public.

Further development of WHO global strategy

In 2000, the Member States of WHO-Europe (European region of WHO) committed themselves to the guidelines of the First Action Plan for Food and Nutrition Policy for the period 2000-2005 (WHO, 2001). This action plan was incorporated in 2004 in the Global Strategy on Diet, Physical Activity and Health (WHO, 2004). The plan was accepted despite heavy opposition from the sugar industry (Norum, 2005). The plan provides the Member States with a number of possible policy measures to tackle problems related to an unhealthy diet and too little physical activity. The plan claims that effective weight control for individuals and risk groups is particularly feasible with the implementation of long-term strategies. Prevention, weight maintenance, treatment of comorbidity and weight loss should all be part of an integrated and intersectoral approach that is aimed at the entire population. Attention must also be given to environmental factors that support a healthy diet and invite people to take up physical exercise. A second WHO-Europe Action Plan for Food and Nutrition Policy is currently under preparation.

At the end of 2006, a ministerial conference on overweight, physical activity and nutrition took place. It was here that the WHO-Europe Member States reported their results on policies for overweight and obesity. One important result stemming from this conference was the 'European Charter on Counteracting Obesity'. This Charter calls for governments to promote a comprehensive approach towards overweight (WHO, 2006b). It suggests that the problems of obesity are not solely due to the responsibility of individual citizens. With this statement, WHO has adopted a clear position. This Charter – that has the support of all the European health ministers – also claims that supranational synchronization between countries is necessary to prevent strict market regulations in some countries leading to a shift in the supply of energy-dense foods and drinks (that contribute to overweight) to other countries.

4.3 Policy measures concerning overweight

In this section, following a brief outline of the complexity of obesity policy, the effectiveness of interventions for the prevention of overweight will be reviewed. Subsequently, the Dutch policy on overweight will be discussed.

Tackling the problems of overweight is an extremely complex policy area

The main points to be considered in the search for effective policy are the complexity of the problems surrounding overweight and the approach that is finally chosen.

However, what is the right and most wanted policy for overweight and obesity is still subject to discussion (Lang & Rayner, 2007). If overweight is defined as a problem of individuals then solutions (care-directed and expensive) will have to be found that focus on the individuals themselves. This basically means that individuals are left to their own devices when it comes to developing their social skills and knowledge in relation to diet and exercise. The increasing incidence of overweight in young children illustrates how this choice for an individual approach is not always effective and that the prevention of overweight also requires a collective and integrated approach (Lang & Rayner, 2007). At present, it looks as if policy for overweight and obesity needs to be multisectoral, integrated and long-term for permanent success to be achieved. In the meantime, more structured policy scope and frameworks are starting to emerge such as those of the WHO strategy.

Prevention of overweight through a multifactorial approach

Many people are not aware of how much they eat or how little exercise they take. Therefore, from an individual perspective, people need to raise their own awareness of their dietary and exercise habits as a first step in a conscious effort to change their behaviour. Moderate daily exercise is more important than peak exercise sessions for preventing an increase in body weight. The interventions should therefore be aimed at increasing the daily physical activity and reducing the energy intake.

Such interventions require a healthy environment that enables healthy choices to be made. Various measures are needed to realize such a healthy environment for the prevention of weight gain (Storm et al., 2006). For example, a healthy school environment can be encouraged by enforcing a minimum number of physical education hours at national level (Storm et al., 2006). Further, ensuring that cycle paths and footpaths are safe for use will encourage people to use them more often. The supply of healthy food at school and work can also be improved. In practice, such a mixture of measures is often difficult to achieve due to different interests being at stake (Storm et al., 2006). The development and implementation of such measures, requires a broad coalition of factors in which national government, local authorities, the business sector, the health care sector, and the general public all carry their own share of responsibility.

4.3.1 The effectiveness of overweight prevention

Evidence on the effectiveness and sustainability of policy and interventions regarding overweight and obesity is still scarce. This is not just due to the complexity of the problems surrounding the onset and battle against overweight, but also because relatively little evaluative research has been conducted, for example, into the effectiveness of policy.

Still too little known about effectiveness

The long-term effects (more than one year) of prevention measures aimed at reducing body weight are often still unknown. This also applies to data on interventions in schools and workplaces. However, it has been shown that adopting a community approach (such as in the project Heartbeat Limburg) and intensive lifestyle coaching in health care settings, can lead to effects on body weight after one year (Bemelmans et al., 2004). In the Netherlands, a lot of research is currently underway aimed at improving the collection of information about the effectiveness of prevention methods. The following organizations are playing a role in this: the Netherlands Organization for Health Research and Development (ZonMw), TNO, the National Institute for Public Health and the Environment (RIVM), the Dutch Heart Foundation and the universities of Utrecht, Maastricht, and Wageningen. The Dutch Heart Foundation considers the prevention of body weight gain as one of its most important research subjects. The Dutch Knowledge Centre for Obesity (KCO), which is housed at the Medical Centre of the Free University of Amsterdam, has integrated knowledge on the causes, treatment and prevention of overweight and has taken on an advisory role with respect to educating professionals.

Limited number of effective interventions known

A few years ago, WHO presented a summary of some conclusions about the effectiveness of several interventions that either reduce or increase the risk of overweight and obesity (Table 4.1) as well as the strength of evidence for their effectiveness.

Table 4-1 Effectiveness of several interventions that either reduce or increase the risk of overweight and obesity (WHO, 2002)

Evidence	Decreased risk	Increased risk
Convincing	Regular physical activity High dietary intake of NSP (dietary fibre)	Sedentary lifestyles High intake of energy-dense food ^a
Probable	Home and school environments that support healthy food choices for children	Heavy marketing of energy-dense foods and fast-food outlets
Possible	Breastfeeding	High intake of sugars-sweetened soft drinks and fruit juices Adverse socioeconomic conditions (especially for women)
	Low glycaemic index foods Breastfeeding	Large portion sizes High proportion of food prepared outside the home Rigid restraint/periodic disinhibition eating patterns
Insufficient	Increased eating frequency	Alcohol

^aEnergy-dense Energy-dense and micronutrient-poor foods tend to be processed foods that are high in fat and/or sugars. Low energy-dense (or energy-dilute) foods, such as fruit, legumes, vegetables and whole grain cereals, are high in dietary fibre and water.

Cost savings through prevention is possible but difficult to prove

The large-scale deployment of the above-named effective intervention measures for improving dietary and exercise behaviour has also been found to be cost-effective (Wendel-Vos et al, 2005). One recent review of eighty kinds of lifestyle advice in the health care sector showed that a weight reduction of 10% after one year can be set against a reasonable health care saving of 650 euro per patient (Bogers et al., 2006). In particular, obesity is associated with many health problems and consequently huge costs are incurred in this area. The prevention of overweight seems to result in substantial cost savings in the medium to long term, although it is difficult to show these savings in detail (Visscher & Seidell, 2001).

The effectiveness of medical treatment for severe overweight is not always sustainable

According to international guidelines, the treatment of obesity should initially be aimed at a permanent weight loss of approximately 10% (GR, 2003). Achieving this goal can lead to a significant health gain being made. Depending on the degree of overweight and comorbidity present, a choice can be made for an integrated approach aimed at changing behaviour, such as diet therapy or treatment by a behavioural therapist, and a change in cognition. This treatment may or may not be combined with pharmacological or surgical therapy. In children with obesity, group behavioural therapy, in which the parents also participate, has been shown to be the only effective strategy.

Based on strict selection criteria, persons with extreme obesity are eligible either for medicinal or surgical treatment. Both treatment strategies need to be applied in combination with a programme for weight maintenance. The reports on both medicinal and surgical treatment are positive, in terms of weight loss, improvements to health risk factors, and quality of life. The most significant problem with the current treatment for obesity is that once weight loss has been achieved, it is not usually maintained. This does not, however, mean that extreme obesity is untreatable but rather points to the fact that whilst the therapy was shown to be effective, it was probably not pursued for long enough (GR, 2003). One problem related to this is that of limited or absent appropriate funding on the part of health care insurers. Policy for overweight in the Netherlands

Policy often approaches overweight in relation to individual choices

In 2006, the then Minister of Health, Welfare and Sport Affairs claimed that individuals are responsible for their own health and that citizens can be reproached regarding their behavioural choices that could have consequences for their health. The government saw itself fulfilling the role of encouraging people to undertake more physical activity and to eat healthier food and in smaller quantities. A national framework for specific actions was outlined in the first prevention policy document, 'Living Longer in Good Health: also a question of healthy lifestyle' (VWS, 2003), which had overweight as its focal point. The approach towards overweight in people from birth until 19 years of age, was also one of the primary targets of the health policy for four major Dutch cities (Grottestedenbeleid 2005-2009) published in 2003. In the second prevention Memorandum, 'Opting for a healthy life', overweight remained a focal point for which the national government indicated its primary focus was the following positive health aspects: healthy diet and healthy physical activity.

In the Memorandum, 'Time for sport – exercise, participate, perform' (VWS, 2005), people are advised on how to improve their health by doing more sport and physical activity. To achieve this goal, a National Action Plan for Sport and Exercise (NASB) has been set up (see VWS, 2007) which works on the following three principles: more than one sector participates, inactivity is the main focus, and mass media campaigns, such as the FLASH campaign running from 2002 tot 2007 support the activities.

Covenant signed, implementation still under development

At the start of 2005, the Minister of Health, Welfare and Sport (VWS) and the Minister of Education, Culture and Science (OCW) signed the Covenant on Overweight and Obesity: a balance between eating and physical activity. Co-signatories were from the food industry, the catering trade, sports organizations, and employers and health care insurers. Together they want to see the negative trend reversed by 2010 – less overweight among young people and no more increase among older persons (Van Wijngaarden, 2005). The actions that will be taken in relation to this have been specified in the four settings: home, school, work and recreation. In addition, special attention will be paid to two target groups: young people and people with a low socio-economic status. With this move, an important first step towards successful policy has been taken, namely the collaboration between various departments and parties that can influence the energy balance of the Dutch population. In October 2005, the action plan 'Striking the right energy balance' was handed over to the Ministry of VWS. The plan outlines what the partners want to achieve and which specific actions will be taken for this purpose. The subsequent steps will include the obligations and responsibilities of the partners and a description of who will do what, how the activities will be funded, how the results will be measured and how the implementation will be supported.

In the Netherlands, various organizations are concerned with the prevention of overweight and the promotion of a healthy diet and/or physical activity. In 2006, the Netherlands Nutrition Centre published a guideline for the Prevention of overweight in local health care policy, commissioned by the Ministry of VWS. For this purpose, the following organizations worked together: National Institute for Health Promotion and Disease Prevention (NIGZ), National Institute for Public Health and the Environment (RIVM), Dutch Knowledge Centre for Obesity (KCO), Netherlands Institute for Sport and Physical Activity (NISB), the Dutch Heart Foundation, the Dutch Municipal Health Services and the Association of Netherlands Local authorities (VNG). At local level, it is mainly the various departments of the municipal health services (GGD) and the homecare organizations that are active. In addition, various commercial organizations are involved in helping people to lose weight by selling slimming products or programmes such as that of the Weight Watchers organization.

Local level approach towards overweight also important

The local authorities are responsible for the health and welfare of their residents. This is legislated by law in the Social Welfare Act and the Public Health Act (WCPV). Tackling the problems of overweight and obesity has the most chance of success when policymakers from different areas collaborate; after all, the direct living environment can be influenced by local policy. The aim then is to make the healthy choice the easiest choice for people to make. Important policy areas are, health care, welfare, sport, recreation, education, youth, spatial planning, traffic and transport (Van Wijngaarden, 2005).

As a basis for a concrete, but at the same time integrated and structured approach, the NIGZ presented the fifteen rules for growing up with a healthy weight to the VNG in November 2005. (see Text block 4.1). These rules are intended to act as the guiding principle for the behaviour needed for a child to grow up in the Netherlands with a healthy body weight. For this purpose, various people are being called upon to join in a combined effort for success: the young people themselves, parents, grandparents, teachers, and also local authorities, and the food industry. The NIGZ will start to implement the above plans together with a number of local authorities and GGD departments.

Text block 4.1: Fifteen tips for growing up with a healthy weight

1. Get fit and healthy before getting pregnant
2. Stay fit and healthy while pregnant
3. Breastfeed at least 6 months
4. Have breakfast daily
5. No sugary drinks under the age of 5
6. Pay attention to your child by playing with him/her
7. Spend no more than two hours a day watching tv or playing on the computer
8. Play (outside) and be active
9. Knowledge of food, preparation and flavour
10. Snack moderately
11. Drink water
12. Walk and cycle to school
13. Join a sports club
14. Know your body
15. No alcohol under the age of 16

Source: NIGZ, more information: www.nigz.nl/overgewicht

4.4 Comparison of policies for overweight and obesity between countries

Many countries have an action plan for overweight and obesity

In 2005, the year of the pilot study, nineteen EU Member States had policy documents in place directed at nutrition or overweight, four countries (Czech republic, Poland, Cyprus, and Greece) had a draft policy document under preparation and two countries (Austria and Hungary) had a public health policy which covered nutrition and lifestyle but not a separate policy document (WHO, 2006a). One country, Luxemburg had no action plan. Countries that did not have a specific document relating to this issue did however, have various programmes related to nutrition. The areas for which action has been proposed, are baby food (promotion of breastfeeding), food safety, increasing physical activity and reducing levels of overweight.

Hungary, Spain and Sweden all have an action plan aimed at lifestyle in which diet and physical activity are combined. An increasing number of countries have specific strategies for approaching the issues of overweight and obesity. Denmark developed the first action plan for overweight in 2003, followed by Spain's strategy for diet, physical activity and prevention of obesity in 2003, Ireland's strategy for obesity: the policy challenges, and Portugal's national programme for obesity in 2005. Recently, Italy has also developed a national plan for prevention focussing on overweight. Finland, the Netherlands, Slovenia and the United Kingdom all have documents that aim at physical activity in relation to either a general public health plan or nutrition plan. The implementation of action plans takes place through appointed advisory boards, through the drawing up of guidelines for healthy diets, through advice on healthy nutrition and through monitoring and surveillance systems. Countries with national institutes that advise the government appear to be the most effective in developing and implementing policy proposals.

Despite more policy plans, still no decrease in the prevalence of overweight

Whilst in many countries advances have been made in implementing policy aimed at nutrition and lifestyle, most countries are still being confronted with an increasing prevalence of overweight and obesity. It is therefore not surprising that many countries with an action plan that has been in place for some time, have not reached their initial goals. One of the main reasons for this shortcoming lies in the original implicit assumptions of the action plans (Crombie et al., 2005). Moreover, an improvement in lifestyle is still mainly regarded as the individual's responsibility, even though it is becoming increasingly clear that recommendations for healthy eating and more physical exercise must be supported by measures that create an environment which facilitates a healthy lifestyle.

Many plans in national policies against obesity have not been realised

A Scottish report compiled for the preparation of policy in Scotland, compared obesity policy in fourteen (mainly Anglo-Saxon and North European) countries and presented a number of interesting observations (Crombie et al., 2005). Various countries have reported the necessity of further development to their policy in this area; for example, many countries agree that policymakers need to be increasingly and suitably made aware that overweight is indeed a problem. Moreover, there is a need for policy aimed at social and environmental factors that could act as a stimulus to more physical exercise and a healthier diet. Many countries also point out that there are plenty of options open where governments can take action. However, they do not indicate whether these actions will actually be deployed.

The Scottish report expresses disappointment at the fact that although many countries indicate a desire to explore the options of collaborating and developing policy plans with those working in the field, as well as achieving an effective exchange of information, they fail to explain how this can be realized. It is also striking to note that fiscal and legal measures that were recommended by WHO and in scientific articles are nearly always missing from the policy documents studied. WHO strategy emphasizes the need for national policy strategies to be supported by legislation, a good infrastructure, implementation programmes and sufficient funding. Most of the national policy documents studied for this report did not comply with this (Crombie et al., 2005).

Good examples from Finland, the United States and France

Some countries appear to be more successful in their approach to obesity than others. We will therefore now outline some of the possible elements for successful policy. The following three countries will be studied in more detail: Finland, the United States and France. Then a few striking elements of policies for overweight and obesity in other countries will be discussed.

4.4.1 Finland: emphasis on physical activity and intersectoral collaboration

Overweight also constitutes a problem in Finland. One-fifth of the Finnish working population (25-64 years) is obese. Only one-third of men and half of the women in Finland have a healthy body weight (BMI between 18.5 and 25; Finnish Heart Association, 2005). Overweight in children has increased faster than in adults. Between 5% and 10% of young children are overweight. Overweight in boys between the ages of 12 and 18 years has increased from 7% in 1977 to 17% in 1999 and in girls from 4% to 10% in the same period. During this twenty-year period, children and young people were less active and started to drink more soft drinks and eat more snack foods (Finnish Heart Association, 2005).

Whilst Finland has no separate action plan for the approach towards overweight, in 2005 the Finnish Heart Association (FHA) came up with an action plan to promote heart-related health for the period 2005-2011. The Finns are very aware of their national public health success story in the last ten years of the twentieth century. Due to a broad collaboration between the ministries and other stakeholders involved, they managed to achieve good results in reducing the mortality of cardiovascular disease. However, some problems have still not been solved and the earlier success apparently needs to be revived. An action plan has recently been developed for this purpose. The first aim is once more associated with an intersectoral approach: the promotion of health through all kinds of policy (promote health in all policies). With this, the FHA hopes to encourage a strengthening of national and local structures by setting up networks and collaborative initiatives for the promotion of good health. Another proposal is to impose an obligatory health impact assessment for all government decisions that need to be taken. This objective is also being pursued at the EU level.

Long-lasting political support has led to an increase in physical activity in Finland

Despite the increase in the prevalence of obesity, Finland has booked considerable success with its policy for improving levels of physical activity in the population. Of all the EU countries, only Finland has shown a continuous increase in their population's physical activity (WHO, 2002). Between the late 1970s and mid-1990s, the percentage of the population undertaking regular physical activities rose from approximately 40% to 60%. One European study from 2002, showed the Finnish population to be the fittest of all Europeans (EC, 2003).

There are several reasons for Finland's success regarding physical activity. Since the 1990s, three national programmes have been initiated in Finland aimed at improving the nation's health. All of these programmes receive political and financial support and are characterized by a bottom-up structure: implementation of projects at local level and intense collaboration between government institutions. A new institute solely focussed on physical activity studies has been set up. Local and municipal institutions such as sports clubs, health centres and schools also supported the actions. The evaluation of the first programme showed that issues such as personalized advice, a consumer-based approach and common aims were important success criteria.

The second programme focussed on promoting regular physical activity in people who were used to being sedentary or inactive for much of the day. This took place through local projects. The third programme more or less adhered to the strategies of the previous ones, although more emphasis was placed on improving the environmental factors to facilitate more physical activity. Various ministries, such as those for Transport and Communication, and the Environment and Agriculture acted as sponsors, thereby emphasizing the multisectoral character of the Finnish policy.

However, the question still remains as to why this intensive policy, often considered to be a success, has not yet brought about a decrease in the prevalence of obesity in Finland. It is possible that a sharper increase has been prevented in Finland but that this country still needs to pay more attention, for example, to healthy nutrition.

4.4.2 United States: need for effective action becoming more urgent

It may seem somewhat of a contradiction to look at the health policy of the United States when it comes to discussing overweight and obesity. After all, nowhere in the world are there so many people with overweight and obesity as in the United States. But this means that the problem is so prominent and urgent that it has also become one of the main pressing priorities of the US Federal Government. In the past, the same scenario applied to the issue of tobacco smoking in the United States where ultimately considerable success has now been achieved. At this point it should also be noted that there are interesting and significant policy differences between the various American states. Consequently, we think it is worthwhile taking a closer look at the US policy for overweight.

In 1960, approximately 45% of American adults were either overweight or obese. At present, almost two-thirds of the American adult population is affected – according to data from the National Health and Nutrition Examination Survey (NHANES, 2006). The obesity prevalence amongst adults has increased from 15% in 1980 to 32% in 2004 amongst a total population of more than 66 million persons. The percentage of children who are overweight has tripled since 1980. Amongst the population group of children and teenagers (2-19 years), 17.1% of these young people out of a total of 12.5 million, are overweight (NHANES, 2006). This means that young children are developing diseases and disorders that up until a short time ago were very unusual at this age. On average obesity appears to be more common in African and Hispanic American populations (De Bekker, 2006). This is referred to as, the Biggest Belt in the South, because the problem is concentrated in nine out of the ten most southern American states (TFaH, 2006).

Surgeon General and Chronic Disease Directors take the lead in the United States

Many initiatives are being unfolded in the United States at both federal and state levels. One important step in the federal policy was the Surgeon General's call to action in 2001 to prevent and decrease overweight and obesity. This call for action was the first occasion on which many parties involved in this issue were brought together and priorities and strategies were determined to reduce overweight in the United States – Department of Health and Human Services (HHS, 2001). Moreover, the Centers for Disease Control (CDC) have funded a large number of programmes and processed statistical information on overweight and obesity. The Trust for America's Health (TFAH) is a non-profit organization that has been evaluating intervention programmes for overweight and giving advice on policy and effect strategies since 2004. In 2006, research showed that experts who are involved in the battle against overweight – the so-called Chronic Disease Directors – agree that no quick fixes are available for the obesity epidemic and that the prevention of overweight requires a holistic and long-term approach. They have signalled a number of important issues of concern:

- insufficient financial means for the serious and long-term support of strategic attempts to prevent overweight
- lack of political support to place overweight and obesity high on the agenda
- difficult battle against the persistent opinion that overweight is a problem for the individual instead of society as a whole
- insufficient translation of research into practical implementation in policy and intervention programmes
- the need to determine different ways for measuring success and behavioural changes other than weight loss and BMI measurements

The Chronic Disease Directors have formulated a number of priority areas for various target groups. For example, they say that children should be approached through their family and through their school setting whilst for adults, the workplace should be the most important setting for prevention initiatives. Companies that subsidize fitness opportunities for their staff, or that take other measures to promote more physical activity, should be rewarded by the government.

Well-known and effective actions in the United States

A number of concrete initiatives taken in the United States have been evaluated by the TFAH as either having a high chance of success or as being effective to some degree. The so-called Victory Camps for young overweight people between the ages of 11 and 17 years, have since been adopted by the Netherlands. The central issues of this approach are diet, exercise, psychology and pleasure. This has led to reports of positive effects on body weight and self-image in the Netherlands (Bruil et al., 2006).

In addition, there is a whole range of preventive measures taken at federal level, such as MyPyramid developed by the US Department of Agriculture in collaboration with the Department of Health. Using the MyPyramid plan, people are able to make their own profile via Internet and to calculate exactly what they should eat and in which quantities. This plan is a follow-up to the Food Guide Pyramid and contains the most recent version of the food guidelines and recommendations on physical activity.

According to the new policy of the American Beverage Association, only water and pure fruit juice should be available to children of primary school age, and for children in high school, only low calorie drinks or those with high nutritional value. Even the big soft drink companies have voluntarily agreed that they need to reduce the size of the portions and, therefore, the daily calorie intake that children receive in a single day. With regards to this, we could raise questions about the issue of replacing soft drinks containing sugar in schools by drinks containing artificial sweeteners instead of mineral water or unsweetened fruit juices.

One remarkable initiative in the US that deserves some attention is the daily advice given on disease prevention and health promotion – largely on diet and physical activity – which the government has offered via Internet since 2005 (www.hhs.gov/news/healthbeat).

Another interesting development is the arrival of personal responsibility contracts. These require insurers and their clients to enter into a contract in which agreements are stated concerning healthy behaviour. In West Virginia for example, citizens state in such contracts that they are working on their health issues. With this they can receive bonus points for additional care services or lose their insurance cover for some disorders or drugs. However, some legal discussion is still taking place regarding this regulation (De Bekker, 2006). Whilst such contracts will probably meet with opposition in the Netherlands, it will be interesting to follow the consequences of this development in those areas where the contracts have been introduced.

4.4.3 France: many new initiatives including new legislation

According to self-reported data from 2006, approximately 36% of French women and 47% of French men aged fifteen years and older are suffering from overweight, while 13% of women and nearly 12% of men are obese (WHO Nutrition Policy Database, 2006). The percentage of children who are overweight or obese in France has increased from 3% in 1960 to 16% in 2000 (WHO, 2005). This is a sharp contrast with the image of France where according to tradition, food has always been prepared and consumed with the greatest care and attention. It seems that even France cannot escape the current trend of increasing overweight and obesity.

The French Ministry of Health launched the National Programme of Nutrition and Health (PNNS) in 2001. This programme contains nine spearheads of which one is aimed at stopping the increasing prevalence of overweight in children. In 2004, the EPODE (Ensemble prevenons l'obesite) programme was started (Preventing child obesity together). This programme is currently being implemented in ten large French cities. The aim is to stimulate teachers, school doctors, health care workers and other involved parties to take initiatives for providing people with information on nutrition and encouraging them to do more sport and other physical activities.

Public health legislation forbids soft drinks to be sold in school vending machines

The prevention of obesity in France has been included in public health legislation since 2004. This new French Bill that came into force on 1 September 2005, outlined numerous measures to be taken: schools were to be prohibited from selling unhealthy food and sugar-sweetened soft drinks in automatic vending machines and the quality of meals provided to students had to improve. Further, an extra surcharge has been imposed on premix (containing alcohol) drinks. Taxes on sweets, junk food and soft drinks containing sugar and syrup are also being considered. In addition, all printed food and drink advertisements are required to carry a health warning. Advertisers who do not comply with this regulation will be charged a levy of 1.5% of advertisement costs, which will be directly donated to the body that promotes healthy living. An attempt to impose an accompanying public health warning on all television advertisements for food and drink failed, due to a lack of consensus on the burden of proof concerning the effect of food advertising on television and its connection with overweight (WHO, 2006a).

Further measures France took in 2005 were the setting up of the Haut Comité de lutte contre l'Obésité [National Committee to fight Obesity] and the Observatoire de l'épidémie d'obésité [Obesity Epidemic Monitoring Agency] as well as an organization for a national campaign to increase awareness of the risks associated with the obesity epidemic.

4.4.4 Striking initiatives against overweight in other countries

Minister of fitness appointed to improve the health of the British nation

If the current trend of overweight continues, one-third of men in the United Kingdom will be obese by the year 2010. The prevalence of obesity in adults has risen by 38% since 2003. In 2010, it is expected that 22% of girls and 19% of boys between the ages of 2 and 15 years will be affected by chronic obesity. Girls under the age of 11 years are particularly at risk. Currently, the UK Minister of Public Health has been assigned the task of increasing the physical activity of the UK population. She wants people to build physical activity into their daily routines to create a healthier nation in the run-up to the 2012 Olympics that will be held in London. To achieve this, the minister will be working across all government departments to develop a new fitness strategy for England.

British television chef achieves good results in schools

One striking British phenomenon is Jamie Oliver, a TV chef also known from the title of his book as 'the naked chef'. For some years now he has made considerable efforts to get healthy meals into schools – the so-called 'feed me better school dinners'. Jamie Oliver has achieved good results with his television programme and accompanying campaign. For example, the total sale of frozen chips to schools has dropped sharply and the sale of other fatty snacks and crisps has decreased. Now more water and cooled fruit juices are sold. In 2005, Oliver handed over a petition to the British government that contained 217,000 signatures. In it he pleaded for more financial subsidy for school dinners. As a result, the British government agreed to provide a further 407 million euro for improving the quality of school dinners.

Parents treated as a risk factor in German policy on overweight

In Germany, the platform Diet and Physical Activity was launched in 2004, and in 2005 an organization was set up to coordinate the activities of the platform (WHO, 2006a). The chairman of the platform expects this to be one of the most far-reaching policy initiatives ever taken in Europe, (www.ernaehrungundbewegung.de). Prevention is considered to be the only solution for the problem of overweight. Counteracting measures should be aimed at young children and their parents. Whilst there are more countries that involve parents in preventive activities, in Germany parents are also seen as a risk factor for overweight. The risk for obesity in a child is 40% higher if one parent is obese, and 80% higher if both parents are obese. Irrespective of whether it is genes or upbringing in the form of a bad example that plays the greatest role here, it is often evident that parents are unable to help their children maintain a healthy body weight. Apart from the various government departments involved in the platform, such as the Ministry for Food,

Agriculture and Consumer Protection, the food industry, food producers, sport organizations and insurance companies, parents also have a specific role in the Platform in the Federal Parents' Council.

Ireland: concrete collaboration between the public and private sectors in the next ten years

In May 2005, on behalf of the Irish Taskforce on Obesity, the Minister of Health and Children launched an important strategic report containing 93 recommendations for reducing overweight (national Taskforce on Obesity, 2005). The recommendations are specific and aimed at six sectors: the national government, education, society, the health care sector, food producers and physical environment. The main emphasis lies on the collaboration between the big stakeholders and the involvement of both the public and private sectors. Concrete recommendations are, for example, to use a certain percentage of the traffic budget for pedestrian paths; multisectoral action against the marketing and advertising of products that contribute to body weight increase – especially marketing aimed at children; the development of a national nutrition policy and the regular critical assessment of health claims on products.

Shortly after the publication of the report, the new National Nutrition Policy appeared which adopted many of the taskforce's recommendations. The policy will cover ten years (from 2006) and be further structured and coordinated by the Ministry of Health and Children. Some of the important aims are:

- the development of actions to enable parents and families to more easily prepare meals that are healthy and affordable. The aim here is to involve organizations such as the national Parents Council
- to stimulate young people to eat more vegetables and fruit by initiating practical programmes such as Food Dudes, see www.fooddudes.ie
- to provide information and training that enables key people (especially in health care) to help address the problem of bad diets in young people
- to prevent young people who are overweight from developing obesity

The campaign that was launched as a follow-up is entitled, '5 Steps...to a Healthier You' and has various components including a well-designed website with a wealth of information, games and links. For example, by presenting photos of meals and snacks, the website shows which alternatives are healthier and the effect that this can have on body weight if you decide to choose the healthier option more often www.healthysteps.ie.

Policy in Latvia conflicts with the American soft drink industry

In Latvia there has been a ban on the sale of unhealthy food and drink in schools since 2006. The Latvian government has taken this policy a step further than many other countries and wants to ban all products that contain artificial additives such as artificial colourings and flavourings, sweeteners and caffeine. Instead of sweets, crisps and soft drinks, the school canteens are supplied with unsalted nuts, dried fruits, wholemeal products, oatmeal cookies, mineral water and unsweetened fruit juices. According to the government, the reason for this extensive ban is the increasing number of children who are either overweight or who suffer from allergic reactions as a result of artificial colourings and flavours. However, this policy has led to an international conflict between the government and the food industry. One reaction came from the former American Minister of Foreign Affairs, Madeleine Albright, who is now director of the Albright Group LLC with Coca-Cola as one of its clients. She wrote a letter to the Latvian Prime Minister Vaira Vike-Freiberga, expressing concern that any such ban would harm the interests of US drink manufacturers, particularly Coca-Cola. Incidentally, there is also a ban on the sale of sweetened drinks in primary schools in the United States. This is an interesting example of the clash of interests that can occur between a government's interest (collective health interest) and intervention regarding the power of the free market – as is also seen in policies on alcohol.

Unconventional initiatives also find their way to the policy table in some countries

When searching for literature and especially when screening all kinds of media products, less conventional initiatives come to light. These are often not described in scientific publications and the initiators have therefore usually not been approached by the policymakers. It is possible that these kinds of initiatives

actually belong to the more successful measures. One remarkable example of this kind of initiative is that of top chefs who achieve fame through the television and successful book sales; in the Netherlands, Pierre Wind advocates placing nutrition on the educational curriculum as a permanent item. Also, television programmes such as those seen in the Netherlands where families compete against each other to lose weight and in which viewers are invited to join in at home or look to the Internet for support, could possibly help more people who are overweight than any other kind of intervention programme. More and more focus is being given to these kinds of initiatives by the scientific community and various governments who recognize their potential to help combat overweight and obesity. In some countries, private initiatives have even brought about visible change. For example, we saw that Jamie Oliver managed to obtain a considerable amount of extra money from the British government to produce healthy school dinners. The Netherlands should use these examples to its own advantage. It seems, for example, that the Annual Good Food Prize awarded by the Netherlands Nutrition Centre has enabled some improvement to take place in the Netherlands.

4.5 Discussion and conclusions

In this section, a number of doubts will be discussed regarding the usefulness of pursuing policies on overweight and obesity, the similarities and differences of the various policies, and the discussions taking place about the role of the food industry. This will be followed by the conclusions.

Does it make sense to declare war on overweight?

One question that arises on this whole issue of overweight is whether a war on obesity provides governments with a good solution for the increasing problem of overweight in society. Now and again, the downfalls associated with good intentions are pointed out. For example, Roel Pieterman's lecture, *The Fat Pay Double*, highlights a number of negative side effects associated with policies on overweight (Pieterman, 2006). Dieting whereby people lose weight and then gain it again – known as the yo-yo effect – could be more unhealthy than living with moderate overweight. Moreover, he claims that putting too much emphasis on overweight prevention policy can infringe personal privacy. Nutritional psychologists also point to the sometimes one-sided attitude towards overweight and the limitations of many strategies for losing weight (Roefs et al., 2006). More attention should be placed on the relation that people of this day and age have with their food. In particular, behaviour that is steered by emotions, such as bad eating habits, should receive more attention in the policies aimed at overweight. The stigmatization of children and adults who are too fat can be accentuated in some forms of education and policy promotion and is, therefore, an issue that needs to be addressed during the policy preparation period.

The growing problem of overweight shared by the Western world

The first conclusion that can be drawn from international comparisons of policy documents for overweight and obesity is that it constitutes a large and growing public health problem in almost all developed countries. The problem is particularly alarming in children, which has led to many policy plans being created and actions being taken. The United Kingdom has resigned itself to the fact that what is now known as the epidemic, is about ten years behind the scenario in the United States but appears to be developing in the same direction. Whilst the Dutch statistics are not quite as alarming as those of the United Kingdom, the same lines of argumentation can be used here as well: the increase in overweight and obesity could turn out to be far more serious than we had anticipated. Furthermore, there are no success stories from countries with effective national policies for this problem.

Differences in policies on overweight according to target groups, focus and methods

The policy approach to overweight varies between countries on a number of issues. Italy and Greece emphasize overweight in children as their target group, while New Zealand and the United Kingdom have disadvantaged groups as their target populations. These groups are mainly made up of people from ethnic minorities. In some countries breastfeeding is included in the policy objectives, for example, in Ireland where this health issue falls under the Ministry of Health and Children.

One target group that has remained underexposed in national policy is that of parents and families. Ireland and Germany, however, are the exception here as these target groups have recently been the focus of attention in these countries and involved in the creation of policy through national Parents Councils. In the Netherlands, the project 'Hallo World' has made a start towards approaching parents directly. This project is an information programme through Internet and e-mail that supports parents in the healthy upbringing of their children.

In Finland, one issue that has historically grown in importance to become part of the culture is that of sport and physical activity. All areas of government support this issue by the long-term allocation of financial subsidies for sport events and to schools for the encouragement of much physical activity on a national level. Incidentally, in the Netherlands substantial amounts of funding are allocated for the stimulation of exercise – one point where the Netherlands is possibly a front-runner. France has recently implemented a number of far-reaching measures with its new legislation on public health. It will be interesting to follow the effects of this legislation closely.

Involvement of the food industry is important but sometimes controversial

Some parties involved in policy creation and implementation see the power of the food industry as a source of frustration. In the case of the EU Platform for Diet, Physical Activity and Health, the involvement of the industry does not seem to be primarily aimed at the objectives of the Platform, but more at the interests of the sector to avoid legislation and regulatory requirements that limit turnover. Most parties recognize the involvement of the food industry and many initiatives from within the sector aim at making food healthier, which in principle contributes to solving the problems of overweight and obesity.

In the United States, the large soft drink companies have agreed to reduce the size of their portions. At the same time, the large food production companies do not appear to be doing enough to make their products healthier, if the claims on food packaging are anything to go by (Lang et al., 2006).

Funding of research by the industry is under discussion

Apart from advertisements (that incidentally are not always considered necessary by everyone) the food industry also spends a lot of money on scientific research. Recently, it was shown that research into the health effects of food often have more positive results when the food industry contributes to their costs. The outcome is then often four to eight times more positive than when it is conducted without their contribution (Lesser et al., 2007). One response to this study was a call for the Netherlands to more frequently fund nutritional research with public funds. After all, it is mainly the lack of available university funding that leads researchers to look elsewhere, in this case, to industry. Ideally, the researchers need to be financially independent. Or as an old saying puts it: he who pays the piper calls the tune (Trouw, 2007; Katan, 2007).

Many comparable policy initiatives in Europe

In recent years, much attention has been paid in Europe to the problem of overweight and obesity, especially in children. Taskforces have been set up, extensive national action plans developed and evidence has been collected on effective policy measures and interventions. In all of the countries investigated, the action plans have the same global focus areas and objectives. Policies related to food and nutrition may be created in separate strategies and documents or included in a wider public health strategy policy. Sometimes overweight is the most important objective and contained in a separate nutrition policy. The focus often covers more than one lifestyle factor at the same time.

All countries agree that a thorough approach to the problem of overweight is needed and are aware of the many different aspects that play a role. Intersectoral collaboration is a key concept that recurs throughout the various programmes. The various sectors considered to be important in the codevelopment and implementation of policy plans are: education (schools, universities), transport, food industry, and sport institutions. Bringing together the various parties does not, however, automatically guarantee an effective policy. In daily practice, striking a good balance between the separate and common interests of all the various parties involved is far from easy. Moreover, there are international influences that cannot be counteracted by national collaboration but require international collaboration.

Most policy plans focus on a limited number of settings. The local community, school, and the workplace are the locations deemed most suitable for implementing measures to combat overweight or where information campaigns should be aimed at.

International collaboration at EU level important

In addition to the local policy level (which includes the setting and the community), the international policy dimension regarding overweight is important. Besides the international stimulation of policy realized by the provision of policy frameworks and the encouragement of international collaboration through WHO and EU networks, the EU Member States are also working towards unambiguous rules on marketing and product information and other such issues. As well as the efforts of Member States and NGOs aimed at prevention, market parties also have a clear influence at the EU level. As all EU Member States share the growing problems of overweight action is needed at EU level. For example policy needs to be developed in the areas of agriculture or transport, and a proactive attitude on the part of the national ministries of health is needed in all relevant EU advisory boards.

Learning from each other – an important and feasible option

Whilst international differences in history, culture or habits might mean that policy measures from other countries cannot always be directly translated into the Dutch situation, trying to identify certain elements that could be useful is still important. For example, successful initiatives such as the American ‘Colour Me Healthy’ and VERB projects could be copied to create Dutch equivalents. Like in the United States and Ireland, all programmes aimed at young people should be accompanied by attractive websites containing clear information and useful links. Further, the idea of Victory Camps has been adopted in Europe and the first results appear to be promising. At policy level, the possibilities of assigning a policy official – or as in the case of the UK, a minister – for looking into the effects of policies in areas other than health care should be examined, to see whether or not these could also have an effect on the issue of overweight.

Learning from difficulties and barriers encountered in other countries

Learning from the difficulties and barriers that other countries have experienced in creating effective policy for overweight is a useful learning curve. In the United States, for example, a lack of political support for placing overweight and obesity high on the agenda has been signalled – this obstructs the process of effective policy. Political support for all aspects of overweight that need to be addressed is also vitally important in the Netherlands. Here, as equally in other countries, self-regulation is one form of policy that does not always lead to an effective approach towards overweight. This approach appears to encourage some parties to relinquish their obligations to create or adhere to clear regulations and legislation.

Several key conclusions can be drawn from the international comparisons about overweight and obesity policy described in this chapter.

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

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

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

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

The control and prevention of overweight will benefit from an EU-wide approach.

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

References

- Baal PHM van, Heijink R, Hoogenveen RT, Polder JJ. Zorgkosten van ongezond gedrag. Zorg voor euro's - 3. RIVM-rapportnr. 270751015. Bilthoven: RIVM, 2006.
- Bekker P de. Preventie en bestrijding van overgewicht en obesitas in de Verenigde Staten. *Intermezzo* 2006;6(4):24-26.
- Bemelmans WJE, Wendel-Vos GCW, Bos G, Schuit AJ, Tjihuis MAR. Interventies ter preventie van overgewicht in de wijk, op school, op het werk en in de zorg. Een verkennende studie naar de effecten. RIVM-rapportnr. 260301005. Bilthoven: RIVM, 2004.
- Berg SW van den, Scholtens S, Wijga AH, Verschuren WMM, Boer JMA. Overgewicht bij jonge kinderen en volwassenen: kwantificeren van de kloof tussen energie-innemings- en energieverbruik. RIVM-rapportnr. 350020002. Bilthoven: RIVM, 2006.
- Bogers RP, Vijgen SMC, Bemelmans WJE. Costs of lifestyle interventions within health care and the amount of weight loss achieved. RIVM-rapportnr. 260701002. Bilthoven: RIVM, 2006.
- Bruil J, Vries SI de, Dommelen P van, Chorus A, Baan-Slootweg OH van der. Evaluatie van Victory Camp en Real Victory 2004- 2005: resultaten van het zomerkamp en de nazorg voor jongeren op overgewicht, gedrag en kwaliteit van leven. TNO-rapport 06.048. Leiden: TNO Kwaliteit van Leven, 2006.
- Colditz GA. Economic costs of obesity and inactivity. *Med Sci Sports Exerc*, 1999;31(1 1Suppl):S663-667 (review).
- Cole TJ, Bellizzi MC, Flegal KM, Dietz WH. Establishing a standard definition for child overweight and obesity worldwide: international survey. *BMJ* 2000;320(7244):1240- 1243.
- Crombie IK, Irvine L, Elliott L, Wallace H. Public health policy to tackle obesity: an international perspective. Edinburgh: NHS Health Scotland, 2005.
- EC, Europese Commissie. Protection. Status report on the European Commission's work in the field of nutrition in Europe. Luxembourg, DG Sanco, October 2002.
- EC, Europese Commissie. Physical Activity. Special Eurobarometer. 183.6; wave 58.2. European Opinion Research Group. Luxembourg: DG Sanco, 2003.
- EC, Europese Commissie. Groenboek. Bevorderen van gezonde voeding en lichaamsbeweging: een Europese dimensie voor de preventie van overgewicht, obesitas en chronische ziekten. Brussel: DG Sanco, 2005.
- Energie in Balans (actieplan). Convenant Overgewicht. http://www.convenantovergewicht.nl/assets/Image/actieplan_ener-gie_in_balans.pdf, 27 October 2005.
- Eurodiet: Nutrition & Diet for Healthy Lifestyles in Europe Science & Policy Implications. DG Health & Consumer Protection. Co-ordinated by university of Crete School of Medicine, 2002.
- Finnish Heart Association. Action for promoting Finnish heart health for the years 2005-2011. Including promoting heart health and preventing cardiovascular disease as a part of the Finnish Heart Plan. Helsinki: Finnish Heart Association, 2005.
- Flegal KM, Graubard BI, Williamson DF, Gail MH. Excess deaths associated with underweight, overweight, and obesity. *JAMA* 2005;293(15):1861-1867.
- GR, The Health Council of the Netherlands. Overgewicht en obesitas. GR-publicatienr. 2003/07. The Hague: GR, 2003.
- Hurk K van den, Dommelen P van, Wilde JA de, Verkerk PH, Buuren S van, HiraSing RA. Prevalentie van overgewicht en obesitas bij jeugdigen 4-15 jaar in de periode 2002-2004. TNO-rapport KvL/JPB/2006.010. Leiden: TNO, 2006.
- Katan MB. Does Industry Sponsorship undermine the Integrity of Nutrition Research? *PLoS Med* 2007;4(1): e6 doi:10.1371/journal.pmed.0040006.
- Lang T, Rayner G, Kaelin E (City university, Centre for Food Policy). The food industry, diet, physical activity and health: a review of reported commitments and practice of 25 of the world's largest food companies. London: City university, 2006.
- Lang T, Rayner G. Overcoming policy cacophony on obesity: an ecological public health framework for policymakers. *Obesity Reviews* 2007; 8(Suppl. 1),165-181.

- Lesser LI, Ebbeling CB, Goozner M, Wypij D, Ludwig DS. Relationship between Funding Source and Conclusion among Nutrition-Related Scientific Articles. *PLoS Medicine* 2007;4(No.1), e5 doi:10.1371/journal.pmed.0040005.
- Lucht F van der, Picavet HSJ. Sociaal-economische verschillen in persoonsgebonden kenmerken. In: *Volksgezondheid Toekomst Verkenning, Nationaal Kompas Volksgezondheid*. Bilthoven: RIVM, <<http://www.nationaalkompas.nl>> Bevolking\ Segv, 20 June 2006.
- National Taskforce on Obesity. OBESITY: The Policy Challenges. Report of the National Taskforce on Obesity. http://www.dohc.ie/publications/report_taskforce_on_obesity.html (last visited 2 January 2006). Ierland, 2005.
- NHANES. Data Sets and Related Documentation, National Health and Nutrition Examination Survey (NHANES), National Center for Health Statistics, Centers for Disease Control and Prevention. <http://www.cdc.gov/nchs/about/major/nhanes/datalink.htm> (last visited 6 July 2006), 2006.
- Norum K. World Health Organisation's Global Strategy on Diet, Physical Activity and health; the process behind the scenes. *Scand J Nutr* 2005; 49(2):83-88.
- NRC. Citaat De Goeij in: *NRC Handelsblad*, 2-3 July 2005.
- O'Loughlin E. Het Eu Platform voor Voeding, Lichaamsbeweging en Gezondheid. Een blik van binnenuit. *Intermezzo* 2006;4(themakatern),21-22.
- Pickett KE, Kelly S, Brunner E, Lobstein T, Wilkinson RG. Wider income gaps, wider waistbands? An ecological study of income inequality. *J Epidemiol Commun Health* 2005;59:670-674.
- Pieterman R. The Fat Pay Double. Discriminatie en andere mensenrechtenproblemen bij het overgewichtbeleid. Lezing voor het NJCM op 16 June 2006. http://www.rechtsamenleving.nl/page1/files/Pieterman-The_Fat_Pay_Double.pdf (last visited 9 November 2006), 2006.
- Roefs A, Quaedackers L, Werrij MQ, Wolters G, Havermans R, Nederkoorn C, et al. The environment influences whether high-fat foods are associated with palatable or with unhealthy. *Behav Res Ther* 2006;44(5):715- 36. Epub 2005 Jul 21.
- RVZ, Raad voor de Volksgezondheid & Zorg. *Gezondheid en gedrag*. Publicatienummer 02/14. Zoetermeer: RVZ, 2002.
- Salmon J, Campbell KJ, Crawford DA. Television viewing habits associated with obesity risk factors: a survey of Melbourne schoolchildren. *MJA* 2006;184(2):64-67.
- Schokker DF, Visscher TLS, Nooyens ACJ, Baak MA van, Seidell JC. Prevalence of overweight and obesity in the Netherlands. *Obesity Reviews* 2006;8:101-107. doi: 10.1111/j.1467-789X.2006.00273.x.
- Storm I, Nijboer GCW, Wendel-Vos TLS, Visscher TLS, Schuit AJ. Een gezonde omgeving ter preventie van gewichtsstijging: Nationale en lokale mogelijkheden. RIVM-rapportnr. 270061002. Bilthoven: RIVM, 2006.
- TFAH. F as in Fat: How Obesity Policies are Failing America <http://healthyamericans.org/reports/obesity2006/Obesity2006Report.pdf> (last visited 30 November 2006), 2006.
- Trouw. Citaat Katan in *Trouw*: 19 January 2007.
- US DHHS. The Surgeon General's call to action to prevent and decrease overweight and obesity. <http://www.surgeongeneral.gov/topics/obesity> (last visited 3 January 2006). Rockville, MD: US. Dept of Health and Human Services, Public Health Service, Office of the Surgeon General, 2001.
- Vereecken CA, Todd J, Roberts C, Mulvihill C, Maes L. Television viewing behaviour and associations with food habits in different countries. *Publ Health Nutr* 2006;9(2):244- 250.
- Visscher TLS, Seidell JC. The Public Health Impact of Obesity. *Ann Rev Public Health* 2001;22:355-375.
- VWS, Ministry of Health, Welfare and Sport. Kabinetsnota Langer gezond leven: ook een kwestie van gezond gedrag. The Hague: Tweede Kamer [Dutch House of Representatives], 2003.
- VWS, Ministry of Health, Welfare and Sport. Nota: 'Tijd voor Sport - bewegen, meedoen, presteren. The Hague: VWS, September 2005.
- VWS, Ministry of Health, Welfare and Sport. Nationaal Actieplan Sport en Bewegen. <http://www.minvws.nl/dossiers/sport/bewegen/nationaal-actieplan-sporten-bewegen> (last visited 23 April), 2007.

- Wang LY, Yang Q, Lowry R, Wechsler H. Economic analysis of a school-based obesity prevention program. *Obes Res* 2003;11(11):1313-1324.
- Wansink B, Park SB. At the movies: how external cues and perceived taste impact consumption volume. *Food Quality and Preference* 2001;12:69-74.
- Wendel-Vos GCW, Ooijendijk WTM, Baal PHM van, Storm I, et al. Kosteneffectiviteit en gezondheidswinst van behalen beleidsdoelen bewegen en overgewicht - Onderbouwing Nationaal Actieplan Sport en Bewegen. RIVM-rapportnr. 260701001. Bilthoven: RIVM, 2005.
- WHO Nutrition Policy Database. <http://data.euro.who.int/Nutrition>, 2006.
- WHO, World Health Organization. The First Action Plan for Food and Nutrition Policy, European Region 2000-2005. Nutrition and Food Security Programme Division of Technical Support and Strategic Development. Copenhagen: WHO-Europe, 2001.
- WHO, World Health Organization. Diet, Nutrition and the prevention of chronic diseases. Geneva: FAO/WHO, 2002.
- WHO, WHO Europe and Health Evidence Network. WHO Global Strategy on Diet, Physical Activity and Health. Resolution of the Fifty-seventh World Health Assembly. WHA57.17. Geneva: WHO, 2004.
- WHO, World Health Organization. The challenge of obesity in the WHO European Region. Fact sheet EURO/13/05. WHO: Copenhagen, Bucharest: WHO-Europe, 12 September 2005.
- WHO, World Health Organization. Nutrition, physical activity and prevention of obesity: recent policy developments in the WHO European Region. Report in progress - finalization expected based on review at the WHO European Ministerial Conference on Counteracting Obesity. WHO, August 2006a.
- WHO, World Health Organization. European Charter on Counteracting Obesity. www.euro.who.int/Document/E89567.pdf (last visited 12 december 2006). WHO, Copenhagen: WHO, November 2006b.
- Wijngaarden R van. Integrale aanpak van preventie van overgewicht. Een handreiking voor Gemeenten. Leiden: GGD Zuid-Holland Noord, 2005.

DEPRESSION

Contrary to international recommendations, the promotion of mental health is not a component of Dutch policy on preventing depression

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

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

To date, Dutch policies on preventing depression have been aimed at individual risk factors, such as depression symptoms. However, the risk for depression can also be reduced by ensuring healthy living conditions, such as a healthy and safe home environment, good social conditions, good social relationships and a good education for the entire population. The Dutch government could also reduce such environmental risk factors by including these in its policy on preventing depression. This goes hand-in-hand with measures to reduce socio-economic health inequalities.

The current Dutch policy on preventing depression could be further specified in a nationally coherent long-term policy framework

Such a detailed policy framework would support local authorities by formulating and implementing a coherent long-term policy on preventing depression. It could encourage local authorities to continue investing in mental health and the prevention of depression. At the same time, it provides guidelines for a coherent range of interventions based on a nationally supported vision. Furthermore it would allow indicators suitable for evaluating the objectives of a prevention of depression policy to be established.



5 DEPRESSION

Susan Meijer, Jantine Schuit and Nicoline Tamsma

5.1 Introduction

5.2 Policy in the Netherlands

5.2.1 Infrastructure

5.2.2 Action points for Dutch policy

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5.3.1 WHO and EU priorities

5.3.2 How do Dutch policies comply with international policy frameworks?

5.4 Policies of model countries on preventing depression

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5.4.2 Finland

5.4.3 Australia

5.5 Discussion and conclusions

References

5.1 Introduction

Preventing depression is a relatively recent phenomenon in public health policies

Preventing depression as a systematic form of intervention is a relatively recent phenomenon. Only since the 1990s has there been worldwide attention for policies aimed at systematically preventing mental health disorders. Depression is one of the disorders focussed on because it occurs frequently, results in a considerable health care burden and has a negative affect on social participation. Moreover, it is known that depression can be prevented and that effective interventions are available. Preventing depression can lead to health gains. The prevention of mental health disorders is one of achieving a mentally healthy population and is an objective of the European Union (EU) and the World Health Organization (WHO). These organizations regard mental health as a goal in itself, but also regard it as an important basis for a healthy, active population and therefore as an important condition for a healthy society (EC, 2005a; WHO, 2005).

Depressive mood and loss of interest are the most significant characteristics of depression

Depression is a mood disorder. The most significant symptoms are a persistent depressive mood lasting at least two weeks and a severe loss of interest in almost all daily activities (APA, 1994). In addition are several symptoms that have a disruptive effect on a person's functioning, such as an increase or loss of appetite; changes in weight; sleep problems; agitation and restlessness, or to the contrary, inhibition; loss of energy; a sense of worthlessness; concentration problems; delayed cognitions and indecisiveness as well as recurring suicidal ideations. Depression is indicated if a person has at least five symptoms simultaneously, including depressive mood and/or loss of interest. Besides depression, dysthymia and bipolar disorder are other mood disorders. Although fewer symptoms are present in the case of dysthymia, these last for a longer period, usually for a minimum of two years. A bipolar disorder is when depression alternates with periods of excessively elevated mood and energy (Spijker & Schoemaker, 2005). This disorder occurs less frequently than depression or dysthymia.

Depression is a major health problem

Depression is ranked high – fourth place – on the list of causes of the major health burdens worldwide (WHO, 2002b; EC, 2004b). Depression is even predicted to take second place on the list, after coronary heart disease, by 2020. Depression is responsible for 3.9% of the entire health burden in the Netherlands (De Hollander et al., 2006). This is because depression reduces the quality of life for a large group of people. People with depression make considerable use of the health care system and are frequently absent from their workplace. Depression therefore has economic consequences as well: the annual costs for depression are at least 1.3 billion euros. These costs are mainly due to productivity losses arising from absenteeism due to depression (Meijer et al., 2006).

The prevalence of depression in the Netherlands is the same as or somewhat higher than other European countries.

An estimated 5.4% of people aged 13 years and older suffer from depression in the Netherlands; that is more than 737,000 people (Meijer et al., 2006). The number of new cases of depression in the Dutch population is estimated to be approximately 359,000 people each year. Four to ten percent of the Western population suffers from depression every year (WHO, 2000; Simon et al., 2002). These figures cannot be compared to the prevalence of depression in the Netherlands due to various methodological differences in how prevalence is measured. The prevalence figures from seven European countries can be compared as the measurement method used is the same; the 'WHO World Mental Health Survey Consortium' has published prevalence figures for mood disorders – including depression and dysthymia – for these countries (Figure 5.1). The Netherlands has a relatively high prevalence of mood disorders compared to Italy, Germany and Spain. Mood disorders occur more frequently in the Ukraine and France than in the Netherlands. Belgium is at approximately the same level as the Netherlands (WHO World Mental Health Survey Consortium, 2004).

Prevention is an important addition to treating depression

The effectiveness of treating depression at a population level is limited. With the current state of affairs, almost three-quarters of the disease burden cannot be alleviated with treatment (Andrews et al., 2004; Chisholm et al., 2004). There is also a severe influx of new cases. This is why preventive interventions are an important addition to the treatment of depression. They can prevent the occurrence of new cases and maintain the quality of life for many other people with symptoms. Both WHO and the EU believe that the prevention of mental health disorders – primarily depression – should receive priority in public health (EC, 2004a; Jané-Ilopis & Anderson, 2005; WHO, 2004). In a number of recommendations, these organizations have established how European countries or Member States can interpret this. Preventing depression in the Netherlands was mentioned as a spearhead for Dutch policy over the next four years in the recently published prevention memorandum ‘Opting for a healthy life’ (VWS, 2006b).

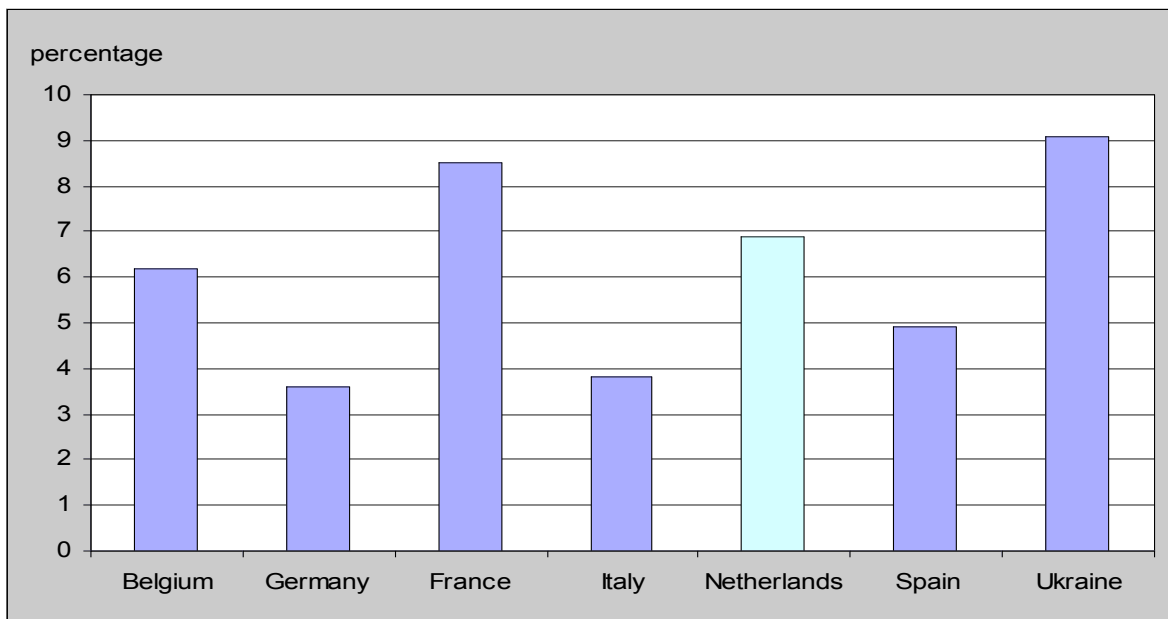


Figure 5-1: Year prevalence of mood disorders according to the DSM-IV in 2001-2002 (depression and dysthymia) (WHO Mental Health Survey Consortium, 2004)

Effective strategies for preventing depression are known

There are different evidence-based prevention programmes and policies that could favourably influence the risk factors of mental health disorders and improve mental health (WHO, 2004). On average, controlled studies reveal an 11% reduction in depression symptoms following a prevention intervention. Some prevention interventions have demonstrated that they can prevent a depressive disorder in people during the onset of depressive symptoms (Meijer et al., 2006; WHO, 2004). An example of this would be the course, ‘In the doom, out of the gloom,’ which is provided in group sessions and individual self-help sessions with minimum counselling. Such preventive interventions seem to be cost effective. They avoid the costs associated with the cases they avert and the interventions themselves are not expensive. Prevention can also have positive effects on people’s psychological capacity and other protective factors (Bohlmeijer & Mutsaers, 2007).

Prevention can also focus on promoting mental health

Interventions for preventing depression can be implemented at various levels (Figure 5.2). They can focus on people who already have depressive symptoms or who have a high risk for depression, for example, children of parents with a mental disorder or people with a chronic illness and their partners (Schoemaker & Spijker, 2005). Such interventions are specifically focused on the prevention of a depressive disorder.

The primary objective of other forms of interventions is to positively influence public mental health. Although these are not specifically focused on preventing depression, they almost certainly contribute to this indirectly (WHO, 2004).

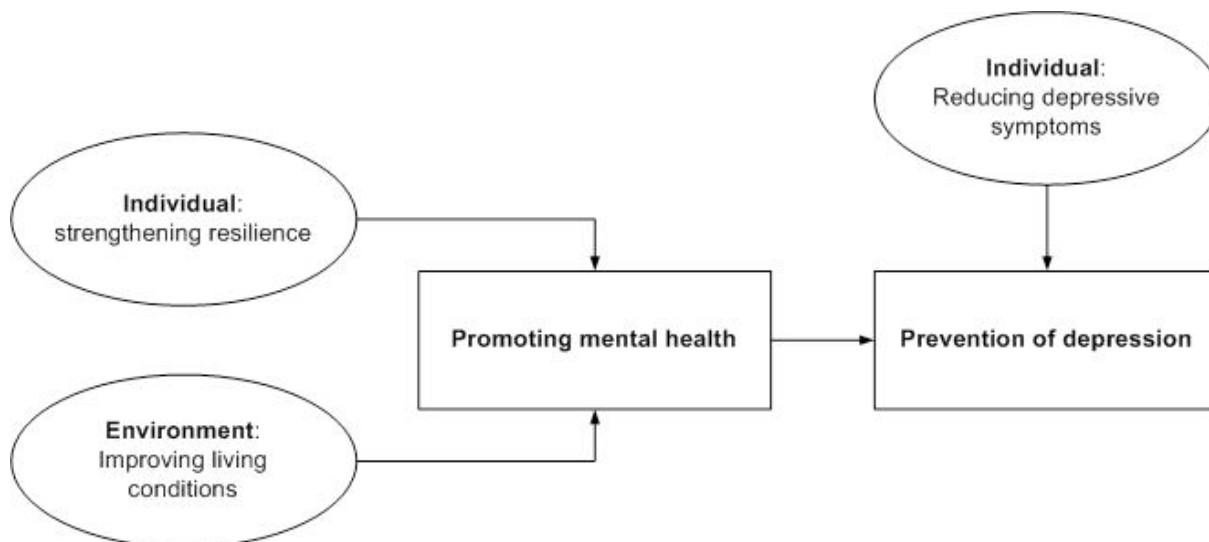


Figure 5-2 Different types of interventions to prevent depression

Broadly speaking, there are two types of intervention that promote mental health: interventions focused on individuals and interventions focused on the immediate environment. The former concern strengthening the capacity of individuals, for example, through courses that strengthen general social and emotional skills, problem-solving capacities or enhance a person’s self-esteem. This frequently occurs in specific settings, such as schools. Psychoeducation is also regarded as a form of mental health promotion. This is primarily focused on conveying information: informing the public directly about mental health disorders, how they can be identified at an early stage, how people can help themselves and who they should approach for further help if needed. The latter has to do with government measures aimed at reducing the risk factors in the immediate environment.

Examples of this are the creation of a safe living environment; the realization of social provisions; counteracting isolation, loneliness, violence and poverty or providing parenting support. When such government measures aimed at positively influencing mental health are implemented in combination with each other, the result is an integrated health care policy.

Model countries chosen on the basis of adherence to international policy frameworks

Preventing depression is a policy priority in many European countries. It was not possible to find countries that have a more effective policy for preventing depression than the Netherlands for this international policy comparison because in most cases, the effectiveness of policies is unknown. This is why we only focused on describing countries who are implementing different – potentially effective - policies for preventing depression than the Netherlands. The international policy frameworks from the EU and WHO regarding the prevention of mental health disorders, among which depression, and the promotion of mental health formed the starting point for selecting the model countries. We selected a few countries with policies that more closely adhere to these international policy frameworks than Dutch policies do. The conditions for this were a) preventing depression has a priority in the country involved and b) available English-language documents with a description of policy objectives. On the basis of this the following countries were selected for the policy comparison: Finland, Scotland and Australia. We want to emphasize that these

are not the only countries that could be used as examples. However, taken together they provide a clear indication of important areas in which Dutch public health policy could develop further. Having said this, it should be noted that we do not know the extent to which the policy plans described have actually been implemented. Finally, only the general policy for the prevention of mental health disorders is described in some of the policy documents used. In such cases we have assumed that this policy also applies to the prevention of depression.

Overview of this chapter

The central question of this chapter is twofold:

1. How does Dutch policy on preventing depression relate to international policy frameworks?
2. What is the national policy for preventing depression in the model countries, and what can the Netherlands learn from that?

Section 5.2 and 5.3 address the first question: Dutch policy on preventing depression (5.2) and its relationship with the international policy frameworks of the EU and WHO (5.3). The second question is addressed in Section 5.4. The discussion and conclusions of the entire chapter are presented in Section 5.5.

5.2 Policy in the Netherlands

The Dutch policy plan for preventing depression is partially linked to the problems signalled in the infrastructure, or rather, the manner in which preventing depression is embedded in policy and the health care system. Therefore, we first of all provide a brief description of the infrastructure before addressing Dutch policy plans.

5.2.1 Infrastructure

National government creates preventing depression framework for local authorities and the health care system

National government, local authorities and the health care system all have a role in preventing depression. The national government is obliged to establish national policy spearheads and a research programme in the area of public health and prevention once every four years (Busch, 2005). The government must also ensure there is a national support structure for public health and prevention. Its legal obligations also include the tasks of promoting interdepartmental and international collaboration. The Ministry of Health, Welfare and Sport (VWS) recently included the prevention of depression as a policy spearhead for the first time in its prevention memorandum 'Opting for a healthy life' (VWS, 2006b). With this memorandum the national government created a framework for local authorities and for initiatives in the area of preventing depression in the health care system. The memorandum builds upon the prevention memorandum from 2003, which called for priority to be given to efforts to prevent depression (VWS, 2003). Therefore, this is new territory at the level of policy.

The role of local authorities in preventing depression via public mental health care

The Dutch government has largely decentralized the prevention tasks to the local authorities. The Public Health Prevention Act (WCPV) gives local authorities the responsibility for public health and prevention in the general public and for youth health care (see the chapter on Youth). This concerns preventive tasks that do not directly stem from a request for assistance by the individual (Bohlmeijer & Mutsaers, 2007). Preventing depression is also part of this responsibility. Local authorities establish their ambitions and choices in the area of public health and prevention once every four years in a local health care policy memorandum (Ruiter et al., 2005). Two-thirds of the local authorities devote attention to the public mental health system in the local health care policy memorandum, and approximately half of them free up

additional funds for it (GGD Nederland), 2004). The most important issues are the prevention of risky stimulant use in young people and the prevention of loneliness in older people. Preventing depression is still largely a new theme.

Considerable collaboration in the health care system for implementing measures to prevent depression

Prevention interventions against depression are provided in different places and by different agencies (Meijer et al., 2006). Prevention teams or prevention departments of secondary mental health services (GGZ) are currently the most important providers of preventive intervention against depression. However, the public health care system, the primary health care system and sometimes the somatic secondary health care system, also provide preventive interventions focused on depression. This frequently occurs in collaboration with the prevention departments and mental health services. The municipal health services (GGD) within the public health care system have the main role in preventing depression. They are active in the early detection and treatment of depression. They coordinate these activities, but also regularly perform these themselves. Health care professionals in primary and secondary care are mainly involved with the early detection and treatment of depression symptoms. The local authorities, particularly via the municipal health service, as well as the health care system must be active in this form of prevention. Local authorities and the prevention departments at the municipal health services frequently collaborate on local policies. The Netherlands has an intricate organization for implementing the prevention of mental health disorders. This makes the Netherlands a forerunner within Europe with respect to infrastructure in the area of preventing mental health disorders (Mik, 2007). As of 1 January 2008, the Health Care Insurance Act (ZFW) is the judiciary basis for activities for people during the onset of psychological problems.

5.2.2 Action points for Dutch policy

Improved infrastructure extends the coverage of measures aimed at preventing depression

With preventing depression as a policy spearhead, the Dutch government wants to achieve the goal of more people receiving preventive assistance to prevent depression in the coming years (VWS, 2006b). Approximately 4000 people receive this assistance every year. That is merely one percent of the 359,000 people who develop depression each year. If preventing depression is to have an affect on public health, the number of people it reaches will have to increase greatly. To increase the coverage of measures aimed at preventing depression, the Dutch government wants to ensure that there is a proper national infrastructure. The Ministry of Health, Welfare and Sport wants to undertake action on a number of development points in the current infrastructure in the coming years. It has therefore created a 'Depression Prevention Partnership', which is a collaboration among different national organizations. This partnership mainly focuses on how the prevention of depression is embedded in local policies and the Dutch health care system. Below we describe the action points formulated by the Dutch government to tackle the development points in the health care system and in local policies.

Partnership supports local authorities in a coherent approach to preventing depression

The main aim of the prevention memorandum 'Opting for a healthy life' is to bring into line the national and local policies with regard to the spearheads chosen. Action points have also been established for preventing depression and local authorities have been given a greater role in this. Local authorities can assist in preventing the development of depression and encourage people with depression symptoms to seek help earlier. The local authorities can set up many activities in consultation with the municipal health service and the mental health care service. Local authorities need support to realize a structured and coherent approach for the early detection and prevention of depression. They also need an accessible overview of standardized and effective prevention activities to develop a coherent policy for the prevention of depression. One of the objectives of the 'Depression Prevention Partnership' is to support the local implementation of the early detection of depression and of preventive interventions for people with a high risk for depression. In addition to this, there is a 'Preventing depression in local health care policies

manual' that arose from the action plan associated with the prevention memorandum (Bohlmeijer & Mutsaers, 2007).

Partnership works on embedding the prevention of depression in the health care system

Even though the Netherlands has a broad-based network for implementing the prevention of depression within the health care system, preventing depression is not yet formally embedded in the health care system. It has not yet been included as the first step in 'multi-stage care', a care model that is increasingly regulating the Dutch health care system. Preventing depression is also not yet a component of evidence-based regulations for general practitioners or the secondary mental health services. Moreover, standardized forms of depression prevention have a very limited place in primary care. Another consideration is that people with depression symptoms experience a barrier in seeking help due to a fear of being stigmatized. To address this point, the 'Depression Prevention Partnership' has the following objectives: raising public awareness regarding depression, improving the professionals' ability to detect depression early, increasing the accessibility of preventive interventions, increasing the percentage of providers of evidence-based prevention, establishing and implementing clinical guidelines for preventing depression and the development of e-health for depression prevention (VWS, 2006b). These objectives are specified in five work plans focused on different target groups: youths, adults and elderly people (VWS, 2007).

Problems in funding the prevention of depression have yet to be resolved

The Dutch government also needs to consider how it will fund the prevention of depression. In particular, the non-individual prevention for people with a high risk has yet to be clearly organized. In addition to this, health care insurers are free to choose the extent to which they remunerate interventions aimed at promoting mental health. It is questionable whether the legal and financial frameworks of local authorities and the health care system connect with each other, even though this is essential for the realization of a coherent prevention service. How the Dutch government will tackle this issue remains to be seen.

5.3 Dutch policy in relation to international policy frameworks

5.3.1 EU and WHO priorities

Increasing importance attached to the promotion of mental health

In recent years, mental health has occupied an increasingly prominent place on international agendas. Both the EU and WHO are paying increasing attention to this theme (WHO, 2001; WHO, 2005). The EU's involvement is based on its existing – albeit limited – competencies regarding public health, social protection, and health in the workplace. The EU also has financial means at its disposal. WHO has gathered a body of knowledge on the epidemiological aspects of mental health disorders and on effective preventive measures (Herrman et al., 2004). It also focuses on generating commitment from and involvement of national governments and other key players, including the EU. In building its knowledge base, WHO is incorporating the expertise generated within networks and projects funded by the EU.

Focus shifts from disorders to promoting mental health

The attention is gradually shifting from a focus on mental ill-health and disorders to promoting mental health and well-being. Under the slogan 'There is no health without mental health' both the EU and WHO want to integrate mental health into broader health objectives. This is reflected in the prioritization of mapping 'positive' indicators of mental health alongside measuring progress in the reduction of mental health disorders. The EU has emphasized that a mentally healthy population is of paramount importance in establishing a socio-economically healthy Europe.

EU involvement in mental health channelled through public health and social policy competencies

The involvement of the EU in mental health is reflected in its public health and social policy portfolios. Through its social policy frameworks and instruments, the EU focuses on social protection and social inclusion of people with mental health problems, given their relatively high risk of social exclusion and poverty. The European Commission collaborates with the Member States to achieve a number of common objectives, including adequate access to health and long-term care services (EC, 2005b). Within the scope of the EU's public health portfolios, the European Commission considers the promotion of mental health and the prevention of mental health problems to be a key priority for public health across Europe (EC, 2004b). This results in work on: building consensus as regards indicators; cost-effective strategies to prevent depression and suicide; and mapping the economic costs of mental ill health (Lehtinen, 2004), all of which is implemented via EU-funded collaborative projects.

Green paper describes the European prevention strategy and mental health promotion

In a Green Paper – a consultation document presenting proposals – the European Commission emphasizes that mental health can significantly contribute to the strategic policy goals of the EU, specifically in the areas of well-being, solidarity, social justice and quality of life for citizens (EC, 2005a). The Green Paper suggests options for an overall European strategy, proposing actions in the area of public health as well as other EU policies. In particular, such a European strategy could focus on the following aspects:

- the promotion of mental health
- addressing mental health through preventive action
- improving the quality of life of people with mental ill health or disability through social inclusion and the protection of their rights and dignity
- the development of a mental health information, research and knowledge system for the EU. This system will be used to acquire greater insight into the state of mental health in the EU Member States, and to enable comparisons across Member States.

The European Commission considers schools and workplaces as important settings for preventive action. Specific target groups mentioned are: infants, children, and adolescents; the working population; older people; and vulnerable groups in society. Depression, substance use disorders, and suicide are mentioned as the most urgent mental health problems.

In their response to the Green Paper consultation, most of the Member States acknowledged the added value of a comprehensive EU mental health strategy. The Dutch Ministry of Health, Welfare and Sport and the French counterpart have, however, expressed their reservations on grounds of subsidiary issues (EC, 2006). Nevertheless, both countries do support the importance of further collaboration between Member States, as well as the exchange of expertise. A White Paper was expected for the spring of 2007.

WHO and the EU have formally confirmed the importance of mental health promotion and prevention

The importance of promoting mental health and the prevention of mental ill health in Europe was formally established in the 'Declaration of Helsinki'. This declaration was endorsed by all the 52 WHO-Europe Member States, the EU, and the Council of Europe¹. The endorsement of this declaration by the EU has cleared the way for a comprehensive EU strategy: the EU's contribution to mental health in Europe is not limited to efforts from within its public health remit but other EU policy areas can positively contribute as well. An action plan is linked to the Declaration of Helsinki, covering twelve different subareas, among which are the promotion of mental well-being, and the prevention of mental health problems and suicide.

¹ The Council of Europe concerns itself with mental health in the context of the protection of human rights (Council of Europe, 2004). They adopted a resolution in which Member States are called upon to grant special attention to the improvement of the mental health of children and adolescents (P^{ACE}, 2005).

5.3.2 How do Dutch policies comply with international policy frameworks?

The policy frameworks of the EU and WHO have resulted in a number of documents with recommendations concerning the prevention of mental health disorders and the promotion of mental health (EC, 2004a; EC, 2004b; Jané-Ilopis & Anderson, 2005; Jané-Ilopis & Anderson, 2006; WHO, 2004). EU Member States can use these recommendations in the development and implementation of their own action plans. The recommendations are relevant to four aspects:

- policy
- health care infrastructure
- target groups and settings
- effectiveness, monitoring and documentation

Using these four aspects we shall address the extent to which Dutch policies adhere to the international policy frameworks.

Policy

The Netherlands adheres to international frameworks with action points for local policies

Dutch policy for preventing depression adheres to the recommendations by the EU and WHO on a number of points. The Dutch policy plans to work on an improved harmonization and collaboration among all parties involved in preventing depression at local levels and to adhere to the recommended integrated approach. The planned activities to enhance the population's awareness of depression also comply with the international policy recommendations. The EU and WHO both emphasize the importance of a link to continuous local actions. The prevention of mental health disorders in the Netherlands is also a component of the general public health policy.

Promoting mental health is not a component of the policy to prevent depression

On other points, Dutch policies deviate from the international recommendations. The EU and WHO call for the introduction of policies to promote public mental health and to integrate the prevention of depression in health care promoting strategies. However, up to now, public health policies in the Netherlands have focussed exclusively on preventing depression and not on the promotion of mental health in people who do not have depression symptoms yet. This approach for preventing depression would properly contribute to the latest prevention memorandum theme: 'Opting for a healthy life' (VWS, 2006b).

Promotion of mental health can consist of activities focused on individuals and of activities focused on the immediate environment (Section 5.1). Activities focused on individuals have the goal of promoting thoughts, feelings, behaviours and activities that strengthen the well-being of people. These activities can take place in different settings and in different target groups. At schools, they can include activities that motivate the social and emotional development of students and the detection of children with a high risk. The desired goals in the workplace are the reduction of work stress, social support in the workplace and proper working conditions. For target groups, it specifically deals with activities in risk groups, for example, in relation to parenting and developmental support. An example of a risk group would be parents with a low socio-economic status and teenage mothers. This would involve parenting skills, enhancing mother-child interaction or stimulating socio-emotional development with pre-school education. Activities focused on the immediate environment consist of government measures aimed at reducing risk factors in the immediate environment.

No link between socio-economic health and the promotion of mental health

The EU and WHO place a great deal of emphasis on the relationship between mental health and socio-economic health inequalities. According to them, the promotion of mental health of the population can mobilized to reduce the socio-economic health inequalities. No link has been established between socio-economic health inequalities and the promotion of mental health in Dutch public health policies.

Integrated policies at a national level and national coordination are absent

The EU and WHO recommend that countries introduce integrated policies to prevent depression and promote mental health. More cohesion can be created in intervention strategies focused on individuals and measures focused on immediate environment-related risk factors by involving policy areas such as social inequality, safety, employment and housing in preventing depression and the promotion of mental health (see Storm et al., 2007 for examples of integrated health policies). In line with that is the recommendation to coordinate prevention strategies across different sectors and through the course of life. It is advantageous to create more cohesion between a) interventions that promote mental health and interventions to prevent depression and other mental health disorders, and b) interventions that promote physical health and interventions that promote mental health. Depression is specifically coupled with all sorts of physical symptoms and diseases. It can be a symptom of a physical condition like Parkinson's disease for example, or an adverse effect from prescribed medications. It can also be a reaction to the consequences of a physical condition like pain, restricted functioning, as well as consequences from other situations like loss of work, loss of a relationship or reduced life expectancy (Schoemaker & Spijker, 2005). Centralized coordination makes it possible to mobilize a combination of preventive activities that would increase the effectiveness and efficiency of preventing depression. In the Netherlands, however, introducing an integrated policy for preventing depression is not yet common practice and neither are the promotion of mental health at a national level or the centralized coordination of prevention measures.

Evaluation of current policies for preventing depression is advised

Finally, the EU and WHO emphasize the importance of evaluating the policies introduced. So far, no policies for preventing depression have been introduced in the Netherlands and therefore evaluation is a non-issue. However the effectiveness of measures implemented under current policies should be evaluated.

Infrastructure of the health care system

Strengthening of informal and primary health care adheres to international recommendations

The Dutch health care system infrastructure fully adheres to the policies in the EU and WHO frameworks. The Netherlands increasingly involves informal care and primary care in the early detection and treatment of people with depression symptoms. Specific objectives of Dutch policy are the development and implementation of clinical guidelines for preventing depression and making interventions available for a larger group of professionals in informal care in local authorities. The Netherlands is also developing a greater role for primary health care professionals in mental health problems. Upon the initiative of the Ministry of Health, Welfare and Sport, a wide range of activities are being mobilized to quantitatively strengthen the primary mental health sector. The aim of this is to prepare primary care practitioners – general practitioners, general social workers, primary psychologists and social-psychiatric nurses in general practice offices – to treat mental health problems within primary care whenever possible. These measures contribute to the principle of 'multi-stage care' (Section 5.2.2), even though they do not have the explicit objective of preventing mental health disorders. The government measures are aimed at expanding expertise and the capacity to treat mental health problems in primary care and to improve the collaboration between primary care and the specialized mental health sector (Meijer et al., 2004). These measures are, however, not being deployed from the perspective of public health policies. The importance of primary health care in the prevention of mental health disorders and promoting mental health are also discussed by the European Forum for Primary Care, whose aim is to strengthen primary care throughout Europe (European Forum for Primary Care, 2006).

Target groups and settings

Target groups in the Netherlands adhere to international recommendations

The target groups and settings in which the Netherlands has implemented its policies are also largely in accordance with the international frameworks. Depression – just like excessive alcohol consumption – has priority with respect to the prevention of mental health disorders. Children with mental health problems and

their parents are given priority in Dutch policies in the form of parenting and developmental support. However, this takes place through youth policies (see the chapter on Youth as well) and not through the public health policies (Meijer et al., 2006; VWS, 2004). It mainly concerns preventing regression from bad to worse and has less to do with promoting mental health before the onset of problems. No settings are formulated in Dutch prevention policies, but there are many health-promoting activities that take place in schools and in the workplace. The development of self-help interventions to prevent depression via the Internet is one of the policy plans. In addition to this, the Trimbos Institute – National Institute of Mental Health and Addiction – coordinates a programme study called ‘e-mental health’ (Trimbos Institute, 2006). Self-help interventions in the form of support via family or friends are not a policy issue in the Netherlands.

Older people are an important target group for studies of effectiveness, but not for policy

Regarding target groups, the EU and WHO recommend encouraging preventive interventions for older people. Although there are no target groups mentioned in Dutch policies, older people are an important target group for scientific research into preventive interventions. The Netherlands Organisation for Health Research and Development (ZonMw) is funding several studies into the effectiveness of preventing depression in older people. Early detection of depression is an important theme. This group is also not considered in policies that promote mental health or prevent depression. Yet various measures could be taken to support mental health while aging such as stimulating physical and social activities preventing loneliness, reducing discrimination against the elderly and stimulating social, cultural, economic and political contributions by older people in society.

Effectiveness, monitoring and documentation

In the Netherlands there is a strong focus on using scientific evidence as a basis for measures to prevent depression

The international recommendations for basing measures to prevent depression on scientific evidence is reflected to a certain extent in Dutch policies. It is one of the action points in the prevention memorandum ‘Opting for a healthy life’. The Ministry of Health, Welfare and Sport commissioned the Netherlands Organisation for Health Research and Development to fund more than twenty research projects on preventing depression. Examples of these are: efficacy studies on the early detection and early treatment of depression; prevention interventions for children and young people, older people and migrants; implementation of effective programmes for psychosocial capability and stress management; long-term research on the prevention of bullying; the relationship between prevention and genetic aspects of depression and the prevention of mental health problems in the workplace. The Netherlands Organisation for Health Research and Development (ZonMw) increasingly takes into account initiatives from abroad. With support from the Netherlands Organisation for Health Research and Development (ZonMw), the Australian programme ‘Triple-P’ was introduced in the Dutch parenting system and was tested for its applicability in the Netherlands (ZonMw, 2006). The ‘Triple-P’ is a multi-intervention programme for the early detection of mental health problems in children and treatment by means of parental support. In addition to this, the National Institute for Public Health and the Environment (RIVM) and the Trimbos Institute (National Institute of Mental Health and Addiction) wrote a theme report about evidence-based prevention of mental health disorders on behalf of the Ministry of Health, Welfare and Sport (Meijer et al., 2006). The knowledge available is accessible to policymakers and professionals via the RIVM website ‘National Public Health Compass’ (www.nationaalkompas.nl) and is available to the public via the RIVM website ‘Choose better’ (www.kiesbeter.nl).

Monitoring mental health in the Netherlands via the municipal health services (GGD), Statistics Netherlands (CBS) and population surveys

The Netherlands updates national and regional trends in mental health in accordance with international recommendations. Each municipal health service performs a health monitor approximately every four years in which mental health is also included. These data are similar nationwide. The monitor also registers a number of risk factors for mental unhealthiness, such as loneliness, living conditions and social contacts.

The health monitor is an initiative of different national parties, among which the National Association of Municipal Health Services (GGD Nederland). In addition to this, the Netherlands Health Care Inspectorate (IGZ) has developed a number of indicators, including one for depression, for its surveillance of the public health care sector. It also uses the data from the health monitor for its surveillance (Bohlmeijer & Mutsaers, 2007). Statistics Netherlands (CBS) periodically registers the health status, including mental health, on behalf of the Ministry for Economic Affairs. Statistics Netherlands (CBS) also provides data about the Netherlands to its European counterpart, Eurostat. The European public health policies include the so-called European Community Health Indicators, which also has a number of indicators about mental health (see Section 5.3.1). The National Institute for Public Health and the Environment made an important contribution to that process. Finally, mental health in the Netherlands was charted via a large-scale population survey on the prevention of mental health disorders: The Netherlands Mental Health Survey and Incidence Study (NEMESIS). That was in 1997. A follow-up to this study will probably take place in the near future.

5.4 Policies of model countries on preventing depression

In this section, we outline how other countries introduce policies on preventing depression and what the Netherlands can possibly learn from that. We address the policies from three countries: Scotland, Finland and Australia. These countries provide a broad picture of the areas in which Dutch policies could further be developed in line with international policy frameworks.

5.4.1 Scotland

Reducing poverty is a fundamental assumption of the national programme

People with a low income or who are unemployed are at a higher risk for mental health disorders. This is why the Scottish government chose to make the promotion of mental health a component of a greater goal, specifically, the reduction of socio-economic health inequalities and the improvement of the quality of life by means of economic and social public services.

The prevention of mental health disorders is, therefore, not only a task for the public mental health sector in Scotland, but also for the social affairs sector. Furthermore, particular attention is paid to social justice and the reduction of socio-economic health inequalities (Jané-Llopis & Anderson, 2006). Consequently, in its National Programme 2003-2006, Scotland mainly focuses on the inequalities in mental health that result from poverty, deprivation, discrimination and inequality. The objectives of the national programme are (Myers et al., 2005):

- promoting public awareness about mental health disorders and mental health
- banishing stigmatization and discrimination
- preventing suicide
- stimulating support and rehabilitation for mental health disorders

Long-term involvement by the national government

NHS Health Scotland is the government service responsible for implementing the national programme. The Minister of Health is the chairman of the Programme Committee. The national programme has already been running for four years and will still continue for a number of years. This long-term involvement and motivation from the government is important because it leads to: long-term programmes instead of short-term projects, more manpower, competence, capacity, training, networks and infrastructure provisions.

Mental health is a component of general health promotion

The different intervention programmes developed and implemented in the framework of the national programme distinguish themselves not only by focussing on the reduction of socio-economic health inequalities, but also by promoting both physical and mental health in a positive manner (NHS Health Scotland, 2007). ‘Scotland’s Health at Work’ is an example of such a programme. This programme rewards employers who have demonstrated that they contribute to the mental and physical health of their employees. Employers who provide employees with health programmes in the workplace, perform risk analyses or perform stress audits are rewarded. This programme also includes the prevention of employees’ depression symptoms. Besides programmes in the workplace, there are also integrated approaches for children, such as ‘Social inclusion: opening the door to a better Scotland’; and ‘Social Justice: a Scotland where everyone matters’, both of which were initiated in 1999 and focus on the reduction of poverty in children. Finally, there is ‘Starting well’, which focuses on the improvement of the socio-economic development of children. In the programme ‘Health Promoting Schools’, the focus is on a healthy lifestyle and attention for bullying, self-esteem, preventing depression and dealing with changes (see Section 7.5.3 in the chapter on Youth). For parents, there is the programme called ‘Equality in Scotland – older people’ in which attention is also paid to promoting mental health.

Local authorities are largely responsible for promoting mental health and preventing mental health disorders

The local authorities have recently received a more prominent role in providing well-being and mental health for the public by means of the ‘Mental Health Bill’ (Johnston & Herbert, 2002). According to this Bill, local authorities are obliged to:

provide care to people with a mental condition who are not in an institution

- promote the mental health and social development of people with mental health disorders
- collaborate with health councils, national health care institutes and non-governmental organizations (NGOs)
- appoint enough professionals in the area of mental health and provide proper training

Prevention and care policies integrated: the crucial role of primary care

The policies on prevention of mental health disorders and the promotion of mental health are integrated with the policies on treatment in Scotland through legislation and care facilities. Different settings and sectors, such as national and local care providers, teachers, prison personnel, visiting nurses and health care promoters are involved in the prevention of mental health disorders. Most of the mental health symptoms are treated within primary care. The national programme ‘Doing well with depression’ has the goal of improving the treatment of people with mental health symptoms and making effective interventions in primary care accessible (Scottish Executive, 2005). This is realized by promoting expertise, better communication between primary and secondary care and through multidisciplinary networks. The aim of this is to make better and more efficient use of the existing resources and manpower. This programme was implemented in seven different regions. Specific measures performed involve providing support to local primary care providers by establishing an electronic referral system, providing information and granting support through self-help programmes.

5.4.2 Finland

Policies on mental health and social affairs are strongly integrated

Mental health is a component of the general public health policy in Finland, just as it is in the Netherlands. This policy is the responsibility of the ministry that has social affairs as well as public health in its portfolio. Social policy is therefore strongly integrated with public health policy. Moreover, Finland effects an integrated health care policy that is also extended more broadly to other policy areas. Finland has two national projects that integrate mental health and the mental health sector with developments in health and welfare systems (SAH, 2005). At national, local and European levels, Finland works on increasing the

awareness of the prevention of mental health disorders and the promotion of mental health by policymakers as well as by the public.

Different national programmes for the prevention of mental health disorders

The Ministry of Social Affairs and Health (SAH) has launched different national programmes in the area of mental health in recent years. In primary care, these programmes address suicide prevention, schizophrenia, depression, meaningful life and mental health (SAH, 2005). A number of issues have changed over the course of time during this process. There has been a shift from treatment in a mental health care facility to a district-oriented approach; the disease approach was changed to a health approach; the family rather than the workplace now tends to be the focus; and a broader approach is more frequently employed while fewer specific issues are worked on. Specifically, two national programmes have had strong influence on the mental health policies in Finland: 'Cornerstones of Mental Health' (Text block 5.1) and 'Meaningful Life'. Both programmes have been an important vehicle for keeping mental health in the media spotlight and public debate.

Prevention of mental health disorders is also the responsibility of local authorities

Just as in the Netherlands, Finland has decentralized the responsibilities for public health to the local authorities. Local authorities can formulate their own policies and can organize their own health care facilities. The Ministry of Social Affairs and Health and the local authorities also finance regional programmes. There is an earmarked budget available for these.

Finland has a large role in mental health policies at the European level

Finland is also active at the European level in the area of mental health. The Finnish are one of the instigators of the increased focus on mental health in EU context. Since their EU chairmanship in 1999, the Finnish have argued for more attention, and also more integrated attention, for mental health. Via the mental health organization, National Research and Development Centre for Welfare and Health (STAKES), Finland coordinates and participates in different mental health projects that are financed by the European Commission. Moreover, the Minister Social Affairs and Health was co-host at WHO Ministerial Conference in 2005, where he emphatically placed mental health on the map.

5.4.3 Australia

Australia actively introduces national policy on the prevention of mental health disorders

Just like in the Netherlands, the policies in Australia for the prevention of mental health disorders and the promotion of mental health are a component of the public health policies. Since 1992, Australia has implemented an active national, in this case federal, policy for the promotion of mental health and the prevention of mental health disorders. The national policies are described in the National Mental Health Plans, which are five-year plans with agreements about the goals to be achieved (Bohlmeijer et al., 2004). Three of them have since been published (AHM, 2003; CDHAC, 2000; CDHAC, 2001). On the basis of the national policy plans, states and territories select target groups and issues to further specify the plans, including plans for prevention. It usually takes a period of one year to establish either an integrated prevention programme or to develop guidelines based on scientific knowledge. The Australian government supports the policies in the states with additional funds to facilitate the developments. Other parties across the states also receive resources, sometimes with co-financing of one or more states. The role of local authorities in the area of public health is generally limited.

Text block 5.1 Cornerstones of mental health

Current Finnish Association of Mental Health (FAMH) policies focus on the promotion of mental health and the prevention of mental health problems and disorders. One priority identified in line with this focus is better inclusion of mental health policy issues in municipal planning and decision-making. This formed the basis for the three year Cornerstones of Mental Health project, which began in 2000.

The aim of the Cornerstones in Mental Health project was to influence mental health policies in municipal planning and decision-making. The project's action strategies were mental health policy drafting and a new kind of grass-roots level participation.

The chosen operational model of the project was the involvement of several actors with the widest possible cross-sector cooperation, and the active participation of citizens to ensure the broadest coverage and effect. The project had two major long-term objectives:

- to ensure the inclusion of mental health issues in political decision-making and in public debate, and to influence the concepts and attitudes related to mental health through publicity.
- to strengthen and support the mental health and well-being of citizens and communities, and find practical ways of supporting mental health and preventing disorders.

The five main recommendations, or Cornerstones, and their strategies for achievement, are listed below.

1. Securing the safe growth and development of children and young people
 - A sufficient standard of living for families with children should be secured.
 - The skills and resources of parenting should be supported.
 - Family life and the demands of the work place should be harmonized in a manner supporting the family.
2. Strengthening of community spirit and involvement
 - New opportunities for participation should be guaranteed and, if necessary, created, and the know-how required for participation should also be ensured.
 - Citizens' opportunities to be heard and to influence common issues should be improved.
 - People's mutual support and feeling of togetherness should be enhanced.
3. A good physical, mental and social environment
 - People should be given the practical means to influence the planning of their environment and the decision-making regarding it.
 - People's environments should be built with care and maintained properly. Social inequality should be fought against.
 - Information about living conditions and environments should be collected systematically to facilitate municipal decisionmaking.
4. Sufficient basic security
 - People should be supported and encouraged to earn their living by their own work.
 - Problems of everyday life should be prevented by supporting people and dealing with their problems at the earliest possible stage.
 - People should be guaranteed housing suitable to their respective life situations.
5. Good mental health services
 - Mental health promotion should be everyone's concern and people should define their duties and actions accordingly.
 - Problem situations should be identified early and dealt with actively.
 - Quick help is essential in a crisis situation.
 - The quality of life, standard of care, nursing and rehabilitation of long-term patients should be ensured.

More details of these cornerstones can be found on the Consensus Meeting on Mental Health's web site at <http://www.mielenterveysseura.fi/kulmakivet/konsensus/recommendations.htm>

Integrated approach in policies and the implementation of programmes to prevent mental health disorders

The national policy for the prevention of mental health disorders and the promotion of mental health is based on a holistic approach: Mental health is influenced by an interaction between biological, social, immediate environment and economic factors, all on the levels of individual, family and population. This approach pays attention to all phases of peoples' lives and places the priority on working intersectorally and on a coherent implementation of prevention programmes. The five-year plan 2003-2008 (AHM, 2003) places the focus on operating intersectorally. Cooperation with other sectors such as housing, education, well-being, justice and employment occupies an important place in the plan. As a result of this integrated approach there is hardly any fragmentation or compartmentalization in the mental health sector. Australia attaches considerable value to an integrated approach in the implementation of prevention programmes as well. There are many programmes available in Australia that consist of several interventions with different objectives in mind, but they are implemented coherently. Examples are the 'Triple-P' parenting support for children with behaviour problems (see Section 5.3.2) and a school-orientated programme like 'Schoolink', which focuses on the prevention of students' mental health problems (Bohlmeijer et al., 2004).

Priority for preventing depression and a clear focus on strengthening capacity

The focus in the second five-year plan from 1998 to 2003 is on preventing depression and anxiety disorders (CDHAC, 2000). Depression is specified as a separate national action plan. The objectives were focused on expanding public awareness about depression and using psychoeducation to reduce stigmatization and discrimination. Early detection and early treatment of depression are equally part of the objectives. At the same time, there is also a clear focus on strengthening peoples' capacity (Figure 5.2). This is concerned with minimising risk factors and improving protective factors for depression. Examples of this are the evidence-based initiatives to reduce the emotional and social impact of negative life events. This occurs in the form of programmes at schools that use cognitive behavioural techniques, such as solving problems and positive thinking.

Evaluation of policies has led to a full budget and working intersectorally

The results of the policies from each state are collected annually in 'National Mental Health Reports', which enables a comparison among states, as well as competition. This cycle has made sure there that every state has a full budget made available for the mental health sector and that there is substantial investment in the informal care and primary care. More use is made of the results from scientific research, there are connections with other sectors (housing, employment and income-support benefit) and it operates in a more client-oriented manner. All the mental health parties evaluate the national policy plans as being very positive (Bohlmeijer et al., 2004).

Primary care has an important role in the prevention of mental health disorders

The Australian government regards promotion of mental health, the prevention of mental health disorders and early intervention to be an important addition to treatment (AHM, 2003). From this perspective, primary health care is an essential setting along with the specialized mental health care, with general practitioners having a key role. Other relevant informal care and primary care providers are social workers, pharmacists, teachers, clergymen and public welfare organizations. The government invests in promoting expertise in primary care and in the area of mental health by way of training and support. Many general practitioners in Australia work in private practice and private clinics. These general practitioners are immediately remunerated by the central government on the basis of declarations. General practitioners receive additional payment if they take time for mental health problems, provided they have received sufficient additional training.

5.5 Discussion and conclusions

Depression is a major health problem

Preventing depression is a relatively new theme in public health policies. Only since the 1990s has there been worldwide attention for policies aimed at preventing mental health disorders, including depression. Depression is a serious mental disorder that severely reduces the quality of life in individuals and it is also an important health problem at the population level. In the Netherlands, as well as in other European countries, depression occurs frequently, resulting in high costs that are specifically caused by work absenteeism. This is why preventing depression is a priority in many European countries. It is estimated that 5.4% of the Dutch population aged 13 years and older suffer from depression. The absence of unequivocal and qualitatively good figures, make it difficult to compare the prevalence and consequences of depression in the Netherlands with other European countries. However, compared to other Western European countries, it seems that depression in the Netherlands occurs at least as often if not more often.

Preventing depression is possible

There are different evidence-based prevention programmes and policies that could positively influence the risk factors for mental health disorders and improve mental health. Interventions could focus on the reduction of depression symptoms or on positively influencing the mental health of people with a high risk for depression and for the population in general. By strengthening individuals' capacity on the one hand and developing government policies on the other, a positive influence can be exerted on mental health in an attempt to reduce the risk factors in the immediate environment.

The Dutch government, local authorities and the health care sector all have a role in preventing depression

The Dutch government, local authorities and the health care sector all have a role in preventing depression. By making the prevention of depression a policy spearhead, national government creates a framework for local authorities and the health care sector in the area of depression prevention. This occurred for the first time in the prevention memorandum of 2006. Local authorities are responsible for the preventive tasks at the local level, and with that, they are also responsible for preventing depression at the local level. Policy plans in this area are established in the local health care policies. The health care sector is active in implementing measures to prevent depression with prevention teams or prevention departments in the secondary mental health services as the most important providers. There is a great deal of mutual collaboration between mental health services and other providers, for example, professionals in the public health care sector or in primary or secondary care.

A greater range of preventive interventions is the most important policy objective for preventing depression

The Dutch government has mobilized a 'Depression Prevention Partnership' to improve the existing infrastructure in the municipal policies and the health care sector. They want to achieve a greater range of depression prevention measures with this. The action plans focus on:

- supporting local authorities by implementing early detection of depression and of interventions for people with a high risk for depression
- supporting local authorities in the formulation of local health care policy on depression prevention
- embedding prevention in the health care sector by establishing and implementing clinical guidelines for depression prevention and by improving the accessibility of preventive interventions

Health care sector infrastructure in the Netherlands adheres to international recommendations

The EU and WHO have devoted an increasing amount of attention to the prevention of mental health disorders and the promotion of mental health. Depression is also regarded as one of the most urgent mental health problems. The policy frameworks of the EU and WHO have resulted in a number of recommendations that countries could employ in the development and implementation of their own action plans. These frameworks concern policies, health care sector infrastructure, target groups, the settings and

effectiveness for target groups, monitoring and documentation. In regard to health care sector infrastructure, the Netherlands adheres well to the international policy recommendations. The same applies for Dutch policy plans to invest in public awareness regarding depression and collaboration at the local levels. There are no policies in the public health care sector that address a number of other points, but a great deal does occur in practice, such as the monitoring of mental health, focussing on the prevention of depression in older people and the development of self-help interventions to prevent depression.

Promoting mental health and integrated health care policies are not a component of Dutch policies

Concerning policy plans, there are a number of points that adhere to the international recommendations to a lesser degree. The most noteworthy differences are that the promotion of mental health in the Netherlands is not a component of the public health policy and that the Netherlands still does not implement an integrated health care policy. An integrated and coherent policy enables a combination of prevention strategies to be mobilized and to better harmonize the already existing activities — in different sectors and in different policy areas — with each other, through which depression prevention could be more effective.

Promoting mental health and integrated policies are components of policies in Scotland, Finland and Australia

Scotland, Finland and Australia are among the countries that implement central and coherent policies in the area of preventing depression and the promotion of mental health. These countries distinguish themselves with long-term involvement in and national government commitment to the prevention of mental health disorders. They also implement policies on the promotion of mental health in association with the prevention of mental health disorders. Furthermore, each of the three countries has its own distinctions. The promotion of mental health is explicitly implemented as a way of reducing socio-economic health inequalities in Scotland. Moreover, policy pays more attention to the link between physical and mental health: activities that promote mental health are also integrated in general health-promoting strategies. The public health policies in Finland are strongly integrated with social policies, which benefit the implementation of an integrated health policy. Finland has also specified a national strategy to stimulate policies for mental health at the local level. Key concepts to this are an integrated approach, investing in positive mental health and increasing the awareness of the local population as well as involving the parties involved regarding mental health. Moreover, Finland is actively working in line with European policy. Finally, Australia has practical implementable national action plans that are evaluated on specific end results. In addition, this country has an extensively specified integrated approach to mental health promotion and preventing depression. The national policies devote considerable attention to risk and protective factors for depression. This means that the policy – more so than in the Netherlands – focuses on strengthening the capacity of people and on a coherent implementation of prevention programmes.

Promoting mental health as an addition to preventing depression

The international policy frameworks and policies in the three countries presented demonstrate that the promotion of mental health from an international perspective is an essential component of public health policies. This positive approach emphasizes the importance of activities that strengthen the capacity of individuals and reduce risk factors as a component of policies to prevent depression. Moreover, this approach in itself contributes to the efforts towards a mentally healthy population. The strive towards a mentally healthy population in the Netherlands, chiefly takes form by implementing policies for the absence of disease, in this case depression. However, health is more than the absence of disease: According to WHO, health is ‘a state of complete physical, mental and social well-being’. In that context, a positive approach of striving towards a mentally healthy population could be a valuable supplement to the current public health policies. For mental health, that means a) the promotion of thoughts, feelings, behaviours and activities that strengthen the well-being of individuals; and b) creating an immediate environment that structurally contributes to positive mental health (European Forum for Primary Care, 2006).

Environment-related risk factors are also considered by way of integrated health policy

Along with the promotion of mental health, an integrated policy approach for the prevention of mental health disorders is an essential policy distinction in the three countries described. This approach is specified the furthest in Australia. The EU and WHO recommend that all European countries implement integrated policies in regard to mental health. An integrated health policy goes further than collaboration by all parties involved in the health care sector. It also has to do with public health policies that attempt to contribute to a mentally healthy population in association with the policy areas outside of the health care sector. People in difficult socio-economic circumstances have an increased risk for depression or other mental health problems (also see the chapter on Health inequalities). The reverse is also true, mental health problems can have a negative effect on socio-economic circumstances, as with the consequences of long-term work absenteeism, for example. The risk for depression or other mental problem can be reduced by ensuring healthy living conditions, such as a healthy and safe home environment, good social conditions and social relationships as well as a good education for the entire population. So far Dutch policies on preventing depression have been aimed at individual risk factors, such as depression symptoms. The Dutch government could also implement policies for the reduction of environment-related risk factors by involving policy areas such as well-being, housing, safety and youth in preventing depression. Australia and Scotland could serve as a source of inspiration for this.

A national policy framework that is specified supports municipal policies

By including the prevention of depression as a policy spearhead in the latest prevention memorandum, the Dutch government has given local authorities an important stimulus to invest in the prevention of depression. Moreover, the recently established ‘Depression Prevention Partnership’ helps local authorities to work on an improved harmonization and collaboration for depression prevention within the existing infrastructure. The national policy framework for preventing depression could be further developed on the basis of the policies described in the model countries and the recommendations from the EU and WHO. Firstly, it is advantageous to set down a structural policy framework that indicates the importance of a long-term investment in mental health and in preventing depression. That could stimulate local authorities to continue investing in mental health even when the effects are not visible in the short-term. Secondly, a national action plan offers the possibility of coordinating local authority policies on preventing depression; the government can ensure that the local authorities implement their policies from the perspective of a nationally supported vision. The national action plan to stimulate local policies on mental health in Finland can serve as a source of inspiration for this. Finally, the Dutch government can substantiate a specified policy framework that is more efficient and effective when local authorities provide preventive activities that are in line with each other. It is recommended that the national policy framework developed takes into account the coherency between (see WHO, 2002a):

- promotion of mental health and preventing depression
- individual-related and environment-related measures
- promotion of physical and mental health

Evaluation of policies on preventing depression as a component of a national policy framework

A national action plan for the prevention of mental health disorders and the promotion of mental health also provides the possibility for shaping a structured evaluation of the policies implemented. Such a policy evaluation is an important basis for gaining a perspective on the extent to which the objectives are realized and an insight in the success and failure factors of the policy implemented. On the basis of that, policy objectives can be adjusted in a timely manner and new policy plans made. A national action plan can establish which indicators are suitable for measuring the progress of prevention measures, how those data should be collected and analyzed and which time interval should be monitored. Australia already has some experience with this.

Conclusions

All in all, the recommendations by the EU and WHO as well as the public health policies in Scotland, Finland and Australia provide various ideas about how policies on preventing depression in the Netherlands

can be further developed. In summary, we can draw the following conclusions from this international perspective:

Contrary to international recommendations, the promotion of mental health is not a component of Dutch policy on preventing depression

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

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

To date, Dutch policies on preventing depression have been aimed at individual risk factors, such as depression symptoms. However, the risk for depression can also be reduced by ensuring healthy living conditions, such as a healthy and safe home environment, good social conditions, good social relationships and a good education for the entire population. The Dutch government could also reduce such environmental risk factors by including these in its policy on preventing depression. This goes hand-in-hand with measures to reduce socio-economic health inequalities.

The current Dutch policy on preventing depression could be further specified in a nationally coherent long-term policy framework

Such a detailed policy framework would support local authorities by formulating and implementing a coherent long-term policy on preventing depression. It could encourage local authorities to continue investing in mental health and the prevention of depression. At the same time, it provides guidelines for a coherent range of interventions based on a nationally supported vision. Furthermore it would allow indicators suitable for evaluating the objectives of a prevention of depression policy to be established.

References

- AHM, Australian Health Ministers. National Mental Health plan. 2003-2008. Canberra: Australian Government, 2003.
- Andrews G, Issakidis C, Sanderson K, Corry J, Lapsley H. Utilizing survey data to inform public policy: comparison of the cost-effectiveness of treatment of ten mental disorders. *British Journal of Psychiatry*, 2004;184:526-533.
- APA, American Psychiatric Association. Diagnostic and statistical manual of mental disorders, 4th edition. Washington DC: APA, 1994.
- Bohlmeijer E, Franx G, Vries A de, Cuypers P, Blekman J. integrale preventie van psychische problematiek in Australië. Leerzame ervaringen voor de Lage Landen. *Maandblad Geestelijke Volksgezondheid* 2004;59:52-64.
- Bohlmeijer E, Mutsaers K (red.). Handleiding preventie van depressie in lokaal gezondheidsbeleid. Utrecht: Trimbos-instituut, 2007.
- Busch MCM. Welke rol spelen overheden bij preventie? In: Brancherapporten VWS. The Hague: VWS, <<http://www.brancherapporten.minvws.nl>> De VWS-sectoren/preventie, 24 mei 2005.
- CDHAC, Commonwealth Department of Health and Aged Care 2000, National action plan for promotion, prevention and early intervention for mental health, mental health and special programs branch. Canberra: Commonwealth Department of Health and Aged Care, 2000.
- CDHAC, Commonwealth Department of Health and Aged Care 2000. National Action plan for Depression, Mental Health and special programs Branch. Canberra: Australian Government, 2001.
- Chisholm D, Sanderson K, Ayuso-Mateos JL, Saxena S. Reducing the global burden of depression. population-level analysis of intervention cost-effectiveness in 14 world regions. *British Journal of Psychiatry* 2004;184:393-403.
- EC, Europese Commissie - DG Employment and social Affairs. Guidance on work-related stress - spice of life or kiss of death? Brussels: EC, 2000.
- EC, Europese Commissie. Actions against depression. improving mental and well-being by combating the adverse health, social and economic consequences of depression. EC, 2004a.
- EC, Europese Commissie. The state of mental health in the European union. EC, 2004b.
- EC, Europese Commissie. Groenboek. De geestelijke gezondheid van de bevolking verbeteren. Naar een strategie inzake geestelijke gezondheid voor de Europese unie. COM(2005) 484. Brussel: EC, 2005a.
- EC, Europese Commissie. Samenwerken, beter werken: voorstellen voor een nieuw kader voor de open coördinatie van het beleid inzake sociale bescherming en integratie. COM(2005) 706. Brussel: EC, 2005b.
- EC, Europese Commissie. Responses to the Green paper: promoting the mental health of the population. Towards a strategy on mental health for the European union. Luxemburg: EC, 2006 (revised version).
- ETUC, UNICE, UEAPME, CEEP. Framework agreement on work-related stress. http://ec.europa.eu/employment_social/news/2004/oct/stress_agreement_en.pdf, 2004.
- European Forum for primary Care. Mental health in Europe, role and contribution of primary care. Position paper 2006.
- Europese Raad. Richtlijn 93/104/EG betreffende een aantal aspecten van de organisatie van de arbeidstijd. Europese Raad, 1993.
- Europese Raad. Richtlijn 89/391/EEG van de Raad betreffende de tenuitvoerlegging inzake veiligheid van de verbetering van de veiligheid en de gezondheid van de werknemers op het werk. Europese Raad, 1989.
- GGD Nederland. OGGZ-activiteiten bij GGD-en, stand van zaken in Nederland. Utrecht, 2004.
- Herrman H, Saxena S, Moodie R (eds.). Promoting Mental Health: concepts - emerging evidence - practice. Genève: WHO, 2004.
- Hollander AEM de, Hoeymans N, Melse JM, Oers JAM van, Polder JJ (eindred.). Zorg voor gezondheid. Volksgezondheid Toekomst Verkenning 2006 [English: Care for health. The 2006 Dutch Public Health Status and Forecasts Report. RIVM report 270061003]. RIVM-rapportnr. 270061003. Houten: Bohn Stafleu van Loghum, 2006.

- Jané-Llopis E, Anderson p (eds.). Mental health promotion and mental disorder prevention across European member states: a collection of country stories. Luxembourg: EC, 2006.
- Jané-Llopis E, Anderson p. Mental health promotion and mental disorder prevention. A policy for Europe. Nijmegen: Radboud university Nijmegen, 2005.
- Johnston C, Herbert s. Mental health (Scotland) Bill. An act of the scottish parliament to restate and amend the law relating to mentally disordered persons. www.scotland.gov.uk, 2002.
- Lehtinen v. Action for mental health: activities co-funded from European Community public health programmes 1997-2004. Brussel: EC/stakes, 2004.
- Meijer SA, Smit F, schoemaker CG, Cuijpers p. Gezond verstand: preventie van psychische stoornissen. RIVM-rapportnr. 270672001. Bilthoven/ utrecht: RivM/ Trimbos-instituut, 2006.
- Meijer SA, verhaak pFM. De eerstelijns GGZ in beweging. Resultaten, conclusies en beschouwing van het evaluatieonderzoek 'versterking eerstelijns GGZ'. integrale eindrapportage. utrecht: Nivel, 2004.
- Mik W. vraagesprek Clemens Hosman. Lobbywerk zet GGZ-preventie op de Europese agenda. PrePost 2007; 9,28:15-17.
- Myers F, McCollam A, Woodhouse A. National programme for improving mental health and well-being. Addressing mental health inequalities in schotland. Equal minds. Edinburgh: scottish Executive, 2005.
- NHS Health scotland. Mental health improvement: What works? A briefing for the scottish Executive. www.healthscotland.com (last visited 8 March 2007), 2007.
- PACE, parliamentary Assembly Council of Europe. Improving the response to mental health needs in Europe. http://assembly.coe.int/Documents/AdoptedText/TA05/ EREs1460.htm#_ftn1#_ftn1. Resolution 1460, 2005.
- Raad van Europa. Recommendation Rec 10 of the Committee of Ministers concerning the protection of the human rights and dignity of persons with mental disorder, 2004
- RivM, Rijksinstituut voor volksgezondheid en Milieu. KiesBeter.nl wijst u de weg in de zorg (www.kiesbeter.nl.), 2007.
- RivM, Rijksinstituut voor volksgezondheid en Milieu. Nationaal Kompas volksgezondheid, versie 3.9 (www.nationaalkompas.nl), 2007.
- Ruiter M, Bohlmeijer E, Blekman J. Derde gids preventie van psychische stoornissen en verslavingen. Utrecht: Trimbos-instituut, 2005.
- SAH, Ministry of social Affairs and Health. Mental health in Finland. Helsinki: sAH, 2005.
- Saxena s, Garrison p (eds.). Mental health promotion. Case studies from countries. Geneva: World Federation for Mental Health / WHO, 2004.
- Schoemaker C, spijker J. Welke factoren beïnvloeden de kans op depressie? in: volksgezondheid Toekomst verkenning, Nationaal Kompas volksgezondheid. Bilthoven: RivM, <<http://www.nationaalkompas.nl>> Gezondheid en ziekte\ Ziekten en aandoeningen\ psychische stoornissen\ Depressie, 13 december 2005.
- scottish Executive. Doing well by people with depression. A guide to whole systems change in the management of depression in primary care. Edinburgh: scottish Executive, 2005.
- Simon GE, Goldberg Dp, von Korff M, ustun TB. understanding cross-national differences in depression prevalence. psychological Medicine 2002;32:585-594.
- Spijker J, schoemaker C. Wat is depressie en wat zijn de gevolgen? in: volksgezondheid Toekomst verkenning, Nationaal Kompas volksgezondheid. Bilthoven: RivM, <<http://www.nationaalkompas.nl>> Gezondheid en ziekte\ Ziekten en aandoeningen\ psychische stoornissen\ Depressie, 13 december 2005.
- Storm i, Nijboer C, Wendel-vos GCW, visscher TsL, schuit AJ. Een gezonde omgeving ter preventie van gewichtsstijging: nationale en lokale mogelijkheden. RIVM-rapportnr. 270061002. Bilthoven: RivM, 2006.
- Storm i, Zoest F van, Broeder L den. integraal gezondheidsbeleid: theorie en toepassing. RIVM-rapportnr 270851003. Bilthoven: RivM, 2007.
- Trimbos-instituut. Jaarverslag 2006. internet vergroot slagkracht GGZ. utrecht: Trimbosinstituut, 2006.
- VWS, Ministry of Health, Welfare and Sport. Living Longer in good health: also a question of healthy lifestyle. The Hague: VWS, 2003.

- VWS, Ministry of Health, Welfare and Sport. Jeugdagenda. Brief van de staatssecretaris van volksgezondheid, Welzijn en sport aan de Tweede Kamer [Dutch House of Representatives] (29248, 5). The Hague: sdu uitgevers, 2004.
- VWS, Ministry of Health, Welfare and Sport. Beleidsvisie GGZ. The Hague: VWS, 2006a.
- VWS, Ministry of Health, Welfare and Sport. Preventienota Opting for a healthy life, 2007-2010. The Hague: VWS, 2006b.
- VWS, Ministry of Health, Welfare and Sport. Persoonlijke mededeling mw. E. Wennink, 2007.
- WHO World Mental Health survey Consortium. Prevalence, severity, and unmet need for treatment of mental disorders in the World Health Organization World Mental Health survey. *JaMa* 2004;291(21):2581- 1590.
- WHO, World Health Organization. international Consortium in psychiatric Epidemiology. Cross-national comparisons of the prevalences and correlates of mental disorders. *Bulletin of the World Health Organisation* 2000;78:413-426.
- WHO, World Health Organization. The World Health Report 2001 - Mental Health: New understanding, New Hope. Geneva: WHO, 2001.
- WHO, World Health Organization. prevention and promotion in mental health. Geneva: WHO, 2002a.
- WHO, World Health Organization. The European Health Report 2002. Copenhagen: WHO, 2002b.
- WHO, World Health Organization. prevention of mental disorders; effective interventions and policy options. Geneva: WHO, 2004.
- WHO, World Health Organization. Mental health: facing the challenges, building solutions. Report from the WHO European Ministerial Conference. <http://www.euro.who.int/document/E87301.pdf>. Copenhagen: WHO, 2005.
- ZonMw, programma preventie 2008-2011. http://www.zonmw.nl/fileadmin/cm/preventie/documenten/pp3_definitief_pro-grammatekst_23_mei_2006.pdf. ZonMw, 2006.

HEALTH INEQUALITIES

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

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

Policy needs clear targets and instruments to measure their achievement

In the Netherlands, reducing the gap in healthy life expectancy between socio-economic groups has been the only policy target for health inequalities since 2001. The health inequalities monitor does not yet contain any information about this target. This is mainly due to the lack of information on mortality differences by socio-economic status. The addition of these data to the monitor is planned for this year. The monitor does contain data on trends in the extent of education differences in health, lifestyle, prevention and the use of care, but no policy objectives have been formulated for these data. The progress of policy (who does what to tackle health inequalities) is not monitored in the Netherlands. England can be used as a model country because it extensively monitors the progress and results of its policies.

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

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



6 HEALTH INEQUALITIES

Carola Schrijvers and Lea den Broeder

6.1 Introduction

6.2 International policy frameworks

6.2.1 EU policy

6.2.2 World Health Organization

6.2.3 Link with other international frameworks

6.3 Policy practice around health inequalities

6.3.1 Policy in the Netherlands

6.3.2 Policy in England

6.3.3 Policy in Sweden

6.3.4 Policy in New Zealand

6.4 Discussion and conclusions

References

6.1 Introduction

Health inequalities are an important topic in public health policy

Health inequalities have always been one of the basic themes of public health and hence cannot be omitted in a report on public health policy. Since the industrial revolution, concern about the working and living conditions of the low social classes has given rise to a lot of public health interventions. Public health centres on collective interests, namely the protection and promotion of the health of groups of citizens. Health inequalities centre on groups and the structural differences in health in relation to specific social and economic group characteristics. Health inequalities are interesting for public health policy because a health gain is achieved by tackling them. Today's focus on health inequalities dates from the 1980s, when the 'Black report' in England revealed that there was a connection between socio-economic status and health (Townsend et al., 1988).

Considerable difference in health by ethnicity

There are several definitions of health inequalities. This chapter discusses differences in health or in the most important health determinants that can be influenced by policy. Less privileged social groups have a structurally poorer health and higher health risks than more affluent groups (Braveman, 2006). The most common type of health inequalities is referred to as socio-economic health differences (SEHD). These differences occur in all of the EU countries for which data are available. Health inequalities also occur in specific ethnic or minority groups compared with the native population of a country and between men and women. The groups with a health inequality usually have an unfavourable socio-economic status. There are also differences in health between regions and within a region's neighbourhoods. For a large part, these differences can be traced back to differences in the socio-economic status of the inhabitants (De Hollander et al., 2006). In the Netherlands, reducing health inequalities based on socio-economic status is an objective in the prevention policy (VWS, 2006a). This topic is on the international agenda as well as on the agenda of several other countries. In the Netherlands, there are considerable differences in health between ethnic groups (De Hollander et al., 2006). Reducing health inequalities based on ethnicity is, however, not an objective in Dutch prevention policy (VWS, 2006a).

Table 6-1 Odd ratio for self-assessed health by socio-economic position^a (Mackenbach, 2006)

Country	Period	Age	Odds ratio
Austria	1991	25-69	3.22
Belgium	1997	25-74	2.55
Bulgaria	1997	18+	2.19
Denmark	1994	25-69	2.16
England	1995	25-69	3.08
Estonia	1996	25-79	3.11
Germany	1990-1991	25-69	1.76
Finland	1994	25-69	2.99
Italy	1994	25-69	2.94
Latvia	1999	25-70	2.21
Netherlands	1997-1999	25-69	2.81
Spain	1997	25-69	2.58
Sweden	1997	25-69	2.37

^aOdds ratio: ratio of odds (a measure of risk) of less-than-'good' self-assessed health in lower socio-economic groups as compared to that in higher socio-economic groups for men. All odds ratio's are statistically significant higher than 1.00.

Integrated approach to health inequalities is needed

SEHD is a topic that is present in every aspect of public health (see the chapters on Smoking, Alcohol, Overweight, Youth and Depression). It is a problem with many causes that cannot be tackled by the health care sector alone. An integrated approach based on integrated policy is needed (Wilkinson & Marmot, 2003; De Hollander et al., 2006).

Important differences in how countries address socio-economic health differences

In 2005, WHO-Europe commissioned a review of public health policy with regard to health differences in thirteen developed countries inside and outside of Europe (Crombie et al., 2005). The review revealed that the reduction of health differences is an important public health policy objective in all of the studied countries. A 2006 review (Judge et al., 2005) of policies and strategies aimed at addressing health differences in the EU countries revealed that there are considerable differences in the way policy addresses the issue. The three countries, namely England, Sweden and New Zealand, discussed in this chapter in addition to the Netherlands, all have in common that they are trying to tackle health differences in an intersectoral way, but each with a different emphasis. England, where a national strategy aimed at a comprehensive approach to the problem was implemented, is the international leader in addressing SEHD. In Sweden, the reduction of health differences is the recurrent theme of public health policy. In New Zealand, every policy sector is tackling SEHD.

Overview of this chapter

This chapter first describes the frameworks for each country's policy on socio-economic health differences, namely the health inequality programmes of the most important international organizations (Section 6.2). Section 6.3 describes the SEHD approach in Dutch public health policy, followed by a discussion of the policies in England, Sweden and New Zealand respectively. This chapter concludes with a discussion of the lessons that can be learned by comparing policy in the Netherlands with that of other countries (Section 6.4).

6.2 International policy frameworks

Different international and supranational organizations are focusing on health inequalities. Their programmes provide contextual frameworks for national policy formulation. The international policy frameworks can also inspire Dutch policy.

European countries mainly need to focus more on programmes and activities of the European Union (EU) and WHO. These programmes and activities are described below.

6.2.1 EU policy

EU has been focusing on health differences for some time

Health differences have been on the EU's agenda for a number of years. In 1993, the European Commission presented the first strategy in the area of public health (EC, 1993). Back then, the strategy touched on socio-economic and regional health differences caused by unemployment, discrimination and poverty. It also mentioned social exclusion as one of the most important challenges in the area of public health and made a link to a social exclusion programme that was presented at the same time. This first strategy advocated attention for the health aspects of other EU policies. In practice, however, the first public health programme (1996-2002), which actually consisted of eight small programmes, focused on specific disorders. One of the eight programmes was, however, aimed at the promotion of health. In the next public health programme (2003-2007), 'addressing health determinants' it was specifically and more clearly stated as one of the three main objectives, but its lifestyle components were given relatively more emphasis than its socio-economic aspects. The British gave new impetus to health differences by making them a prominent theme during their European presidency in 2005.

Health differences remain on European agenda

Since the EU's first public health strategy, the topic of health differences has always more or less remained on the EU's agenda (EC, 2000; EU, 2002a). The topic is also often addressed in EU activities within the framework of public health (EC, sa a; EC, 2005b). The EU formulates three objectives for health differences:

- elevate the health of all citizens to that of the most privileged
- guarantee the health needs of the least privileged are met
- step up the pace at which the health of people in less healthy regions and countries is improved

The public health programme that is planned to start at the end of 2008 contains a section that explicitly states that the programme must contribute to more quality in health. The programme must also identify the causes of health differences and stimulate the exchange of best practices to reduce them.

The EU considers health differences mainly as a problem that each individual country must solve on its own, but also as a collective issue (Kyprianou, 2005). The EU believes that it is a good platform where a lot of different partners can work together to tackle the problem (Madelin, 2005). The EU also considers research into the causes of health inequalities as necessary and wants to gain knowledge on measures to tackle inequalities (EC, sa b).

EU makes connection with different policies

According to the EU, the issue of health inequalities must also be integrated with other policies ('Health in All Policies'), such as the policy for employment, families, the physical environment and education (Madelin, 2005). Other sectors in the EU have made the connection with health inequalities on their own. This is, for example, expressed in the so-called Lisbon Strategy, which expresses the ambition to make the EU 'the most dynamic and competitive knowledge-based economy in the world'. The reduction of unemployment and social exclusion are integral parts of the strategy. The European Action Programme on Social Exclusion and Poverty explicitly states, for example, that this programme is carried out in association with community activities in relevant areas. One of the areas mentioned is public health (EU, 2002b). Conversely, the EU believes that health is a prerequisite for productivity and economic growth (EC, 2005a). This approach was repeated in a number of conclusions of the Council of the European Union that were made based on an EU conference entitled 'Health in All Policies' that was held in 2006 (Council of the European Union, 2006).

Text block 6.1 The Lisbon Strategy

At the European Council of Lisbon in 2000, EU government leaders decided that Europe should strive to be the strongest knowledge economy in the world. Calls were also made for the reform of social security systems, so that the citizens of an aging Europe could continue to rely on the availability of sufficient good quality services in the future. The realization of these objectives depended partly on action in policy fields that lay largely outside the competencies of the EU, such as employment and social protection. To enable member states to work together in pursuit of this European ambition, the Open Method of Coordination (OMC) was developed. The Open Method of Coordination is a structured form of cooperation between member states, with the following features:

- Agreeing common objectives at the European level.
- Establishing common indicators and benchmarks as a means of measuring progress and comparing best practices.
- The formulation of more specific objectives based on the common objectives, and of time lines for realization of these objectives.
- Translating the common objectives into member states' national action plans, describing how the European objectives are to be realized at the national level.
- The exchange of best practices.
- Periodic monitoring, evaluation and peer review to facilitate multilateral learning processes

- among member states.
- National progress reporting. The process is subject to ongoing development through continuous dialogue between the European Commission and the member states; the European Parliament is not involved. It is, however, explicitly agreed that member states are to involve stakeholders in the development and implementation of national action plans. The term ‘open’ does not relate to the flexibility of the process itself, but to the way in which member states are free to individually decide:
- How the European objectives can best be applied to and realized within the national setting.
- How ‘best practices’ should be assessed and implemented within the national setting.
- How stakeholder organizations and representatives best be involved in the process.

Source: De Hollander et al., 2006

6.2.2 World Health Organization

World Health Organization (WHO Europe); from Health 21 to now

Health inequalities are also on the agenda of WHO. In 1998, WHO-Europe published¹ the document ‘Health 21’, which describes 21 goals in the area of public health that should be worked towards (WHO, 1998). It was the European elaboration of the WHO’s worldwide ‘Health for All’ policy. Following the World Health Declaration, health was interpreted in Health 21 as a human right, and one of the three fundamental values was that everyone be given the same chance to be healthy. In addition to Health 21, the topic of health differences was also addressed in the existing ‘Healthy cities’ programme. Health differences have always been a constant factor in the WHO’s policy (see, for example, Wilkinson & Marmot, 2003).

Integrated approach to health determinants

Health 21 emphasized that all of the policy areas are responsible for the reduction of health differences through health determinants. The document states ‘health impact assessment’² as an important instrument that can be used to define the policy. This line is repeated in the further policy developments of WHO-Europe. Since 2003, the subject of health inequalities has been an integral part of WHO-Europe's programme for social health determinants.

Text block 6.2: Article 2 of the World Health Declaration (1998)

We recognize that the improvement of the health and well-being of people is the ultimate aim of social and economic development. We are committed to the ethical concepts of equity, solidarity and social justice and to the incorporation of a gender perspective into our strategies. We emphasize the importance of reducing social and economic inequities in improving the health of the whole population. Therefore, it is imperative to pay the greatest attention to those most in need, burdened by ill-health, receiving inadequate services for health or affected by poverty. We reaffirm our will to promote health by addressing the basic determinants and prerequisites for health. We acknowledge that changes in the world health situation require that we give effect to the ‘Health-for-All Policy for the 21st century’ through relevant regional and national policies and strategies.

Source: WHO, 1998

¹ The area that falls under WHO-Europe is larger than the European Union, and consists of 51 countries in and around Europe. The area also includes countries surrounded by EU Member States that are not members themselves, such as Switzerland. It also includes countries along the borders of the EU such as Turkey and Tajikistan.

² Health impact assessment is a combination of methods, procedures and instruments used to assess the effect of a policy proposal, programme or project on the health of a specific population and the distribution of the effects within the population.

The European Office for Investment for Health and Development is carrying out the project for WHO-Europe. The programme's goal is to integrate the social and economic health determinants with the policy of the countries in the European region (WHO, 2005a). Moreover, the programme indicates that there is a correlation between health and other policy areas. The benefits health has for the economy, for example, have been mapped out. The programme also states that health care systems can help reduce the effect poverty has on health. One of the programme's main starting points is that the health care system must be set up in such a way that illness does not force people into poverty (WHO, 2005a). One of the backgrounds of this specific point is the fact that the majority of the work in WHO-Europe's region is carried out in the poorer new Member States, which include former Soviet countries.

WHO worldwide: attention for social health determinants

WHO-Europe's programme is closely related to the work carried out by the Commission on the Social Determinants of Health that was established by WHO in 2005. The Commission's goal is to ensure that policy in all kinds of areas has a positive influence on social health determinants. The promotion of equity³ for health is central. Intersectoral collaboration is an important component of all of the Commission's activities and projects (WHO, 2006).

The reduction of health differences is an important part of WHO's health promotion policy. Here too, WHO is appealing to countries to apply an intersectoral approach. WHO is also appealing to countries to close the implementation gap to prevent written policy not being executed (WHO, 2005b).

6.2.3 Link with other international frameworks

Many international organizations, such as the International Labour Organisation (ILO), the World Bank with the Millennium Development Goals and the Organisation for Economic Co-operation and Development (OECD) make statements about health in relation to socio-economic differences. For example, in the so-called OECD Health Project, which expired in 2004, the OECD addressed the topic of socio-economic inequalities in relation to health care systems (OECD, 2006).

6.3 Policy practice around health inequalities

6.3.1 Policy in the Netherlands

Two research programmes in the 1990s in the Netherlands

Before 1980, Dutch public health policy did not address SEHD. This changed when a study about differences in mortality between neighbourhoods in Amsterdam was published in 1980 (Lau-Ijzerman et al., 1980). The study revealed that there was still a health inequality in the Netherlands despite the efforts made in the area of social security and health care. This resulted in the publication in 1986 of the 'Health 2000' report by the then minister of Welfare, Public Health and Culture (WVC), which contained one section on health differences (WVC, 1986).

The national conference on SEHD that was held in 1987 resulted in a proposal for a five-year national research programme funded by the government. The programme, which started in 1989, was aimed at

³ Equity refers to social justice. In the area of public health, it relates to having equal access to care, or an equal chance to be healthy for different social groups.

generating knowledge about the extent and causes of SEHD in the Netherlands. Differences by socio-economic status were found for almost all of the health indicators that were studied (Mackenbach, 1994a).

In 1995, a second national research programme that focused on the development and evaluation of interventions and policy aimed at reducing SEHD was started. The programme created by the Albeda Committee produced concrete recommendations aimed at reducing SEHD (Programme Committee SEHD-ii, 2001). These recommendations were well received by the government, which formulated its position in November 2001 (see 'Concrete objectives but no action plan'). A clear action plan to realize these objectives was never created at any time thereafter.

Concrete objectives but no action plan

In November 2001, the government formulated its position on the final report of the Programme Committee SEHD-ii 'Reduce socio-economic health differences' (Programme committee SEHD-ii, 2001) and on the RIVM study 'Health in the large cities' (Van der Lucht & Verkleij, 2002). The government adopted the opinion of the SEHD-ii Committee that part of the SEHD can be prevented and that the government has a responsibility when it comes to reducing avoidable SEHD.

The goal of the Dutch policy, which was established in 2001, is as follows:

'To extend the healthy life expectancy of the low socio-economic status groups in 2020 by at least 25% of today's difference in healthy life expectancy which is three years'. To achieve this goal, the government intends to focus on an integrated approach from different policy areas (interdepartmental) with the following four starting points: 1) reduce the differences in education, income and socio-economic factors, 2) reduce the negative effects of health problems on socio-economic status, 3) reduce the negative effects of a low socio-economic status on health and 4) improve access to and the effectiveness of health care for low socio-economic groups (Dutch House of Representatives, 2001).

The Government presented an agenda, which consisted, on the one hand, of continuing and/or intensifying existing policy and, on the other hand, of options for new policy initiatives for the new cabinet term. An action plan that addresses SEHD was, however, never created in this or the following cabinet term.

In 2006, the National Audit Office made recommendations on preventive health care. It examined whether the Minister of Public Health, Welfare and Sport had followed the recommendations the National Audit Office had made in 2003. The National Audit Office noted that the announced measures aimed at reducing SEHD were only a fraction of the measures listed in the Government's position of 2001. Moreover, the memorandum 'Living longer in good health: also a question of healthy lifestyle' (VWS, 2003b) did not address the effects the announced actions could have on the healthy life expectancy of people with a low socio-economic status. This makes it difficult to determine if the policy objective is realistic. The National Audit Office was positive about using the health inequalities monitor to monitor progress in the reduction of SEHD (Dutch House of Representatives, 2006).

Prevention memoranda describe vague actions

The first prevention memorandum 'Living longer in good health: also a question of healthy lifestyle', that the Government published in 2003, contains a section called 'Persistent differences' (VWS, 2003b). This section concludes that socio-economic health differences have not decreased in the last ten years. As a range of factors contribute to these differences, it was also concluded that a combined approach is needed in which individual responsibility for a healthy lifestyle plays a central role.

For the different spearheads, the memorandum contains information about the relationship between health problems on the one hand and socio-economic status and ethnicity on the other. However, the National Audit Office also noted in its 2006 report that the description of the spearheads was not followed by concrete actions aimed at reducing SEHD (Dutch House of Representatives, 2006).

Text block 6.3 Health Inequality Monitor

In the summer of 2006, the Health Inequality Monitor was added to the National Compass on Public Health (www.nationaalkompas.nl). The Monitor provides detailed information on educational status-related differences in several health indicators (diseases and afflictions, perceived health and physical disabilities), lifestyle factors, environmental factors and care consumption. The first version of the Monitor is based mainly on data from the Statistics Netherlands' health surveys (since 1997, the Work and Health module of POLS). In the future, the information will be obtained from the Local and National Public Health Monitoring System, through which the RIVM and the MHSs periodically collect data on (the determinants of) health.

Source : De Hollander et al., 2006

The second prevention memorandum, 'Opting for a healthy life', contains a section on the influence socio-economic status has on health, followed by the objective to decrease differences in inequality for people in 'low socio-economic environments' (VWS, 2006a). The accompanying action plan does not explain how the objective is supposed to be achieved. An exception is the action within the framework of the urban policy, in which a district-oriented approach to health inequalities is implemented and evaluated in four local authorities according to a basic methodology (VWS, 2006b).

National research programmes have provided a lot of knowledge

As previously mentioned, the Netherlands ran two national research programmes on SEHD. The first programme, which ran from 1989 to 1993, was aimed at gaining knowledge about the extent and the nature of SEHD and determinants (Mackenbach, 1994a). The programme consisted of forty studies, one of which was a large follow-up study (the GLOBE study) aimed at unravelling the causes of SEHD. A lot of knowledge about the extent and causes of SEHD was gained from the programme. One of the findings was that the effect socio-economic status (SES) has on health contributes more to the explanation of SEHD than the opposite effect (the effect health has on SES) (Mackenbach, 1994b).

The goal of the second national research programme consisted of increasing knowledge of the effectiveness of interventions and policies aimed at decreasing SEHD. The above-mentioned GLOBE study was also continued within the framework of this programme.

The programme was based on four possible strategies aimed at decreasing SEHD (see 'Concrete objectives but no action plan'):

- improve the socio-economic status of people in lower strata
- decrease the effect health problems have on socio-economic status
- decrease exposure to circumstances and lifestyles that are harmful to health
- offer additional curative health care to people in lower socio-economic groups

The final programme consisted of twelve evaluation studies, most of which were related to the third and fourth strategy (Stronks & Mackenbach, 2006).

Many parties working on reducing SEHD

The above shows that the Netherlands does not have a clear national policy aimed at addressing SEHD. After the Government formulated its position in 2001 in response to the findings of the Albeda Committee, elections were held in 2002 and the political climate in the Netherlands changed. At the local and national level, a number of organizations were involved in activities that were aimed at reducing SEHD. The activities of a number of health-promoting organizations, such as the Dutch Foundation on Smoking and Health (STIVORO), the Netherlands Institute for Health Promotion and Disease Prevention (NIGZ), the Netherlands Nutrition Centre and the Netherlands Institute for Sport and Physical Activity (NISB), address

people with a low SES. A lot is also being done at the local level to address SEHD. Tackling SEHD is mentioned in almost 70% of the local authority memoranda (GGD Nederland, 2006).

A lot to learn from other countries' approach

After a period of heightened focus on socio-economic inequalities, mainly in the form of two national research programmes in the 1990s, the above description of Dutch policy shows that little progress has been made in the area of SEHD. Since the completion of the second research programme in 2001, which produced clear policy recommendations, little concrete action has been taken at the national level. At the same time, the Netherlands introduced a concrete policy objective in 2001 that was aimed at reducing the differences in healthy life expectancy between socio-economic groups. The Government's stance of 2001 states that 'the complexity and interwovenness of the problem requires an integrated approach' and 'separate policy initiatives are not sufficient'. The following sections discuss the policy to reduce health inequalities that has been implemented in three model countries, namely England, Sweden and New Zealand. These countries have an integrated approach to reducing health inequalities. A number of key messages for Dutch policy can be derived from the key points of these three countries' policies.

6.3.2 Policy in England

An about-face in English policy at the end of the 1990s

In England,⁴ from time immemorial a class society, health differences between the social classes have been on the political and research agenda for more than 150 years. National policy aimed at decreasing socio-economic health differences was not introduced until the end of the 1990s. The introduction of the policy was preceded by years of discussions on social and economic changes in the country and how they increased poverty, unemployment and social exclusion. These developments were also conveyed in the health data. During the Conservative Government of 1979-1997, a research working group mapped out the health differences in England. The government rejected the recommendations from the ensuing 'Black Report' (Townsend et al., 1988) claiming that they were too expensive.

The Labour Party, which took office in 1997, recognized the relationship between poverty and health and started an 'Independent Inquiry into Inequalities in Health'. The report resulting from the inquiry confirmed that the inequality in health had increased in England (Acheson, 1998). Although life expectancy at birth had increased since 1972 for all social classes in England, the difference in life expectancy between the social classes had also increased. For men, the difference in life expectancy at birth between the highest and the lowest social classes had increased from 5.5 years in the period 1972-1976 to 9.5 years in the period 1992-1996. For women, the difference had increased from 5.3 years to 6.4 years (Hattersley, 1999). This is the background against which the government developed a programme to tackle health differences.

Broad approach to inequality in health with concrete objectives

The English programme for action, 'Tackling Health Inequalities: A Programme for Action' has a broad approach, as is shown by the government's aim: to reduce health inequalities by tackling the wider determinants of health inequalities, such as poverty, poor educational outcomes, unemployment, poor housing, homelessness, and the problems of disadvantaged neighbourhoods (DH, 2003). This general, broad aim is translated into the following concrete objectives for 2010:

- starting with children under one year, to reduce by at least 10% the gap in mortality between routine and manual groups and the population as a whole
- reduce by at least 10% the gap in life expectancy between the 20% areas with the lowest life expectancy at birth and the population as a whole

The programme for action is aimed at reducing inequalities in health across different geographical areas, between men and women and different ethnic communities, and between different social and economic groups. The programme for action is organized around four themes:

⁴ This section is about England and not the United Kingdom, which includes Northern Ireland, Scotland and Wales.

- supporting families, mothers and children – to ensure the best possible start in life and break the inter-generational cycle of poor health
- engaging communities and individuals in interventions and programmes – to ensure relevance, responsiveness and sustainability
- preventing illness and providing effective treatment and care – making certain that the National Health Service (NHS) provides leadership and makes the contribution to reducing inequalities
- addressing the underlying determinants of health

Policy in England is cross-governmental

The English programme was led by the Department of Health, whose remit covers public health, health care, long-term care and social care. The Department created a small team, the 'Health Inequalities Unit' that coordinates the work to realise the programme's aims in a cross-governmental working group. Twelve departments are working together on the development of the programme, including the Department of Education, the Department of Trade and Industry and the Department for Transport. The action programme explains in detail what each party (department, local authority and the NHS) has to do within which time frame. It also defines how the progress and the results of the programme are monitored.

Local approach in England with focus on disadvantaged neighbourhoods

The agreement that the English government reached on local priorities with local authorities is described in the 'Public Service Agreement' (PSA). The PSA strongly focuses on the improvement of local services (DH, 2003). One of the aims of this agreement is to reduce inequalities in health. With a broad approach to health differences that is integrated at the national level, the most important contributions to the national objectives are made locally. The Programme for Action assumes that local solutions are needed for local health differences and that the local communities know best what the problems are and how they can be tackled. The work is carried out at the local level by forming local strategic partnerships between the government (both the NHS and the local authorities) and other actors, especially in the non-profit sector, aimed at, among other things, reducing health differences.

Concrete indicators for the evaluation of policy with a broad approach in England

The English policy has been evaluated since the publication of the Programme for Action in 2003 (DH, 2005a). Among other things, the evaluation looked at 12 indicators that were created at the national level to monitor the progress of the programme. Examples of indicators are: mortality rates from the main causes of death (cancer and cardiovascular diseases), smoking prevalence, the number of teenage pregnancies, the percentage of children living in low-income households, the percentage of influenza vaccinations and the percentage of fruit and vegetable consumption. These indicators show that the policy is aimed at different determinants of health. The policy is aimed in part at improving the socio-economic status, in part on factors that are 'intermediary' to the relationship between the SES and health, and in part on differences in the use of care.

Policy evaluation shows progress in some areas

Evaluation reports published in 2005 and 2006 show that the inequality in infant mortality has remained unchanged in England in recent years. The gap in life expectancy at birth for men has slightly decreased, while the gap for women has slightly increased. Progress was made in the areas of child poverty and housing, and some progress was made in the areas of cardiovascular mortality, cancer, influenza vaccinations, education and road traffic casualties among children (DH, 2005a; DH, 2006a). The evaluation also shows that almost all of the commitments that the government made within the framework of the national strategy had been met by April 2004. It is, however, worth noting that the most recent evaluation data are from 2002-2004 and that a number of interventions did not start until after 2002, meaning that any effects these policies and interventions will have had will only be visible at a later date.

Additional emphasis on promoting healthy choices

The White Paper ‘Choosing Health: making healthy choices easier’ was published in November 2004 (DH, 2004). The government will use the agenda of the White Paper to make it easier for people to make healthy choices. The agenda consists of practical actions for six health priorities, which emerged from consulting the population and other interested parties. The first priority is to tackle health inequalities.

The White Paper was followed by an action plan, namely the ‘Choosing Health Delivery Plan’ (DH, 2005b). Within the framework of this action plan, the Department of Health launched the ‘Health Profile of England’ in October 2006. The Health Profile is a collection of national and regional data on the six priority areas of the above-mentioned White Paper. The data are also available at the local level, enabling a comparison with data from other areas. The following key successes are mentioned in the Profile:

- life expectancy is increasing
- the quality of housing is improving
- mortality from cancer and cardiovascular diseases under the age of 75 has been decreasing since the mid-1990s
- the number of children living in poverty has decreased
- the gap between the poorest areas and the national average has decreased

Despite these successes, the population in the north of England still has poorer health than the population in the south, and life expectancy is one year shorter for women and two years shorter for men in the north compared to that of women and men in the south (DH, 2006b).

England has a long tradition in research

England has a long tradition in the research of health differences. The research is funded by medical and social research centres, a number of private welfare organizations and the Department of Health. Since the publication of the Black Report (Townsend et al., 1988), a lot of effort has been put into research on the nature and extent of SEHD and into researching the relative importance of the different causes of SEHD. England is running a number of research programmes with a special focus on health differences for a number of specific themes, including:

- the effect of circumstances throughout the course of life on the health of adults
- the role of mainly work-related psychosocial factors
- the role of people’s geographical location as a cause of health differences
- the effect of social policy and local public health interventions on the reduction of health differences (Benzeval, 2002)

6.3.3 Policy in Sweden

Renewed interest in public health policy in Sweden in mid 1980s

During the post-war period, public health in Sweden focused heavily on the medical sector. The focus was the result of a belief that doctors and the health sector could solve the most pressing health problems. The health policy focused on medical care, pushing prevention into the background. In the 1980s, public health was given a higher status. The spread of AIDS, among other things, raised the question as to whether an increase in health-care spending would actually improve public health. It also became apparent that even an egalitarian society such as Sweden was not immune to growing differences in health between the social classes. These observations meant that the Swedish public health policy needed to be reformulated (Ågren, 2003). In 1997, the ‘National Public Health Committee’, a parliamentary committee consisting of representatives of all of the parties in parliament, research experts and interest groups, was put in place. In December 2002, the committee issued a proposal consisting of eleven general objectives in the area of public health. The proposal was the basis of Sweden’s new public health policy (Ågren, 2003).

Text block 6.4: Eleven objectives of the Swedish public health policy containing the most important determinants of Swedish public health

1. Participation and influence in society
2. Economic and social security
3. Secure and favourable conditions during childhood and adolescence
4. Healthier working life
5. Healthy and safe environments and products
6. Health and medical care that more actively promotes good health
7. Effective protection against communicable diseases
8. Safe sexuality and good reproductive health
9. Increased physical activity
10. Good eating habits and safe food
11. Reduced use of tobacco and alcohol, a society free from illicit drugs and doping and a reduction in the harmful effects of excessive gambling

Source: Ågren, 2003

National strategy with focus on health determinants

In April 2003, the Swedish parliament approved the new intersectoral national strategy for public health. The strategy is based on one overall aim: to create social conditions that ensure good health for the entire population. It was also established that it was particularly important to improve the public health of those groups most vulnerable to poor health. The policy is also aimed at reducing differences in health by gender, social class, ethnicity and sexual orientation. The objectives of the Swedish policy target the most important health determinants in Sweden. The first six objectives relate to structural factors that influence the health of people, such as income, social capital, conditions during youth, and working conditions. The other five objectives relate to lifestyles such as nutrition, physical activity, prevention, and communicable diseases (Ågren, 2003).

Intersectoral approach is central in Sweden

In Sweden, public health falls under the jurisdiction of the Ministry of Health and Social Affairs, which, in principle, bridges the gap between two policy areas. From the Swedish perspective, the area of public health is a perfect example of intersectoral and interdisciplinary collaboration. After all, other policy areas influence most of the factors that determine health. The broad focus on health determinants as the basis for public health policy means that it is mainly realized outside of the health care sector, for example, in the area of the labour market, welfare policy, people's consumption patterns and health care policy.

Text block 6.5: Mental health proposals from the Swedish Public Health Policy Report 2005

The National Institute of Public Health recognizes that inequitable living conditions contribute to mental ill-health. Therefore the National Institute of Public Health feels it is important:

- that labour market policy initiatives are strengthened for the long-term unemployed
- that the working methods of the social services, employment agencies and national insurance office are spotlighted and the scope for cooperation is better utilised regarding people with multiple needs requiring action by several different authorities
- that local and regional efforts to combat discrimination are strengthened
- that those living in vulnerable urban districts are given the opportunity for greater participation in and influence over the development of their own district and their own living conditions
- that wide-ranging groups of parents with children of all ages are given the opportunity to participate in parental support groups
- that existing international public health research into pre-schools, schools, skills and health is made available to teachers and other key personnel in the education system.

Source: Ågren, 2003

Coordination at the national level and implementation at the regional and local levels

At the national level, the government disposes of policy instruments such as the creation of objectives, the monitoring of their progress in the policy areas, and the reports on the results. The target groups of the policy are national, regional and local authorities, the private sector and the voluntary sector. At the regional and local levels, public health work is carried out by non-governmental organizations (NGOs). Local authorities and county councils play a crucial role in the execution of public health work at the local and regional levels, because it is at the local level that most of the decisions affecting people's actual living conditions are made. The county councils are also responsible for the implementation of preventive measures under the Health and Medical Care Services Act (Ågren, 2003).

National policy coordination and monitoring

The Swedish National Institute of Public Health plays a central role in the coordination of public health at the national level. The institute supports the implementation, monitoring and evaluation of the eleven public health objectives and has developed indicators to monitor their progress. Examples of indicators are the percentage of people with paid work (measured at the municipal level), self-reported work-related health (measured at the regional level), and the quality of the relationship between parents and children (measured at the national level).

Every four years, the institute publishes a report for the government that is used as the basis of the discussion on the success of the public health policy. The first 'Public Health Policy Report' was published in 2005 (Swedish National Institute of Public Health, 2005). It included the state of affairs for the different health determinants and the measures that were implemented to influence people's health. The report described the positive developments in the area of public health care (such as a decrease in the number of smokers in all population groups, an increase in the vaccination rate for children, a decrease in the number of work-related accidents and a decrease in the number of traffic accidents) as well as the negative developments (an increase in the number of long-term unemployed since 2002, a recent increase in HIV and chlamydia, an increase in the number of people who are (seriously) overweight and a 30% increase in alcohol consumption in the last ten years, especially among young people).

In the report, the Swedish National Institute of Public Health also made recommendations for future policy, for example in the area of mental health. In total, the institute made 42 proposals that are related to the 11 objectives of the Swedish public health policy.

A special part of policy monitoring consists of making health impact assessments, which consist of mapping out the effects the policy of other sectors has on health.

6.3.4 Policy in New Zealand

Health differences are socio-economic and ethnic

In New Zealand, as in many other countries, health inequalities are a source of concern. Data from the period 1988 to 1999 show an increase in socio-economic health differences. In this period, the gap between life expectancy at birth between rich and poor men increased from 3.4 to 5.0 years, but decreased slightly for women from 2.9 to 2.7 years (Blakely et al., 2005). New Zealand's policy, however, not only addresses socio-economic health differences, but also ethnic health differences. Inequalities occur mainly among the Maori (New Zealand's indigenous population) and the Pacific people (immigrants from the smaller islands in the Pacific, such as Polynesia and Melanesia). Life expectancy at birth of the Maori population is 8.5 years shorter than that of other population groups; the difference is 8.7 years for women and 8.2 years for men (Statistics New Zealand, 2004). The majority of these data can be traced back to the relatively poor socio-economic position of the Maori and Pacific people in New Zealand, which are characterized, among other things, by higher unemployment, higher school drop-out rates and lower education (Te puni kokiri, sa).

A report published in 2003, revealed that the Maori population was lagging behind other ethnic groups in terms of the decrease in mortality rates (Ajwani et al., 2003). This triggered the formulation of additional measures to change the situation. In the foreword to the report, the Deputy Director-General of Public Health wrote that this was the task of all government sectors and the community. According to him, the health sector also had a special responsibility to improve access to and provision of health care for those in greatest need (Ajwani et al., 2003).

Health differences are the spearhead of public health policy

There are two overarching strategies that drive public health policy in New Zealand, namely the national health strategy and the strategy for people with disabilities. Both strategies focus on the reduction of health inequalities. The national health strategy launched in the year 2000 states the importance of focusing on the Maori and the Pacific people, and on people with a low socio-economic status. The position of the Maori and the Pacific people is emphasized in the strategy for people with disabilities. This spearhead is present in almost all of the programmes that fall under the overarching strategy (New Zealand Ministry of Health, 2006). An example is the cancer programme, which is aimed at reducing the differences in the incidence and the mortality rates for cancer between Maori and other groups (Maori have an 18% higher chance of being diagnosed with cancer and hence a 93% higher chance of dying from cancer) (Robson et al., 2006). One of the programmes under the national health strategy is even exclusively aimed at improving the health of said ethnic groups. The ministerial departments of Public Health and Maori Health are working together to reduce health differences.

Health sector operates according to overarching vision

The Ministry of Health published a vision document that sets out the starting points for the approach to health inequalities (New Zealand Ministry of Health, 2002). The vision centres on four strategies:

- tackle underlying social, cultural, economic and historic causes of health inequalities (structural approach)
- work on the routes along which inequalities are created: material, psychosocial and behavioural factors (causal approach)
- develop specific activities in care and in the care for people with disabilities (approach in care and disability services)
- reduce the influence of poor health on socio-economic status (impact-oriented approach)

The strategies are leading for the regional and local approach taken by the government, care and the funding bodies.

Health inequalities also key objective at regional level

New Zealand has 21 District Health Boards that are partly elected by the people. Their task is to ensure that health care services and disability care are available to the regional inhabitants. The District Health Boards both have tasks in curative health care as well as in public health care and prevention. The reduction in health inequalities among the Maori and the elimination of health inequalities among other specific groups are integral parts of their assignment (New Zealand Ministry of Health, 2005a).

Monitoring of results: annual accountability at the regional and national level

The District Health Boards are accountable to the Ministry of Health for all of their work, and hence also for the work they do to reduce health differences. The Ministry of Health reports once a year to parliament on the progress made on the reduction of health differences (New Zealand Ministry of Health, 2004). This annual report not only describes the activities that have been carried out and how much they cost, but also how the inequalities are developing (New Zealand Ministry of Health, 2004). This accountability report clearly shows that the main focus is on ethnic health differences.

Health inequalities policy embedded in broader government policy

Tackling health inequalities is part of a broader inequalities policy that encompasses all of the departments (New Zealand Ministry of Health, 2004). The policy that is currently in place to tackle inequalities among

the Maori and the Pacific people was launched by the government in 2004 (Ministry of Social Development, sa). The policy comprises activities for health, parenting, job market, education, income and poverty, housing, crime, cultural identity, and social capital/social cohesion. A range of indicators that spread across the whole breadth of inequalities is used to determine whether the policy is successful (Maharey, 2003). According to the policy plan, the Minister of Social Development and Employment's Role is mainly to maintain the agenda; the actual work is carried out by the ministries working on the different spearheads. Each ministry, including the Ministry of Health, also writes its own report on the activities and their results. Although social justice is one of the policy's major drivers, the minister of social development and employment also has other reasons to tackle inequalities:

- economic growth
- the reduction of social costs, such as a high consumption of care, the cost of social services, crime
- the improvement of social cohesion

Text block 6.6 Priorities that are proposed to reduce inequalities in New Zealand

The government of New Zealand has promoted a wide ranging set of initiatives aimed at reducing inequalities, and many of these are proving successful. Based on analysis of the causes of disadvantage and 'what works', the following priorities are proposed for the future:

- ensuring a robust programme of early intervention for at-risk children and families
- addressing the income needs of children in low-income families through implementation of the Working for Families programme
- continuing the focus on the health needs of families/whanau across the life course through improving access to health services, particularly primary care
- increasing participation in early childhood education by groups where participation is low
- improving participation and achievement amongst young people at risk of leaving school with few qualifications
- improving access to education, training and employment for economically inactive young people
- addressing the barriers to employment and increasing incentives to find employment for disadvantaged groups
- improving models for ensuring high-quality and responsive funding and delivery of services for at-risk groups
- investing in communities and supporting community-led solutions
- tackling risk factors of poor health and improving access to services for those currently at risk of poor health outcomes across the life-course
- improving the quality of evaluative activity within the social sector, and filling gaps in information to improve understanding of outcomes and what works.

Source: Ministry for Social Development and Employment, 2003

The results are encouraging but more can be done

In 2005, the Ministry of Health announced that the first positive results had been achieved for the reduction of health differences. Differences in the incidence of suicide, the prevalence of smoking, and infant mortality had decreased (New Zealand Ministry of Health, 2005b). But the government's policy on health inequalities was still being criticized. The New Zealand 'Public Health Association' indicated that the government's investments focused too much on care and not enough on prevention. A concrete recommendation by the Association was to increase excise taxes on tobacco, alcohol and gambling (New Zealand Public Health Association, 2005).

6.4 Discussion and conclusions

The inequalities policy of model countries is a source of inspiration

This chapter described a number of characteristics of the inequalities policy in three model countries. These countries can be a source of inspiration in a number of areas for the further formulation of the Dutch inequalities policy. These areas will be discussed later in the text. Of course, the social, economic and cultural context of each country is different, which is why it is seldom possible to integrate parts of the policy of one country with policy in another country without some level of adaptation. All three of the model countries have a government-funded Beveridge type of health care system. In such a system, care and public health are closer to each other than in countries such as the Netherlands, which has a so-called Bismarck system with a stronger insurance component.

In addition to examples of countries with successful health inequalities policies, the international policy frameworks of the EU and WHO can be used to steer the reduction of health inequalities. The impetus can also come from several places, for example, from the Lisbon Strategy (see Section 6.2.1) the objective of which is to strengthen the knowledge economy. The Open Method of Strategy Coordination requires EU Member States to report on the progress of tackling poverty and social exclusion, including health inequalities. The issue of addressing inequalities is virtually put on the Dutch agenda by the Lisbon Strategy.

Political and social climate determine acceptance and shape of inequalities policy

The political and social climate is different in each country and can determine the acceptance of policy aimed at reducing health inequalities. In England, for example, there was a long period during which little attention was given to socio-economic health differences. It was not until the end of the 1990s, when a new government came into office that these differences were recognized and that the time was ripe for a national strategy aimed at tackling them. In recent years, the Netherlands has shifted towards the assumption that each person is responsible for his or her own health and policymakers started looking for cost-effective strategies to improve the health of the people. These assumptions still create a sound basis that has enabled policies aimed at reducing health differences to be intensified. The assumption of self-responsibility is only valid if people are in a position to take responsibility. This prerequisite can be created, for example, by aiming interventions at the social environment of people who are affected by inequalities. A number of social gains can be achieved from an approach that is aimed at reducing SEHD: the improvement of the health of groups of people at the bottom of the social ladder will also affect other social areas such as the participation of these groups in education and the labour market.

National strategy as framework for a local approach

The Netherlands lacks a national strategy or a national action plan aimed at tackling health inequalities. The model countries we studied have a clear national strategy with clear management and frameworks. The policy is usually carried out at the local (and regional) level. In the Netherlands there is a lot of attention for the reduction of health inequalities at the local level (GGD Nederland, 2006) although this approach is not part of a broad national framework. The approach in England, Sweden and New Zealand can be used as a model in this area.

In England, the Department of Health set up a Health Inequalities Unit that is working on achieving the objectives at the national level. The Programme for Action describes each party's tasks at both the national level and the regional and local levels. The agreement that the English government reached with local authorities on the approach to reducing inequalities in health is described in the 'National Public Service Agreement' (DH, 2003). In Sweden, the government disposes of a number of policy instruments at the national level: the government determines the policy's objectives, monitors the progress and reports on the results of the national public health strategy. The public health policy is carried out at the local or regional level: local and regional authorities are also responsible for the implementation of the preventive measures described in the Health and Medical Services Act. In New Zealand, the Ministry of Health works from a number of strategies aimed at tackling health inequalities that are leading for the national, regional and

local approach taken by the government, care sector and funding bodies. New Zealand has 21 District Health Boards that carry out the public health policy in the area of care and prevention. The reduction of health inequalities is part of their job and they are accountable to the Ministry of Health (New Zealand Ministry of Health, 2005a).

Intersectoral approach to health inequalities, both nationally as well as locally

Health inequalities cannot be tackled by the health sector alone: many factors have an impact on the rise and continuance of health inequalities. A comprehensive approach based on intersectoral policies is needed. This approach is reflected in the vision that international and supranational organizations such as WHO and the EU advocate. It is also central in individual countries as can be seen in the descriptions of the policies in England, Sweden and New Zealand.

In England, twelve departments work together in a national programme aimed at reducing inequalities in health. They do because all of the governmental sectors – such as Education, Trade, and Industry and Transport – should carry out policies that focus on the goal. This integrated approach is also present at the local level: local parties in both the public and the private sector work together in local strategic partnerships to reduce health differences. The English policy is based on there being ‘a key challenge to work in partnership across traditional boundaries’. In Sweden, the public health policy is based on the assumption that the policy area is intersectoral and interdisciplinary. This is expressed in the policy's broad focus on health determinants. Policies aimed at tackling these determinants, such as labour and welfare policies, will primarily be carried out outside of the health sector. New Zealand has a broad inequalities policy that encompasses all of the departments. Tackling health inequalities is part of this policy. The Netherlands does not have an integrated approach to health differences at the national level. The Ministry of Health, Welfare and Sport does not structurally collaborate with other departments to tackle SEHD as do the model countries. Although the interest in an integrated policy is increasing in the Netherlands, in particular at the local level, a systematic overview of the initiatives is lacking.

Monitoring of progress and results of policy very important

Finally, the countries studied are interested in monitoring both the policy aimed at reducing health inequalities as well as the results of the policy. Here too, the model countries can be an inspiration for the Netherlands. In England, the progress and results of the policy are extensively monitored. The progress of the policy is easy to follow because the different parties' responsibilities are clearly delineated. At the national level, twelve indicators are used to monitor the results of the programme. The indicators cover socio-economic status as well as determinants and the use of care. Local parties, too, report on the progress of the approach to health differences. The Swedish National Institute of Public Health has developed indicators to monitor the progress of eleven of the health policy's goals. Every four years, the institute presents a report to the government as input for a discussion in the area of public health. The Swedish National Institute of Public Health uses the report to make recommendations for future policy (Swedish National Institute of Public Health, 2005). In New Zealand, the Ministry of Health presents an annual report to the parliament on the activities, costs and results of the policy. The link to other policies on health inequalities for which indicators have also been determined enables the link between health inequalities and problems in other areas to be monitored. In the Netherlands, the development of health differences is monitored by the Health Inequalities Monitor. The Monitor, however, does not yet contain any information that would make it possible to assess the extent to which the main objective of the Dutch policy, namely to improve the healthy life expectancy of the low socio-economic groups, has been achieved. It has been recommended to include information on the healthy life expectancy by socio-economic status in the monitoring. In addition, it is important to monitor the progress of the policy to tackle health inequalities, as is done in the model countries.

SEHD on the agenda?

It is not a coincidence that health inequalities are so high on the agendas of a number of model countries. England is renowned for its multi-class society. In a way, talking about health differences as a result of

other social and economic differences in such a context is a logical step. In Sweden it was the shock that health differences could exist in an egalitarian society that led to the implementation of the policy. In New Zealand, the situation is altogether different: because the majority of inequalities run along ethnic lines, one cannot get around them. Moreover, the policy on health inequalities is being implemented at the same time that the historical rights of the indigenous Maori people are being recognized.

In recent years, the Netherlands seems to have lacked the motivation to create a policy aimed at reducing health inequalities. Maybe the previously mentioned economic and social gain that can be achieved by reducing inequalities can stimulate motivation. The example of New Zealand and of the EU, where that type of gain is emphasized, can provide inspiration. The public health forecast of 2006 shows that the Netherlands does not occupy a favourable position in Europe when it comes to the life expectancy of both men and women. The unfavourable position of the Netherlands, which used to be at the top of the EU in terms of life expectancy, is now paired with continuing health differences among the population (De Hollander et al., 2006). The Netherlands can, in part, regain its position as one of the top EU countries by reducing health inequalities among its population.

From an international perspective, we can draw the following conclusions:

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

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

Policy needs clear targets and instruments to measure their achievement

In the Netherlands, reducing the gap in healthy life expectancy between socio-economic groups has been the only policy target for health inequalities since 2001. The health inequalities monitor does not yet contain any information about this target. This is mainly due to the lack of information on mortality differences by socio-economic status. The addition of these data to the monitor is planned for this year. The monitor does contain data on trends in the extent of education differences in health, lifestyle, prevention and the use of care, but no policy objectives have been formulated for these data. The progress of policy (who does what to tackle health inequalities) is not monitored in the Netherlands. England can be used as a model country because it extensively monitors the progress and results of its policies.

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

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

References

- Acheson D. Independent inquiry into inequalities in Health Report. London: The stationery office, 1998.
- Ågren G. Sweden's new public health policy. National public health objectives for Sweden. Stockholm: Swedish National institute of Public Health (revised edition Report), 2003(45).
- Ajwani s, Blakely T, Robson B, Tobias M, Bonne M. Decades of Disparity: Ethnic mortality trends in New Zealand 1980-1999. Wellington: Ministry of Health and university of otago, 2003.
- Benzeval M. England. in: Mackenbach J, Bakker M. Reducing inequalities in health. A European Perspective. London & New York: Routledge, 2002.
- Blakely T, Fawcett J, Atkinson J, Tobias M, cheung J. Decades of Disparity ii socioeconomic mortality trends in New Zealand, 1981-1999. Public Health intelligence occasional Bulletin 25. Wellington: Ministry of Health and university of otago, 2005.
- Braveman P. Health disparities and health equity: concepts and measurement. Annu Rev Public Health, 2006;27:167-194.
- BZK, Ministerie van Binnenlandse zaken en Koninkrijksrelaties, Directie Grote steden en interbestuurlijke Betrekkingen. Samenwerken aan de krachtige stad. Grotestedenbeleid III, 2005-2009. The Hague: BZK, June 2004.
- Council of the European Union. Council conclusions on Health in All Policies (HiAP). http://www.consilium.europa.eu/ueDocs/cms_Data/docs/pressData/en/lisa/91929.pdf (visitedat 17 december 2006). Brussels: council of the European union, 2006.
- Crombie IK, Irvine L, Elliott L, Wallace H. closing the Health inequalities Gap: An international Perspective. Copenhagen: WHO, 2005.
- DH, Department of Health. Tackling Health inequalities. A Programme for Action. Londen: DH, 2003.
- DH, Department of Health. Choosing Health: making healthy choices easier. Londen: The stationery office, 2004.
- DH, Department of Health. Tackling Health inequalities: status Report on the Program-me of Action. Londen: DH, 2005a.
- DH, Department of Health. Delivering choosing health: making healthier choices easier, March 2005b.
- DH, Department of Health; Health inequalities unit. Tackling Health inequalities: status Report on the Programma for Action. 2006 update of headline indicators, 2006a.
- DH, Department of Health. Health Profile of England, 2006b.
- EC, Europese Commissie. Health determinants. Brussel: EC, z.j.a.
- EC, Europese Commissie. Socio-economic determinants of health - health inequalities. http://ec.europa.eu/health/ph_determinants/socio_economics/socio_economics_en.htm (visited 26 June 2006). Brussels: EC, z.j.b.
- EC, Europese Commissie. The social protection and social inclusion process. http://ec.europa.eu/employment_social/social_inclusion/index_en.htm (last visited 4 October 2006). Brussels: EC, z.j.c.
- EC, European Commission. Commission communication on the framework for action in the field of public health. COM(1993) 559 final. Brussels: EC, 1993.
- EC, Europese Commissie. Mededeling van de commissie aan de Raad, het Europees Parlement, het Economisch en sociaal comité en het comité van de Regio's over de gezondheidsstrategie van de Europese Gemeenschap. COM (2000) 285 def. Brussel: EC, 2000.
- EC, Europese Commissie. Communication from the commission to the European Parliament, the council, the European Economic and social committee and the committee of the Regions. Healthier, safer, more confident citizens: a Health and consumer protection strategy proposal for a decision of the European Parliament and of the council establishing a Programme of community action in the field of Health and consumer protection 2007-2013. COM(2005) 115 final. Brussel: EC, 2005a.
- EC, Europese Commissie. Communication from the commission on the social Agenda. COM(2005) 33 final. Brussel: Ec, 2005b.
- EC, Europese Commissie. Portfolio of overarching indicators and streamlined social inclusion, pensions and health portfolios. Brussel: Ec, 2006.

- EU, Europese Unie. Besluit Nr. 1786/2002/EG van het Europees Parlement en de Raad van 23 September 2002 tot vaststelling van een communautair actieprogramma op het gebied van de volksgezondheid (2003-2008). Brussel: Publicatieblad van de Europese Gemeenschappen, 9-10-2002: L271/1-L271/11, 2002a.
- EU, Europese Unie. Besluit Nr. 50/2002/EG van het Europees parlement en de Raad van 7 december 2001 tot vaststelling van een communautair actieprogramma ter aanmoediging van samenwerking tussen lidstaten bij de bestrijding van sociale uitsluiting. Brussel: Publicatieblad van de Europese Gemeenschappen, 12-01-2002: L10/1-L10/7, 2002b.
- GGD Nederland. Taskforce Herijking gezondheidsbevordering bij GGD'en. Verslag van de activiteiten 2002-2006. Utrecht, 2006
- Hattersley L. Trends in life expectancy by social class – an update. *Health statistics Q* 1999;2;16-24.
- Hollander AEM de, Hoeymans N, Melse JM, Oers JAM van, Polder JJ (eindred.). *Zorg voor gezondheid. Volksgezondheid Toekomst Verkenning 2006* [English: Care for health. The 2006 Dutch Public Health Status and Forecasts Report. RIVM report 270061003]. RIVM-rapportnr. 270061003. Houten: Bohn stafleu van Loghum, 2006.
- Judge K, Platt s, costongs c, Jurczak K. *health inequalities: a challenge for Europe*. London: UK presidency of the Eu, 2005.
- Kyprianou M. Facing up to health inequalities in Europe. Speech at the Tackling health inequalities summit: governing for health: London 17 October 2005. London: 2005.
- Lau-ijZerman A, et al. *Vergelijkend buurtonderzoek naar sterfte, ziekenhuisopname en langdurige arbeidsongeschiktheid in Amsterdam: eindrapport*. Amsterdam: Gemeentelijke Geneeskundige en Gezondheidsdienst, 1980.
- Lucht F van der, Verkleij H. *Gezondheid in de grote steden*. RIVM-rapportnr. 270555003. Houten: Bohn stafleu van Loghum, 2002.
- Mackenbach JP. *Ongezonde verschillen*. Assen: Gorcum, 1994b.
- Mackenbach JP. Socioeconomic inequalities in health in The Netherlands: impact of a five year research programme. *BMJ* 1994a;309:1487-1491.
- Mackenbach JP. *Health inequalities: Europe in profile*. Rotterdam: Erasmus MC-iMGZ, 2006.
- Madelin R. Health inequalities: a shared responsibility across society and throughout Europe. Toespraak tijdens de Tackling health inequalities summit'. London: Governing for Health, 18 October 2005.
- Maharey S. *Reducing inequalities: next steps*. Wellington: office of the Minister for social Development and Employment, 2003.
- Ministry of Social Development. Reducing inequalities. <http://www.msd.govt.nz/work-areas/cross-sectoral-work/reducing-inequa-lities.html> (last visited 17 december 2006, z.j.
- New Zealand Ministry of Health. *Annual report for the year ended 30 June 2004*. Wellington: Ministry of Health, 2004.
- New Zealand Ministry of Health. District Health Boards. <http://www.moh.govt.nz/districthealthboards> (last visited 28 November 2006), 2005a.
- New Zealand Ministry of Health. *Reducing Inequalities in Health*. [http://www.moh.govt.nz/moh.nsf/ea6005dc347e7bd44c2566a40079ae6f/523077dddeed012dcc256c550003938b/\\$FILE/Reducineqal.pdf](http://www.moh.govt.nz/moh.nsf/ea6005dc347e7bd44c2566a40079ae6f/523077dddeed012dcc256c550003938b/$FILE/Reducineqal.pdf) (last visited 28 November 2006). Wellington: Ministry of Health, 2002.
- New Zealand Ministry of Health. *Revealed: progress is made in reducing inequalities in health* (persbericht). <http://www.moh.govt.nz/moh.nsf/c7ad5e032528c34c4c2566690076db9b/895cc8ae072a5290cc2570a5001113c9?OpenDocument> (last visited 28 November 2006), October 2005b.
- New Zealand Ministry of Health. *Statement of intent 2006 to 2009*. Wellington: Ministry of Health 2006.
- New Zealand Public Health Association. Submission to the Parliamentary Finance and Expenditure select committee on the 2005 Budget Policy statement from the New Zealand Public Health Association of Nz (PHA). <http://www.pha.org.nz/docs/Health%20inequalities/BPs2005FiNAL.doc> (last visited 28 November 2006). Wellington: PHA, 2005.
- OECD. *Health*. http://www.oecd.org/topic/0,2686,en_2649_37407_1_1_1_1_37407,00.html (last visited 15 November 2006). Paris: OECD, 2006.

- Programmacommissie SEGV-II. Sociaal-economische gezondheidsverschillen verkleinen. Eindrapportage en beleidsaanbevelingen van de Programmacommissie SEGV-II. The Hague: zorgonderzoek Nederland, 2001.
- Robson B, Purdie G, Cormack D. unequal impact: Māori and Non-Māori cancer statistics 1996-2001. Wellington: Ministry of Health, 2006.
- Statistics New Zealand. New Zealand Life tables 2000-2002 (online). <http://www2.stats.govt.nz/domino/external/pasfull/pasfull.nsf/7cf46ae26dcb6800cc256a62000a2248/4c2567ef00247c6acc256e660082353f?> (last visited 22 November 2006), 2004.
- Stronks K, Mackenbach JP. Evaluating the effect of policies and interventions to address inequalities in health: lessons from a Dutch programme. *Eur J Public Health* 2006;16:346-353.
- Swedish National institute of Public Health. the 2005 Public Health Policy Report. Summary. 2005, R2005:44.
- Te puni kokiri. Website. <http://www.tpk.govt.nz/default.asp>, no year (last visited 17 december 2006).
- Townsend P, Davidson N, Whitehead M (eds.). *Inequalities in Health (the Black Report & the Health Divide)*. London: Penguin Books, 1988.
- Tweede Kamer [Dutch House of Representatives]. Geïntegreerd kabinetsstandpunt over het eindrapport en de aanbevelingen van de programmacommissie SEGV II 'Gezondheidsverschillen verkleinen' en de volksgezondheid toekomst verkenning-studie 'Gezondheid in de grote steden' van het RIVM. Kamerstuk: GZB/GZ-2233385. The Hague: Tweede Kamer [Dutch House of Representatives], November 2001.
- Tweede Kamer [Dutch House of Representatives]. Preventieve gezondheidszorg. Rapport Algemene Rekenkamer. Vergaderjaar 2003-2004, 29 300, nrs 1-2, The Hague: Tweede Kamer [Dutch House of Representatives], 2003.
- Tweede Kamer [Dutch House of Representatives]. Preventieve gezondheidszorg. Brief van de Algemene Rekenkamer. Vergaderjaar 2005-2006, 29 300, nrs 5-6, The Hague, 2006.
- VWS, Ministry of Health, Welfare and Sport. Onderzoek Gezondheidsverschillen preventie en gezond gedrag. Brief van de minister aan de Algemene Rekenkamer (kenmerk: PoG/FBi 2.421.107). The Hague: VWS, 2003a.
- VWS, Ministerie van VWS. Living Longer in good health: also a question of healthy lifestyle. The Hague: VWS, October 2003b.
- VWS, Ministerie van VWS. Preventienota Opting for a healthy life. The Hague: VWS, October 2006a.
- VWS, Ministerie van VWS. Speerpunten en actieprogramma Opting for a healthy life. The Hague: VWS, October 2006b.
- WHO, World Health organization. Health 21. An introduction to the health for all policy framework for the WHO European Region. Copenhagen: WHO-Europe, 1998.
- WHO, World Health Organization. Socioeconomic determinants of health. <http://www.who.dk/socialdeterminants> (last visited 14 November 2006). Copenhagen: WHO-Europe, 2005a.
- WHO, World Health Organization. The Bangkok charter for Health Promotion in a Globalized World. Geneva: WHO, 2005b.
- WHO, World Health organization. Commission on social determinants of Health. http://www.who.int/social_determinants/en/ (last visited 14 November 2006). Geneva: WHO, 2006.
- Wilkinson R, Marmot M (eds). *social determinants of health. The solid facts*. Copenhagen: WHO-Europe, 2003.
- WVC, Ministerie van WVC [Ministry of Welfare, Health and Culture]. Nota 2000. Over de ontwikkeling van gezondheidsbeleid: feiten, beschouwingen en beleidsvoornemens. Tweede Kamer [Dutch House of Representatives], vergaderjaar 1985- 1986, 19500, nrs. 1-2. Rijswijk: WVC, 1986.

YOUTH

Dutch young people are predominantly healthy, but appropriate preventive care is needed to keep today's young people healthy in the future

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

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

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

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

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



7 YOUTH

Maartje Harbers

7.1 Introduction

7.1.1 Young people as target group

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7.2 International policy frameworks

7.3 Visions on youth policy

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7.4 Local collaboration in easily accessible centres

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7.6 Discussion and conclusions

References

7.1 Introduction

This chapter discusses three major policy topics that are important for young people, namely developments in the broad youth policy, the creation of a local collaboration in easily accessible centres such as the Dutch Youth and Family Centres (Centra voor Jeugd en Gezin), and finally the ‘Healthy School’ approach. In the current coalition agreement, both the schools and the Youth and Family Centres play an important role in the prevention policy.

Overview of this chapter

Section 7.1 describes the health and well-being of the Dutch youth from a national and international perspective. It is followed by an outline of the broader international frameworks (Section 7.2) and national visions on youth policy in England, Belgium (Flanders)¹ and Sweden (Section 7.3) to provide insight into how these visions influence each of the country’s policies. Section 7.4 describes initiatives in England, Belgium (Flanders) and Sweden that are comparable to the Dutch Youth and Family Centres. These countries were selected because they also try to bring together youth services, albeit from a different setting. Section 7.5 describes the Healthy School approach. In the Netherlands few schools have a school health policy. The same applies to Germany. In England and Scotland, all schools should become Healthy Schools soon. Therefore, it is interesting to look at how these countries stimulate schools to implement health policies.

The main question in this chapter is what the Netherlands can learn from the youth policy in other countries and the way in which these countries bring together the different youth services to create a more coherent approach to care for young people. An answer to this question can be found in the discussion and conclusions in Section 7.6.

7.1.1 Young people as target group

Mental problems and accidents are the main cause of disease burden among young people

Few young people have health problems. By far, most young people are healthy. The few cases of child mortality that still occur are usually due to complications at birth, congenital disorders and accidents. Mental disorders and injuries caused by accidents are most important for the disease burden at a young age (De Hollander et al., 2006). Every year, one in 22 young people (4.5%) between 13 and 17 years of age suffer from depression, and almost one in 50 young people between 15 and 24 years of age need to be treated at the casualty ward due to a traffic accident. Moreover, almost one-quarter of all of the victims of traffic accidents are between 15 and 24 (Schoemaker et al., 2005; Lanting et al., 2006). The most important causes of death among young people are suicide and traffic accidents. Most health in this age group can be gained by preventing psychosocial problems and (traffic) accidents (De Hollander et al., 2006). One of the priorities of the youth policy is the prevention of psychosocial problems among young people through parenting support and early detection (Operatie Jong, 2003; VWS, 2003a) (see the chapter Depression).

Youth important target group to prevent health problems occurring at a later age

Young people are an important target group to prevent health problems occurring at a later age: this is the period during which lifestyle habits such as eating and exercise patterns are developed (De Hollander et al.,

¹ This chapter describes the situation in Flanders, not Belgium. Belgium is a federal state with three regions: the Flemish Region, the Walloon Region and the Brussels-Capital Region, and three communities: the Flemish Community, the French Community and the German-speaking Community. In Flanders, the regional and community agencies merged, creating one Flemish Parliament and one Flemish Government. The Walloon Region and the French Community did not follow suit. In this chapter, ‘national’ refers to the Flemish Government when used in conjunction with Flanders.

2006). In addition, behaviour at a younger age can have irreversible negative effects on one's physical development (for example, the effect early excessive alcohol consumption has on the development of the brain), with consequences for one's (social) functioning at a later age.

Unfavourable trends in lifestyle of young people

Several health determinants are currently developing unfavourably among youth in the Netherlands. Less than one in ten young people eat enough vegetables and this percentage is still decreasing. Only slightly more than one-quarter of the young people meet the norm for healthy physical activity. In fact, the increase in overweight and obesity is highest among children. For boys, the current prevalence of overweight (obesity) varies depending on age between 9.2 and 17.3% (overweight) and between 2.5 and 4.3% (obesity). For girls, the prevalence varies between 14.6% and 24.6% (overweight) and between 2.3% and 6.5% (obesity) (Van den Hurk et al., 2006; Schokker et al., 2006) (see Section 4.1.2 in the chapter Overweight). Overweight, physical inactivity and an unhealthy diet are risk factors for chronic diseases at a later age, such as diabetes. Moreover, diabetes is increasingly less an age-related disease and the number of young diabetics is increasing.

These unfavourable trends provide starting points for a preventive health policy for young people. The Dutch prevention memorandum 'Opting for a healthy life' contains two objectives that are specifically aimed at young people (VWS, 2006):

- restore the consumption of alcohol by young people under the age of sixteen to the level of 1992
- the percentage of young people with overweight must decrease (base year 2005)

The other targets in the prevention memorandum (fewer smokers, fewer adult problem-drinkers, the percentage of adults with overweight may not increase, the number of patients with diabetes may not increase by more than 15% between 2005 and 2025, and more people receive preventive help against depression) are not specifically aimed at young people. Because lifestyles such as eating and exercise patterns are developed in youth, the healthy basis needed to achieve these targets seems to be in the hands of the young people themselves.

Youth policy in the Netherlands is fragmented

The well-being of young people is, however, not only determined by health and lifestyle factors. Reducing the well-being of children and young people to only health and lifestyle factors would undermine a multifactorial approach to their well-being, which requires an intersectoral approach. Several countries around the world are currently working on increasing the cohesion between general youth policy, youth health care and (social) child and youth care and are starting to see them less as separate entities. Although the same trend can be observed in the Netherlands, Dutch youth policy is still characterized by fragmentation. A large number of rules, agencies and governments are involved in the actual implementation of youth policy. This blurs the policy and fragments tasks and responsibilities. Because of poor collaboration, young people do not always get the right help at the right time. It is estimated that between 50,000 and 80,000 children are battered, neglected or abused at home. A recent study has revealed that this number is higher. Some 50 children die of abuse every year (Van Eijck, 2006; Dutch House of Representatives, 2007). The United Nations Committee on the Rights of the Child (UNCRC) has also voiced its concern about the coordination between ministries and between national government and local authorities in the Netherlands (Van Eijck, 2006).

7.1.2 Health and well-being of young people from an international perspective

Significant numbers of Dutch and European young people have unhealthy lifestyle

From an international perspective, the number of smoking pupils (see Section 2.1.2 in the chapter Smoking) in the Netherlands is average compared with other European Union (EU) countries in 2003. Although the percentage of smokers in the Netherlands is decreasing, the decrease is marginal among young people (De Hollander et al., 2006). For alcohol consumption, Dutch young people are at the top of the EU ranking, with alcohol consumption among young people still rising. One-quarter of 15- and 16 year-

old Dutch pupils drink alcohol ten or more times a month. For binge drinking (the drinking of five or more alcoholic beverages during a single event) Dutch pupils rank among the top three in the EU (28%) together with the Irish (32%) and the British (27%) (Hibell et al., 2004) (see Section 3.1.2 in the chapter Alcohol). In terms of XTC use, Dutch young people also rank among the biggest users in Europe (5%), together with, among others, Czech (8%) and British (also 5%) pupils. The percentage of cannabis users among Dutch young people is also relatively high, but in a number of other countries (the Czech Republic, Ireland, France, the UK and Spain) young people use cannabis significantly more often than in the Netherlands (Hibell et al., 2004). And finally, Dutch pupils use condoms less frequently than pupils in other European countries (Currie et al., 2004).

General well-being of Dutch young people relatively good

A good picture of young people's well-being can only be obtained if this is compared in more than one sector. UNICEF recently published a study in which countries were compared according to six different dimensions of child well-being: material well-being (poverty), health and safety, education, peer and family relationships, behaviours and risks, and young people's own subjective sense of well-being. On average, Dutch children scored the best in these six dimensions in a comparison with other OECD countries (Organisation for Economic Co-operation and Development). The Netherlands also ranks among the top ten for all six dimensions. The dimensions in which the Netherlands scored the lowest are material well-being and education (UNICEF, 2007).

7.2 International policy frameworks

The protection and promotion of the health and well-being of children constitute the firm basis by which the public health policy of a country is first assessed. International conventions, policy frameworks and exchange programmes constitute an important benchmark and instrument for the national public health policy. Examples of important documents are:

- the United Nations Convention on the Rights of the Child (UNCRC)
- various reports by the World Health Organization (WHO) and the European Strategy for Child and Adolescent Health and Development by WHO-Europe
- the European Union's recent White Paper on young people
- different networks of the European Union and WHO aimed at health such as the 'European Network of Health Promoting Schools' (ENHPS)
- the programmes of the Council of Europe aimed at youth policy

The UNCRC provides legal and ethical framework for youth policy

The internationally recognized rights in the UNCRC provide both a legal and an ethical framework for youth policy. Like most of the countries, the Netherlands has ratified the UNCRC. This international convention establishes that children have the right to care, protection and participation – or as the Dutch would say – respect. Every country is obliged to respect these rights. By ratifying the convention, the Netherlands also made commitments in the area of child health care (UN, 1989).

The UNCRC is based on the following four core principles:

- No discrimination. All rights apply to all children.
- Devotion to the best interests of the child. For every decision made by the government, institutions and adults, the interest of the child is leading.
- The right to life, survival and development. The government is obliged to ensure the survival and development of children.
- Respect for the views of children. Every child has the right to freely voice their views on issues that affect them. Children have the right to participate and decide on issues that affect them.

The European Strategy for Child and Adolescent Health and Development

The core principles of the UNCRC can also be found in the European Strategy for Child and Adolescent Health and Development by WHO-Europe. The purpose of this strategy is to help Member States formulate and carry out their own national policy. The strategy pays a lot of attention to an unhealthy environment and lifestyle. The overarching goal of the strategy is to enable children and adolescents in the European Region to realize their full potential for health and development and to reduce the burden of avoidable disease and mortality. The strategy is based on four principles: life-course approach, equity, intersectoral action and the participation of young people (WHO, 2005a).

Child health care policy must tie in with the broader youth policy

Different WHO reports indicate the importance of cohesion between youth health care and the broader youth policy. The living environment, which consists of, for example, the welfare and structure of the family, support from family and peers and the school environment, has a big influence on the health and lifestyle of young people. This is why policy aimed at the health of young people is more effective when it takes these influences into account (Currie et al., 2004). Also the 'European Health Report 2005', which has a special focus on children and adolescents, emphasizes the importance of a multisectoral approach in which both the broader determinants of ill health, such as poverty and social inequality, are addressed as well as specific risk factors (WHO, 2005b). A review of WHO-Europe's 'Health Evidence Network' concluded that the most effective programmes for the prevention of disease and the promotion of health among children and young people are carried out by the government and are aimed at reducing poverty and social inequality. In addition, there is also evidence that simultaneous, multidimensional inputs at national, local and individual level increase the effectiveness of general health promotion campaigns. According to the review, a national plan for the health and well-being of young people and the availability of data to assess the impact of interventions can further increase the effect.

Interventions that are least likely to work are ones that deal with single issues and are carried out at only one level in the society (WHO, 2005c).

Health of young people on agenda of European Commission

In 2000, a report by the European Commission drew attention to the large diversity in the health of and the health trends among European young people (15 to 24 years old). Although the majority of the European young people are healthy, a number of chronic disorders such as diabetes and overweight are increasing as a result of an unhealthy lifestyle (EC, 2000). The international comparison of the lifestyle of young people (Section 7.1.2) also revealed that a large number of European young people have adopted lifestyles that are harmful to their health. This means that health promotion must remain a priority for national and international policy (Currie et al., 2004; Van der Wilk & Jansen, 2005).

In recent years, the European Commission has taken a number of measures aimed at young people, such as the ENHPS. This network promotes the collaboration and knowledge exchange in the area of prevention in schools. Today, more than 40 European countries, including the Netherlands, are participating. The network consists of a partnership between three international organizations: the European Commission, WHO-Europe and the Council of Europe (see the website <http://www.euro.who.int/ENHPS>) (Stewart-Burgher et al., 1999). The EU's new Programme of Community action in the field of Health (2007-2013) addresses the health of children and young people. 'The programme should place emphasis on improving the health condition and promoting a healthy lifestyle and a culture of prevention among children and young people' (EC, 2006).

European White Paper must increase cohesion of national policy measures

Children and young people are part of the European public health policy, but there is no formal basis for EU legislation or decisions concerning youth policy. In recent years, the need to collaborate on and harmonize youth issues has also increased in the EU. This finally led to the publication of a White Paper on youth issues entitled 'A new impetus for European youth'. It is not a goal of the White Paper to develop a European youth policy, but to develop a new collaboration framework for youth policy in the European

Union, the purpose of which is to increase the impact and cohesion of national policy measures (EC, 2001; Netherlands Institute for Care and Welfare (NIZW) 2005).

The White Paper has two pillars: the application of the 'Open Method of Coordination' on youth issues and more focus on young people in other policy areas at the EU and national level. The European Commission and the Member States agreed on common targets for the four priorities below (EC, 2001; NIZW, 2005).

The Member States submit regular progress reports on:

- youth participation
- youth information
- encouraging voluntary service
- increasing knowledge of youth-related issues

The Council of Europe also develops guidelines and programmes with the aim of achieving a coherent and effective youth policy at the local, national and European level. Youth participation is one of the priorities (Council of Europe, 2005).

These international frameworks, activities, programmes, networks and reports have produced a number of common starting points for policies aimed at youth. The interests of young people must be central. The government should help young people to develop themselves and promote their participation. Furthermore, policy aimed at young people should be intersectoral. These starting points are a source of inspiration for national youth policy, for example, for a national vision on youth policy as described in the next section.

7.3 Visions on youth policy

This section outlines the broader frameworks of youth policy in the Netherlands, England, Belgium (Flanders) and Sweden to provide insight into how the vision on youth policy influences policy in each of the countries. The central question is what the Netherlands can learn from the approach in youth policy in other countries.

7.3.1 The Netherlands

Operation Young must increase cohesion in youth policy

Dutch youth policy is aimed at children, young people and young adults between 0 and 25 years of age. The goal of the now completed 'Operation Young' project was to increase the cohesion in the Dutch youth policy and improve the collaboration between the departments, authorities and agencies. It consisted of a partnership between the Ministry of Health, Welfare and Sport, the Ministry of Education, Culture and Science, the Ministry of Justice, the Ministry of Social Affairs and Employment and the Ministry of the Interior and Kingdom Relations. Operation Young was to provide more and sustainable cohesion in the approach to youth policy by the five departments.

More focus on prevention

The heart of Operation Young's youth agenda was to help children and young people with problems on time and effectively with respect to their further development. It is essential that prevention has priority over curing and repressing. To intervene and prevent problems on time and appropriately, basic services such as schools, child health centres ("consultatiebureaus"), playgroups and crèches (child day care) must function well and be capable of detecting problems and referring people (Operation Young, 2003).

Steering recommendation advises on future implementation of youth policy

Based on Operation Young, the Commissioner for Youth and Young People Policy issued a steering recommendation containing proposals for simplifying and improving the organization of youth policy (Van

Eijck, 2006). Part 1 of the steering recommendation contains 25 proposals for the future organization of youth policy. Youth policy must give a central position to the needs of the child. And a Minister of Youth, who is accountable for the integrated youth policy, must be appointed for a period of at least four years.

7.3.2 England

Youth policy also fragmented in England

The problems that the Netherlands is experiencing with its youth policy are not unique. In England, too, incidents have occurred in recent years that indicate poor collaboration. In February 2000, for example, the eight-year-old Victoria Climbié died after being badly abused by her great-aunt and her boyfriend. An inquiry led by Lord Laming concluded that poor coordination and a failure to share information between health care professionals were crucial to this drama (DfES, 2003).

Green Paper Every Child Matters puts interests and positive outcomes of youth first

In 2003, the then Department for Education and Skills (DfES) published the Green Paper 'Every Child Matters' in reaction to Lord Laming's report into Victoria's death. The paper describes the government's vision on the reform of services for children and young people (0 to 19 years old). The child and a positive outcome for children are central (DfES, 2003). The government must help children achieve the following five outcomes that matter most to children:

- be healthy
- stay safe
- enjoy and achieve
- make a positive contribution
- achieve economic well-being

Turn from problem solving to prevention

To help young people achieve these five outcomes, a change in the culture and the way care is provided to children is needed. This shifts the focus from counteracting the consequences of problems to early intervention and prevention. To strengthen preventive services for young people, the Green Paper builds on existing plans. The focus is on four themes (DfES, 2003; Van der Pijl & Konijn, 2006):

- increasing the focus on supporting families and carers
- ensuring necessary intervention takes place before children reach crisis point, among other things, by improving the information sharing, by introducing a lead professionals (a kind of case manager) and developing services in multidisciplinary teams close to the child, for example, at school or in children's centres (Section 7.4.2)
- the integration of services for young people as part of Children's Trusts (Section 7.4.2)
- ensuring that the people working with children are valued, rewarded and trained to fill the many vacancies

In July 2005, the government launched another Green Paper with the title 'Youth Matters'. This Green Paper contains proposals to improve the outcomes of young people between 13 and 19 years of age. Every young person is entitled to a positive future through learning in a way that is motivating, opportunities for positive activities and voluntary work, and better information to make well-informed choices about their lives. Help must also be readily available when they have problems. Youth Matters also starts with an integrated approach that on the one hand responds to individual needs and on the other supports all young people to achieve the five outcomes of Every Child Matters. The lack of positive activities for young people is worrisome because these activities can contribute to their personal and social development and hence also to their self-realization. In addition, positive activities help prevent young people becoming involved in crime and developing anti-social behaviour (DfES, 2005; DfES, 2006).

Youth policy in England integrated at local and national level

The vision of the English government is that all organizations, national, as well as regional and local, and both public and private partners can work together to improve the lives of children and young people (Brummelkamp, 2005). In 2003, national responsibilities for policies on all fields relating to children and young people (except youth health care) were integrated in the Department for Education and Skills. The government also appointed a new Minister of Children, Young People and Families whose job it is to coordinate policy within the government. The development of an integrated policy at the national level makes it easier to assess how agencies collaborate at the local level (DFES, 2003).

7.3.3 Belgium (Flanders)

Flemish Youth Policy Plan important step towards integrated youth policy

Flanders is also moving towards a more integrated youth policy. The policy, which is referred to as group-oriented policy or categorical policy, is created from the viewpoint of the youth and intersects with different policy areas and government levels and overlaps with many different sectors. Like in the Netherlands, youth policy in Flanders is aimed at children, young people and young adults between 0 and 25 years of age (Anciaux, 2006; Anciaux et al., 2006).

Since 1999, Flanders has had a Minister of Youth, who falls under the Ministry of Culture, Youth, Sport and Media and is a coordinating authority when there are overlaps with different departments. By decree, the Minister of Youth must create a Youth Policy Plan before the end of his or her first full term, which is rather exceptional in Europe. The first Flemish Youth Policy Plan was published in 2002, and was an important step towards an integrated youth policy. Every minister was involved in the Youth Policy Plan. Meanwhile, a second Flemish Youth Policy Plan, which builds on the first plan and sets out the Flemish government's integrated youth policy for the period 2006-2009 (Anciaux et al., 2006; Anciaux, 2006) has been published.

Positive approach youth in Flemish Youth Policy Plan

The mission statement in both Youth Policy Plans reflects a positive approach to youth, whereby the starting point is the belief in the strength of children and young people (Anciaux et al., 2006; Anciaux, 2006). The mission statement is as follows: 'The objective of the Flemish youth plan is to contribute to the optimal participation, development and self-realization of every child and young person, as an individual and in formal and informal groups. It puts special emphasis on the importance of community involvement and responsibility. It is based on faith in the possibilities and belief in the large diversity of young people who are considered to be fully-fledged actors in and co-owners of society.' The policy centres on giving children as many opportunities as possible for developing themselves. Additional support should be given to young people with physical or social problems to prevent exclusion and the need for curative activities as much as possible (Anciaux, 2006; Anciaux et al., 2006).

Policy plan aims at broad harmonization of youth issues

The policy plan also reveals the ambition to attune every area of policy related to youth. Because youth policy stretches across almost every activity, a pragmatic approach was chosen and a number of points where youth policy intersects with different policy sectors were identified in the Youth Policy Plan. The plan also describes concrete measures that the ministers involved in the different sectors are planning for 2006-2009. This gives the plan broader political support and increases the focus on its implementation (Anciaux, 2006; Anciaux et al., 2006). One of the selected points at which youth policy intersects with several sectors is the welfare sector with the 'Integrated Youth Care' project (Anciaux, 2006).

Integrated Youth Care in response to compartmentalization and poor coordination

The concept of Integrated Youth Care was developed in response to the 'Social Policy Memorandum Special Youth Care' (Maatschappelijke Beleidsnota Bijzondere Jeugdzorg) that was published in 1999. Among other things, the memorandum revealed a compartmentalization of sectors and a lack of

coordination. The bottlenecks were not restricted to the ‘Bijzondere Jeugdbijstand’ (the Flemish child and youth care). There was a murky jungle of services making it difficult for young people to find their way around them. Some young people ended up in several sectors, while others fell between the gaps. And the help offered was based more on supply than on demand. The Integrated Youth Care must ensure intersectoral collaboration and better fine tuning between the supply of youth services and the demand from parents and children (Flemish Parliament, 1999a; Flemish Parliament, 1999b; Integrated Youth Care, 2006).

General prevention in Flanders also strengthened

In a recommendation for the social policy memorandum, the Flemish Parliament asked the Flemish Government to further elaborate the general prevention directed at the national level and to prioritize the organization of general prevention at the local level. In addition, the government also needed to provide more parenting support services in the direct living environment of families and young people, through, for example, Child & Family and the Pupil Guidance Centres (Section 7.4.3) (Flemish Parliament, 1999a; Flemish Parliament, 1999b; Integrated Youth Care, 2006).

7.3.4 Sweden

Integrated Swedish youth policy based on young people's interests

The foundation of Swedish youth policy, which is based on a holistic approach to the living conditions of young people, was already laid in the 1980s. The policy was divided into five areas based on what young people think is important, namely learning and personal development, health and vulnerability, influence and representation, self-support, and culture and leisure time (Hallengren, 2005). Sweden distinguishes between policy aimed at children and policy aimed at young people. The youth policy discussed here is aimed at young people between 13 and 25 years of age (Hallengren, 2005).

Youth policy falls under the Ministry of Integration and Gender Equality. In 1986, Sweden appointed a Minister of Youth Affairs, who coordinates the work the different ministries do for young people (Groen & Van Erp, 2005; Hallengren, 2005; Van der Pijll & Konijn, 2007). Since 1993, Sweden also has an ombudsman for children. The National Board for Youth Affairs coordinates the youth activities of the different ministries (Van der Pijll & Konijn, 2007).

Also Sweden's policy has a positive attitude towards youth

Swedish policy is also based on a positive attitude towards the capacities of young people. This is revealed by the Bill ‘The power to decide – the right to welfare’ (Makt att bestämma - rätt till välfärd), which was adopted by the Swedish parliament in 2004. This Bill provides a new structure for Swedish national youth policy, the overall aim of which is to give all young people equal opportunities to develop, be empowered and gain influence over their everyday lives and be able to realize their dreams. (Hallengren, 2005). The new Bill contains two new overall objectives for the Swedish national youth policy:

- Young people are to have genuine access to power: young people must be given the opportunity to influence the general development of society as well as their own lives and immediate surroundings.
- Young people are to have genuine access to welfare: young people must have genuine access to a decent material, cultural and social standard of living. They will also be protected against crime, bullying, discrimination and other forms of abusive treatment. Good possibilities for physical and mental health are also important for access to welfare.

Influence and participation are the core of positive youth policy in Sweden

In Sweden, influence and representation are considered to be the key to effective youth policy and emerge from the positive attitude towards the capacities of young people. Young people should not only have influence because it is a democratic right, but also because their knowledge, experience and values are a valuable resource for society. Every young person can make a considerable contribution to the development

of society if he or she is given the chance. This is why young people have to be more involved and be given the opportunity to contribute to the making and realization of decisions. Youth organizations play an important role in the creation of space for influence and representation (Hallengren, 2005).

Youth well-being also important determinant in Swedish public health policy

The second objective of the Swedish youth policy states the importance of good health for access to welfare, but in reverse, the welfare of young people also has a prominent place as a determinant in the Swedish public health policy. The overarching aim of this policy is 'to create the conditions for good health on equal terms for the entire population' (see Section 6.3.3 in the chapter Health Inequalities). This is based on eleven objectives containing the most important determinants of Swedish public health (see Text block 6.4 in the chapter Health Inequalities). One of these objectives is: 'secure and favourable conditions during childhood and adolescence'. Family situation, school and recreation are the most important aspects of child health. This is why preventive measures aimed at the health of children and young people must concentrate on improving the societal conditions for families with children, strengthening child care and developing 'Health-Promoting Schools'. The social insurance system and social services play an important role in strengthening the position of families with children in general (Ågren, 2003). In the 2005 'Public Health Policy Report', the Swedish National Institute of Public Health stated that broad possibilities for supporting parents of children of all ages are a priority for tackling mental illness in children (SNIPH, 2005).

7.4 Local collaboration in easily accessible centres

The previous section revealed that England, Sweden and Belgium (Flanders) attach a lot of importance to a positive and integrated approach, the promotion of collaboration and the improvement of prevention. The Dutch government will improve the coherency of youth policy and strengthen preventive tasks by, among other things, creating more Dutch Youth and Family Centres that bundle local tasks in the area of youth and parenting. This section first describes plans in the Netherlands and then comparable initiatives in England, Belgium (Flanders) and Sweden. These countries were selected because they also bring together youth services albeit from a different starting point. The main question is what the Netherlands can learn from the way other countries have integrated or consolidated the different youth services to create a more cohesive care for young people.

7.4.1 The Netherlands

Local authorities given more important role in youth policy

The steering recommendation issued by the Commissioner for Youth and Young People Policy gives local authorities a more central role in youth policy (Van Eijck, 2006). This is apparent from, among other things, the following recommendations:

- Local authorities are responsible for the overall direction of youth policy. This applies to both the general and preventive tasks as well as to the connections with specialized tasks. This responsibility is preferably held by an alderman for youth.
- The central government is responsible for the creation of frameworks for government tasks in the area of education, health care and safety.

Part of the tasks in the area of child and youth care will be transferred from the provincial government to local authorities so that aspects such as preventive health care, parenting support, simple ambulant support and integrated assessment can be managed by the local authorities. The central government defines the tasks and the quality requirements and gives local authorities enough room to adapt the policy and its implementation to the local situation (Van Eijck, 2006).

Comprehensive help for parents and children in Dutch Youth and Family Centres

The steering recommendation issued by the Commissioner for Youth and Young People Policy also recommends consolidating tasks in the area of parenting, preventive health care and protection into an easily accessible walk-in location for all young people and parents: a Centre for Youth and Family (CJG) (Van Eijck, 2006). The broad lines of the CJG were outlined in a letter to the Dutch House of Representatives in October 2006 (Dutch House of Representatives, 2006). The exact structure of the CJG will be left to the local authorities and can therefore be different for each local authority. A CJG can, for example, be built up from an existing service in the neighbourhood or municipality, the youth health care service, primary care centres or from an extended school.

The following tasks should be consolidated in the CJG:

- basic task package of youth health care
- five functions from the Dutch Social Support Act (WMO) for the local authority (information and advice, identification of problems, guidance to help, minor pedagogical help, coordination of care)
- provision of information (including the maintenance and management of the electronic child database (ECD) in youth health care and possibly the reference index)
- if possible, basic obstetric care

It is crucial that the CJG collaborate with primary care (in any case with GPs, obstetric and maternity care), schools, crèches and playgroups, the police, social services, child and youth work and the Youth Care Agencies (Dutch House of Representatives, 2006). The CJG must not only be an easily accessible place where people can ask questions and discuss problems concerning parenting and growing up, but also a place that is able to quickly provide and coordinate the necessary help. If specialist help is needed that the CJG cannot provide, the CJG and the Youth Care Agency will have to collaborate so that people are quickly referred to indicated care or to care based on the Exceptional Medical Expenses Act (AWBZ). This should enable the CJG to play a role in the multidisciplinary chain of care, which is considered to be an essential part of child and youth care.

7.4.2 England

National government determines policy, local authorities execute it

In England, the national government determines the policy but its implementation is decentralized. Local authorities are responsible for the implementation and the actual service offered. The statutory requirements and the national government's expectations in terms of local action are described in 'Every Child Matters: Change for Children', the elaboration of Every Child Matters. It contains a national framework for local change led by local authorities. The document also contains targets and indicators to measure progress (Brummelkamp, 2005; Van der Pijl & Konijn, 2006; DfES, 2004).

Text block 7.1 Children's trusts

One of the recommendations from Every child matters is that all local authorities have Children's trusts by 2006. Children's trusts bring together all services for children and young people in an area, underpinned by the Children Act 2004 duty to cooperate, to focus on improving outcomes for all children and young people. They will support those who work every day with children, young people and their families to deliver better outcomes - with children and young people experiencing more integrated and responsive services, and specialist support embedded in and accessed through universal services. People will work in effective multi-disciplinary teams, be trained jointly to tackle cultural and professional divides, use a lead professional model where many disciplines are involved, and be co-located, often in extended schools or children's centres.

Children's trusts will be supported by integrated processes. Some processes, like the Common Assessment Framework, will be centrally driven, whereas others will be specified at a local level.

All of this requires arrangements for governance that ensure everyone shares the vision and give each the confidence to relinquish day-to-day control of decisions and resources, while maintaining the necessary high-level accountability for meeting their statutory duties in a new way.

Across the whole system there are some unifying features which help to link the various elements:

- Leadership at every level, not just the director of children's services, but at the front line.
- Performance management driving an outcomes focus at every level, from area inspection to rewards and incentives for individual staff.
- Listening to the views of children and young people - on the priorities at a strategic level, and on how day-to-day practice is affecting them personally.

Source: <http://www.everychildmatters.gov.uk/aims/childrenstrusts/>

Local authorities are obliged to promote collaboration

In the 'Children's Act 2004', the national government legally obliged local authorities to promote collaboration in the care for children (DfES, 2004). In the long term, the government wants to integrate the key services for children and youth at both the local and national level (DfES, 2003). At the local level, there is a preference for integration in 'Children's Trusts' (Text block 7.1). Children's Trusts, Children's Centres (Text block 7.2) and extended schools also play an important role in promoting the health of all children and young people in the public health White Paper 'Choosing Health: making healthy choices easier' (DH, 2004) (see Section 6.3.2 in the Health Inequalities chapter).

All local authorities must appoint a 'director of children's services' to whom the Children's Trusts must report. At the local level, the director is responsible for education, social services and delegated health services. Local authorities must also create a 'Children and Young People's Plan' which describes how services for young people are adapted to local conditions (DfES, 2003; DfES, 2004).

First evaluations of the Children's Trusts and Sure Start positive

The first results of an evaluation of a number of pilots with Children's Trusts are reasonably positive (National Evaluation of Children's Trusts, 2005). An evaluation of Sure Start (NESS, 2002) was published in 2002. Here too, the first results were positive. The number of children using child day care has strongly increased and the relationship between parents and children has improved (Van der Pijll & Konijn, 2006). There are, however, also signs that the not-so-poor families in disadvantaged neighbourhoods benefit the most from Sure Start and that this could even be detrimental to the families most in need (NESS, 2005).

Text block 7.2 Sure Start Children's Centres

'Sure Start Children's Centres' offer one of the most important tools to achieve the objectives of Every Child Matters. They were established within the programme 'Sure Start' through which the English government aims to offer every child the best possible start, by bringing together early childhood education, childcare, health services and family support for families with children younger than five years old. This support is bundled into local Sure Start Children's Centres per neighbourhood, offering parents and children an integrated service (Sure Start, 2006; van der Pijll & Konijn, 2006). Local governments are responsible for the location and the development of the Children's Centres. Children's Centres can, for example, be set up by (Pre-)schools, neighbourhood groups and health care centres.

Sure Start mainly focuses on the poorest regions in the country. From 2010 every child must be able to access such a centre. Sure Start forms the foundation for the government's policy aimed at reducing social exclusion and poverty among children (also see paragraph 6.3.2 in the chapter Health Inequalities). Investments in early childhood education, the health of young children and family support should

inevitably stimulate the physical, intellectual and social development of children, so that they reach their full potential at home and at school and the cycle of inequality is broken.

Source: <http://www.surestart.gov.uk/surestartservices/settings/surestartchildrenscentres/>

7.4.3 Belgium (Flanders)

Flemish decree obliges collaboration in regional networks

The Flemish decree Integrated Youth Care obliges all providers of directly accessible help and emergency help to collaborate in six regional networks. This collaboration must result in better fine tuning and the fastest and most efficient use of the most appropriate help without affecting the individual characters of the existing agencies. The collaboration, the details of which are determined by the Flemish government, is documented in a collaboration protocol. Also, the services offered have to become more transparent by describing them in well-defined units (modules). An access portal (office window) also has to be created for major and specialized youth services (not directly accessible) and there will be project coaching (Integrale Jeugdhulp, 2006). The new and primarily theoretical concepts in the Integrated Youth Care were extensively tested in the field in a number of pilot regions. Experiences gathered during the pilots provided input for the policy. This interaction produced two decrees in 2004 that make up the regulatory framework for the implementation of the Integrated Youth Care across the whole of Flanders (Flemish parliament, 2004). To fine tune the policy on Integrated Youth Care at the national and the regional level, the six regions will each create a regional Integrated Youth Care plan that together form the basis for a Flemish Policy Plan Integrated Youth Care that must be completed in 2008 (Flemish parliament, 2004).

Pivotal role for Pupil Guidance Centres (Centra voor Leerlingenbegeleiding)

Among other agencies, General Social Work (Algemeen Welzijnswerk), Flemish child and youth care (Bijzondere Jeugdbijstand), the Pupil Guidance Centres (CLB) and Child & Family joined forces in the Integrated Youth Care. The CLBs play a pivotal role between education and the welfare and health care sector. CLBs were already obliged to create a network with youth services in their region. Moreover, they also provide the preventive health care for school age children (CLB, 2006a). Preventive health care for children who do not yet go to school is provided by GPs, paediatricians and Child & Family. CLBs and Child & Family also play an important role in increasing the availability of parenting support (Flemish parliament, 1999a).

7.4.4 Sweden

Youth policy in Sweden strongly decentralized

Sweden is characterized by a strong decentralization, whereby the local authorities are responsible for the policy and the implementation of child and youth care as well as social services. The national government provides the legal frameworks, but local and regional governments have a lot of freedom to organize and adapt policy to the local situation as they see fit (Van der Pijll & Konijn, 2007). Local authorities are also responsible for the protection and promotion of health (Guldbrandsson, 2005). The regional governments are responsible for things that are difficult or cannot be handled at the local level, such as residential youth services and health care for children. The strong decentralization has the advantage that policy can be adapted to the community's needs (Van der Pijll & Konijn, 2007).

Text block 7.3 The Socialtjänst

Each municipality in Sweden has a Socialtjänst (Social Services). The Social Services Act is a "frame law", regulating several areas of social support and interventions: economic assistance, pre school child care, care for the elderly and handicapped, care for substance abusers etc. Child welfare related duties of local social authorities are roughly, besides creating secure and good conditions for children in the community:

- In partnership with families support children's personal, physical and social development
- Monitor children who show signs of unfavourable development
- In partnership with families make sure that children at risk get the protection and support they need, and - if it is deemed to be in the best interest of the child - place children in care outside their families.

Generally, Swedish child welfare has its main emphasis on social support and service, rather than on child protection.

Social service providers in Sweden are obliged to keep records of their clients. Privacy protection is considered less important when safety of the child comes into play. This enables exchange of information between the different organisations, for example when a child moves from one institution to another

Source: Van der Pijll & Konijn, 2007

Strong integration child and youth care in broader youth policy

Another striking characteristic of Swedish youth policy is that there is no clear distinction between child and youth care and youth welfare. In Sweden, child and youth care is integrated in the broader context of youth policy. This is expressed by, among other things, the lack of a separate agency for child and youth care. Child and youth care, youth welfare and youth protection fall under the local social service agencies, the 'Socialtjänst' (Brummelkamp, 2005; Van der Pijll & Konijn, 2007).

Socialtjänsts carry out care and social service tasks

At the local authority level, the 'Socialnämnd' (Social Welfare Board) is responsible for the implementation of social welfare services. The social workers at the Socialtjänsts (Text block 7.3) carry out the work. The Socialtjänsts are financed from council taxes. The Socialtjänsts, together with the Swedish variant of the Dutch 'consultatiebureau' (child health centre), which also offers parenting support, play an important role in the day-to-day activities of child and youth care and youth services. The child health centres provide general parenting support for parents. All parents come here from the time of pregnancy until the child is seven years old. Parents who are experiencing problems with older children can get parenting support from the Socialtjänst (Van der Pijll & Konijn, 2007).

Sweden also takes measures to improve coordination between services

Sweden is also taking measures to improve the coordination between different types of services. Despite the decentralization and integration of youth welfare services, child and youth care, and youth protection in Socialtjänsts, Sweden also has problems with coordination. These problems primarily occur with children and families experiencing multiple problems. That's why the Socialtjänst introduced a 'social secretary' whose task it is to coordinate activities between the different agencies and who remains responsible for a specific child or family. More local authorities are also creating 'Family Welfare Centres' for families with young children. These centres combine maternity and child health care services with open preschool and access to a social welfare secretary (Brummelkamp, 2005; Bremberg, 2006). Sweden now has some two hundred Family Welfare Centres. Combining these services under one roof in such centres has the advantage that families are more easily brought into contact with open preschools and social services because almost all of the families (99%) use maternity and child health care for children up to the age of six. It also promotes collaboration between the different organizations (Bremberg, 2006).

Indicators must facilitate comparing quality and offer of care between local authorities

A disadvantage of the strong decentralization in Sweden is that the policy, the quality and the offer of care vary considerably between local authorities (Brummelkamp, 2005; Van der Pijll & Konijn, 2007). That is why indicators for child and youth care were introduced to compare the local authorities with each other (Brummelkamp, 2005). Another disadvantage of the strong decentralization and differences between local authorities is that there is hardly any national direction on innovation and development. Moreover, little

emphasis was put on research into the results and effectiveness of child and youth care until recently (Van der Pijll & Konijn, 2007).

7.5 The Healthy School

This section describes the promotion of health in schools, such as is done in the Netherlands, England, Scotland and Germany. In the area of health promotion the 'Health Promoting School' approach is very popular. The Dutch programme 'Healthy School' (Gezonde School) ties in with this concept. The Health Promoting School is based on a 'whole school' approach, the starting point of which is that learning about health promotion and health education do not suffice. Learning about health and life skills is combined with programmes that promote health. Attention is also paid to the social and physical environment of the school and the involvement of parents, pupils and the community. Moreover, the Healthy School is not only about preventing disease and promoting the health and well-being of the pupils (including physical, mental, social and emotional health), but also that of the staff and the parents (Stewart-Brown, 2006). In this way health promotion must improve the quality of the whole school environment and also contribute to the enhancement of learning outcomes (Stewart-Burgher, 1999). The Health Promoting School approach fits in a positive vision on youth policy in which the promotion of the development potential of all young people is central.

The Netherlands still has few schools with a school health policy. The same applies to Germany. In England and Scotland, all of the schools must become Healthy Schools soon (in England and Scotland respectively they are called 'Healthy School' and 'Health Promoting School'). This is why it is interesting to look at how these countries stimulate schools to implement health policies.

7.5.1 The Netherlands

Since the 1980s, attention for environmental factors and the community in which children are raised has been increasing in the Netherlands. The term 'school health policy' was introduced and consisted of three pillars: education, care and environment. In the 1990s, health organizations developed a lot of new health promotion materials, but this growing supply did not tie in with the schools' demands. Moreover, the school health policy seemed to focus mainly on education. And so the 'Action Programme School Health Policy Netherlands' (Actieprogramma Schoolgezondheidsbeleid Nederland) was developed (Buijs et al., 2002). The action programme pleads for a better connection to the questions from the schools, more attention on health at school and a higher quality offer. This resulted in the introduction in 2004 of the national programme 'The Healthy School', an initiative of the Ministry of Health, Welfare and Sport (VWS) and nine national health-promoting agencies (GBIs). The involvement of the Ministry of Education, Culture and Science (OCW) was marginal. The OCW's current key objective policy implies that schools themselves are responsible for their school health policy. The Healthy School approach is based on the so-called schoolSlag method developed in South Limburg.

Healthy School programme must lead to a more cohesive offer

The Healthy School programme must provide a more cohesive offer (demand driven), better accessibility and higher quality of prevention in schools. The programme has to make it more appealing and easier for schools to work on health and safety. Few schools in the Netherlands have a school health policy although sufficient support seems to be present. Between 2006 and 2007, for example, some one thousand primary schools took part in the 'Ga voor Gezond Competitie' ('Say "Yes" to health' competition).

In the prevention memorandum of 2003, 'Living longer in good health', the government's intention was to encourage more schools to become Healthy Schools. Schools were invited to take part in a national network of Healthy Schools (VWS, 2003b). In the national budget of 2005, the Ministry of Health, Welfare

and Sport asked the GBIs to elaborate the concept of Healthy School. The national working group Healthy School, in which the nine GBIs collaborate, documented their vision in the working document 'The Healthy School Method in the Netherlands' (De Gezonde School Methode in Nederland). The overall objective was described as 'the promotion of health and safety at school' (Buijs, 2005). The Healthy School Method consists of four main points:

- the school is central (demand driven)
- methodical development
- connection between individual care and collective prevention
- local collaboration

The Healthy School Model (Gezonde School Model), which consists of eight interrelated components that each contribute to the health and safety of pupils and school staff, was also used. These eight components are:

- healthy and safe school environment
- psychological and socio-emotional support and guidance
- care offer
- nutrition policy
- sports and physical activity
- health education
- health promotion at work
- parent and neighbourhood participation

Healthy and safe school environment basis for health of each pupil

The promotion of health and the prevention of problems for each individual starts with a healthy and safe school environment and the overall school policy for all pupils and staff. This connection between individual care and collective prevention has been elaborated in the integrated chains of care model (Integrale Ketenzorg Model). Integrated multidisciplinary care consists of levels of prevention and care that fit together well. The chains of care model starts with the promotion of health and prevention aimed at the whole school population (Buijs, 2005).

Improving insight into effectiveness has priority

Improving insight into the effectiveness is one of the priorities of the national programme Healthy School. There are few thorough and well-conducted evaluation studies on preventive interventions in schools. This is why, with the exception of a few broadly implemented projects, the effectiveness of many projects is not known (Buijs & Busch, 2005; Leurs et al., 2005).

Quality seal stimulates Healthy Schools

The prevention memorandum for 2006 'Opting for a healthy life' also addresses schools (VWS, 2006). Moreover, the Ministry of Health, Welfare and Sport plans to certify Healthy Schools. The nine GBIs that are subsidized by the Ministry of Health, Welfare and Sport are currently working on creating a national quality seal 'Healthy and Safe School' (Keurmerk Gezonde en Veilige School) (Van Gennip, 2006). An integrated approach to themes around a healthy lifestyle is central. Schools can advertise with the quality seal, which can be an important impetus for schools to focus more on health and safety (Buijs, 2005).

The eight components of the Healthy School Model are the starting point for the quality seal. During the development of the quality seal, schools, municipal health services, GBIs and the Dutch Heart Foundation will be working closely together. The development of the quality seal will be managed at the national level by the organization that will be responsible for the overall coordination of the Healthy School (Van Gennip, 2006). The Ministry of Health, Welfare and Sport gave the task of coordinating the Healthy School working group to the Centre for Healthy Life (Centrum Gezond Leven (CGL)), which was formally launched on 1 June 2007. The municipal health services will support and advise schools on how they can obtain the quality seal for Healthy Schools.

7.5.2 England

More than 85% of the schools are participating in the National Healthy School Programme

The health of children and young people is one of the priorities in the public health White Paper ‘Choosing Health: making healthy choices easier’ (DH, 2004) (see Section 6.3.2 in the chapter Health Inequalities). In the White Paper, Healthy Schools play an important role in the improvement of the health of young people. The English government developed the ‘National Healthy Schools Programme’ (NHSP) in 1998. The NHSP is funded by the Department for Education and Skills (DfES) and the Department of Health (DH). Eighty-five percent of schools are currently participating in the programme and almost 25% have achieved the National Healthy School Status (Healthy Schools, 2007a). The English government has set a target that all schools will be participating in the National Healthy Schools Programme by 2009 and that 75% of schools will have achieved National Healthy School Status (Healthy Schools, 2007b). The NHSP is managed at the national level, but collaboration between the education and the health sector at the local level in local programmes is essential (Text block 7.4).

Text block 7.4: NHSP: based on local team-work supported at a national level

An important element of the National Healthy Schools Programme (NHSP) is the cooperation between the health sector and the education sector, at both the national and local level. Joint education (‘local education authorities’, LEA) and health (‘primary care trusts, PCT) initiatives are being set up that meet a minimum set of standard criteria. The government offers funding for these initiatives that should ultimately lead to the development of a ‘Local Health Schools Programme’ that satisfies the requirements of the NHSP.

These local programmes offer schools an information centre and help them develop into a Healthy School. All 150 LEAs have already set up an accredited joint initiative and a local programme (DH & DfES, 2005).

Healthy Schools way of improving learning outcomes

The NHSP recognizes the importance of health and of a good physical and social environment for the improvement of the children’s learning outcomes. The aims of the NHSP is not only to support children and young people in developing healthy behaviours, but also to help raise the achievement of children and young people. Other aims are to help reduce health inequalities and to help promote social inclusion (Healthy Schools, 2007b). An example of a National Healthy Schools Programme project in which the relationship between health and the improvement of learning outcomes is clearly visible can be found in Text block 7.5.

National criteria for National Healthy School Status

At the beginning of the NHSP, local programmes were allowed to determine which themes and criteria they wanted to carry out locally. In September 2005, a new, more rigorous approach was introduced to create more national consistency. Since then, to obtain the National Healthy School Status, a school has to practise a so-called ‘whole school’ approach and meet the national criteria of four main themes (Healthy Schools, 2007a; Wired for Health, 2006).

The four main themes are:

- Extensive ‘Personal, Social and Health Education’ (PSHE) including sex and relationship education, drugs, alcohol and tobacco: PSHE enables pupils to make informed decisions about their lives.
- Healthy eating: pupils are able to make healthy food choices and healthy and nutritious foodstuffs are available at school.
- Physical activity: pupils understand the benefit of physical activity and the school offers sufficient possibilities to be physically active.

- Emotional health and well-being (including bullying): promotion of positive emotional health and well-being, which enables pupils to express their feelings better, increase their self-confidence and emotional resilience. This improves their capacity to learn.

Audit tool to determine National Healthy School Status

The criteria a school must meet are included in an audit tool (Wired for Health, 2006). The local programmes register the schools that achieved the National Healthy School Status in a database. They use an audit tool to determine whether the school deserves the status. Schools can also evaluate themselves. The audit tool can be adapted for local use and random checks are carried out to ensure it is applied according to the rules, (Wired for Health, 2006).

When evaluating whether a school meets the criteria in the audit tool, the local programmes not only base their conclusion on reports of meetings and other written information, but also on the opinions of pupils, discussions with pupils and school staff, and their own observations. The four previously mentioned main themes contribute to the five positive outcomes for children in Every Child Matters (Section 7.3.2). The English version of the Dutch ‘School Inspection’, Ofsted (Office for Standards in Education), judges schools on achieving these outcomes.

Positive effect National Healthy School Programme on health and well-being

In England, there is a lot of emphasis on research into the effectiveness of interventions and the development of evidence-based strategies. A recent evaluation revealed that the National Healthy Schools Programme has a positive effect on health and well-being, in particular in disadvantaged neighbourhoods. Pupils in secondary Healthy Schools use, for example, less drugs, have more self-confidence and watch less television. In healthy primary schools, pupils are less afraid of bullying. The evaluation also revealed that Ofsted rated healthy primary and secondary schools as having better provision for Personal, Social and Health Education. Moreover, pupils in Healthy Schools have a more positive attitude towards education (DH, 2004; Thomas Coram Research unit, 2004).

Text block 7.5 An example of a National Healthy Schools Programme project: Skip2Bfit

Skip2Bfit is a cross curricular skipping programme incorporating science, numeracy IT and Healthy Eating. Skip2bfit drives performance in the classroom (and the office) by turning playground fun into a competitive sport. The use of specially designed digital counting skipping ropes in the skipping workshops and challenge sessions introduce numeracy as well. Because the physical challenge is simple, it inspires personal achievement, which motivates in other areas of life as well. This trademarked programme claims that it creates a shared pathway into an all-round healthy lifestyle, proving that the resulting self-confidence, self-discipline and resourcefulness benefit not just the individual, but the whole community. Operating successfully in schools across the UK – the Skip2Bfit programme motivates children to improve in all areas of the curriculum.

Source: www.Skip2Bfit.com

A recent review of WHO-Europe's (StewartBrown, 2006) Health Evidence Network concluded that the most effective programmes for the promotion of health in schools are programmes on mental health, healthy food and physical activity. The review also supports a number of main points in the Health Promoting School concept, namely the whole school and multifactoral approach and activities that extend over longer periods of time. However, there is a lack of evidence on the health promoting schools approach as a whole (Stewart-Brown, 2006).

7.5.3 Scotland

Every school in Scotland must be a Health Promoting School by 2007

The Scottish Executive set the target of every school in Scotland becoming a Health Promoting School by 2007. To do this, the Scottish Health Promoting Schools Unit (SHPSU) developed a framework for Health Promoting Schools in Scotland, 'Being Well - Doing Well' (SHPSU, 2004). The starting point is (as the title suggests) that healthy pupils will achieve better learning outcomes and will also function better socially.

Among others, the Scottish Executive Education and Health Departments, the Scottish department of the National Health Services (NHS) and Learning and Teaching Scotland (an advice and research institute in the area of education) collaborate closely in the SHPSU (SHPSU, 2004). The priorities of the SHPSU include the monitoring and evaluation of Health Promoting Schools and the development of an evidence base (SHPSU, 2007). In 2003, the SHPSU established the National Health Promoting School Network. The objective of this network is to improve the flow of information between the different partners. This is managed by the Department of Education.

National accreditation of Health-promoting Schools must improve consistency

As in England, local partnerships must help Scottish schools become Health Promoting Schools. The SHPSU has developed a 'Framework for the National Accreditation of Health Promoting schools in Scotland' to ensure a more consistent and coherent approach to the development of Health Promoting Schools throughout Scotland. The national accreditation operates on the principle of national endorsement of the local accreditation processes. The local Health Promoting School approach must meet the national criteria in the framework. In the meantime, all 32 of the local authorities and their NHS partners have had their local approach to accreditation nationally endorsed (Scottish Executive/SHPSU, 2006; SHPSU, 2006).

7.5.4 Germany

Healthy School not a goal but a means in Germany

Germany also has very few schools with a school health policy. Schools have to meet a variety of quality requirements and are mainly evaluated by their learning outcomes. Teachers are quick to consider health promotion as an additional effort. To increase the number of participating schools, health must not be seen so much as a goal, but as a means to improve the quality of the schools (Paulus, 2006; Paulus, 2005). The 'good, healthy school' (Gute Gesunde Schule) was central to the German project anschub.de. The good, healthy school was defined as a school that wanted to improve the quality of its education for the long term through interventions that are based on scientifically proven facts. anschub.de's motto was 'Using health to make good schools' (Mit Gesundheit gute Schule machen). anschub.de was not only about the school's contribution towards health promotion, but also about the contribution of health towards the quality of the school (Paulus, 2006; Paulus, 2005; see the website www.anschub.de). anschub.de was a national pilot programme on health promotion in schools that was initiated by the Bertelsmann Stiftung and in which several German institutes work together. The project ran from August 2002 to December 2007. At the beginning of anschub.de a lot of emphasis was put on developing evidence-based strategies.

7.6 Discussion and conclusions

Dutch youth is predominantly healthy, but invests in poor health at a later age

One could conclude from the UNICEF report (UNICEF, 2007) in which countries were compared according to six different dimensions of child well-being, that the well-being of Dutch youth is good. Also the majority of Dutch young people are healthy, although they and their European peers are displaying

lifestyles that are a sure investment in poor health at a later age. The disease burden that occurs at a young age is mainly caused by mental disorders and accidents. Therefore, most health in the age group 15-24 years can be gained by preventing psychosocial problems and (traffic) accidents. However, there is not always a clear relationship between these indicators and the quality of care for young people. The well-being of young people is, for example, also highly dependent on national (economic) welfare. This is why it is better to evaluate the success of youth policy by how the different parties and levels of government involved in care and services for young people create cohesive policy. A successful youth policy is dependent on good collaboration between government, care providers and parents.

Foreign initiatives and policies are a source of inspiration for the Netherlands

All of the studied countries are taking measures to increase collaboration between different actors providing services for young people. Foreign solutions will, however, not necessarily be successful in the Netherlands. They have to be considered in their local or national context. In England and Sweden, the local level has much more responsibility for health care than in the Netherlands, meaning that local partnerships are more readily created to address health problems. Sweden and England have a so-called Beveridge type of health care system. In this system, health care and public health are much more closely related to each other than in the Netherlands and Belgium, both of which have a Bismarck type of health care system, which clearly distinguishes between health care and public health. A further limitation is the fact that this chapter is mainly based on a large amount of websites, reports and policy documents of ministries and agencies. These sources only paint a limited picture of how the policy is actually carried out.

Foreign solutions can be a valuable source of inspiration for the Netherlands. This also applies to the policy frameworks of international organizations such as WHO and the European Union. In all of the countries studied, measures are taken to strengthen child and youth care and youth policy in response to criticism about the poor collaboration between health care professionals in different agencies, for example. All of the studied countries are introducing initiatives to improve information sharing and intersectoral cooperation, and to intervene earlier and more effectively in case of problems. A number of elements in the English Green Paper 'Every Child Matters' can be found back in the steering recommendation issued by the Commissioner for Youth and Young People Policy (Steven van Eijck) in the Netherlands in 2006, such as the appointment of a separate Minister of Youth and the focus on the interests of children and young people. There are also similarities with developments in the youth policies in Flanders and Sweden. There are more than enough opportunities to learn from each other's experiences. This section first describes what the Netherlands can learn from foreign visions on youth policy, then what the Netherlands can learn from the way other countries set up local collaboration and finally, the lessons related to the health policy in schools are described.

Visions on youth policy

Broad vision on youth policy must be positive

Like the Netherlands, the model countries are putting a lot of effort into strengthening the prevention and early detection of problems, but seem to be taking things a step further. All of the countries mentioned have a positive approach to youth policy, the starting point of which is the power of young people and what society wants to do with and for them. The emphasis is on increasing development opportunities for all young people so they can make the most of their lives. In the end, this is also a form of prevention, because the young people's participation in positive activities enables them to gain more self-confidence, build up more social skills, stay away from crime and develop less antisocial behaviour. The positive vision in the model countries is supported by the international frameworks of youth policy in which the central position of the young people's interests, their development and their participation also stand out as common starting points.

The Dutch policy is also aimed at all young people, but in recent years, the main focus of the Government's policy has been on the 5% of young people with severe social and psychological problems (Ross-van Dorp,

2006). Operation Young did centre on children, but here too, the focus was mainly on young people with problems. An integrated and positive vision on the youth policy may be the impetus needed to bring out the best in young people in the Netherlands, too.

Positive approach young people leads to an integrated approach

The starting point of the full development of young people as the basis for a positive youth policy also results in an integrated and intersectoral approach to improving the health and well-being of young people. England, Sweden and Belgium (Flanders) have an explicit target-group policy with a broad vision on youth policy in which the young people themselves are central. These countries also had a minister of youth with a coordinating role before the Netherlands did. By appointing such a minister, the governments are giving a good example of intersectoral collaboration. Different publications point out how important a multilevel (national and local government and individual), intersectoral and multifactoral approach, which addresses both the broader determinants of poor health as well as specific risk factors, for health is (WHO, 2005a; WHO, 2005b; WHO, 2005c; Stewart-Brown, 2006). An integrated and intersectoral approach to improving the health and well-being of young people appears to be appropriate.

Local collaboration in easily accessible centres

Countries invest in strengthening prevention services in local centres

The three countries studied prioritize the prevention and early detection of problems just as the Netherlands does. Local services that are not part of the Dutch child and youth care but are open to every child, such as crèches, playgroups, schools and health care, play an important role. The coordination between child and youth care and general and preventive youth services is essential for preventing problems. All of the countries studied are taking measures to improve the coordination between specialized or indicated child and youth care and preventive services. This is done in foreign variants of the Dutch Youth and Family Centre. England has created Children's Centres that offer parenting support and preventive health care in disadvantaged neighbourhoods in a day care centre setting. The reduction of health inequalities is also important. Children's Centres also offer, for example, early education to disadvantaged children and help parents find work or a suitable training programme.

Flanders was already familiar with Centres for Pupil Guidance in the school setting and with the different kinds of services provided by Child & Family for young children that do not yet go to school. However, the Flemish agencies have to intensify collaboration within regional networks and provide more parenting support. Also the Family Welfare Centres and the integration of youth care and welfare in the Socialtjänsts in Sweden can serve as an example for easily accessible and cohesive youth services close to home. It is worth noting that the Swedish Family Welfare Centres (like the English Children's Centres) attach importance to the availability of child day care because they enable parenthood to be combined with work or studies and stimulate the children's development and education opportunities, which, ultimately, is supposed to result in better health. Child & Family in Flanders also has a prominent role in providing child day care.

National direction as basis for local implementation

Interestingly, the policy in England, Sweden and Flanders is based on national frameworks and is mainly carried out by local authorities. The English government organizes the large-scale Every Child Matters, which is tightly managed at the national level but implemented by the local authorities who have to create a Children and Young People's Plan adapted to the local situation. The legal aspects of integrating the services are anchored in the Children's Act 2004, but local authorities are encouraged to be flexible and innovative when developing Children's Trusts and Children's Centres so they can respond to local differences. Sweden's youth policy is also very decentralized. The national government provides the legal frameworks, but local and regional governments have a lot of freedom to organize and adapt policy to the local situation as they see fit. To be able to make better comparisons between local authorities, Sweden introduced child and youth care indicators.

Flanders has a broad national Youth Policy Plan and obliges agencies by decree to collaborate in regions within the Integrated Youth Care. But the process that led to the development of the Integrated Youth Care had a strong 'bottom-up' approach that consisted of developing new concepts in interaction with experiences from pilot regions. The advantage of such a way of working is that the field staff feel involved and are therefore prepared to step up their efforts (Van den Berg, 2007). In the Netherlands, the recently completed project 'Operation Young' started a move towards stronger national direction in the development of multidisciplinary care for young people at the local level. In the Netherlands, local authorities are given a more central position in youth policy while the role of the national government consists more of providing a national framework for general and preventive tasks that can be filled in at the local level. The Dutch national government should at least impose minimum requirements for what local authorities should be responsible for at the local level.

Decentralization not a solution in itself

Although countries do not organize child and youth care at the same level (for example, mainly regionally in the Netherlands, locally in Sweden and England), youth welfare is usually the responsibility of the local authorities. Experiences in Sweden shows that it cannot be concluded that decentralizing or consolidating child and youth care and welfare at the same level or in the same organization (such as in the Socialtjänsts) will, by definition, result in better coordination and more effective service because youth services in Sweden are also suffering from poor coordination (Brummelkamp, 2005). Another disadvantage of the strong decentralization of youth welfare and child and youth care in Sweden is that policy and services offered vary considerably between local authorities. There is also very little national direction on innovation and development, and it is only recently that more emphasis has been put on research into the results and effectiveness of child and youth care (Van der Pijll & Konijn, 2007).

The Healthy School

Quality seal for Healthy Schools can stimulate school participation

The Netherlands still has few schools with a school health policy. Participation of schools is a lot higher in England and Scotland. England has a national programme, the objective of which is for every school to participate in the programme by 2009 and for 75% of the schools to be Healthy Schools. The programme is associated with a kind of quality seal, the National Healthy School Status. Scotland, too, has a concrete goal (all schools are Health Promoting Schools by 2007) and an accreditation system that also can be used to determine whether the goal has been met. The Dutch Ministry of Health, Welfare and Sport is also working on a quality seal for Healthy Schools in the Netherlands. The English and Scottish experiences with a comparable quality seal can serve as a source of inspiration. A quality seal would not only be a good impetus for schools, it would also make the Healthy School Model more concrete. The same applies to the aim of achieving a certain number of Healthy Schools.

Health is a means to improve learning outcomes

Another way of getting more schools to participate is, as Germany, England and Scotland do, to use health more as a means to improve learning outcomes than as a goal in itself. In this way, the Healthy School also helps increase the development opportunities of all children and ties in with a positive approach to youth policy. Although the favourable influence of a healthy school environment on learning outcomes has also been recognized in the Netherlands, the programme seems to focus more on promoting a healthy lifestyle. In the working document 'Gezonde School' (Healthy School), the nine GBIs describe the ultimate goal as follows: 'to improve the health of the Dutch youth by reducing risky behaviour and turning the trend towards an unhealthy lifestyle into a trend towards a healthy lifestyle'. The goals in, for example, England, are much broader and also consist of raising young people's achievement, reducing health inequalities and promoting social inclusion.

Better collaboration between health and education sector necessary at national and local level

Compared to, for example, Scotland and England, collaboration between the health and education sector in the Netherlands is still limited. Although England and Scotland both have national programmes that are tightly managed at the national level, local partnerships between health and education play an important role in the practical execution at the local level. The English government stimulated the creation of these local partnerships with financial incentives and, meanwhile, all of the 150 local education authorities have created such a partnership. These partnerships must create a Local Healthy Schools Programme that in turn will help schools become Healthy Schools. This may be why school participation is much higher in England and why the school health policy is more frequently created by the schools themselves. In 2002, the ENHPS held a conference in Egmond aan Zee on the progress of Health Promoting Schools. One of the conclusions was that the most successful results are booked with programmes that the health and education sector (Young, 2002) develop together. The Ministry of Health, Welfare and Sport appointed the Centre for Healthy Life (Centrum Gezond Leven (CGL)), which was formally launched on 1 June 2007, as the coordinator of the Healthy School working group in which all of the GBIs are represented. The coordination of the working group by the CGL will be used as a pilot for the further fine tuning of national policy aimed at professionals working in different settings such as neighbourhoods, schools and the workplace.

Conclusions

The Netherlands is not alone in its attempts to adjust its overall youth policy, youth health care, and (social) child and youth care to one another and to realize greater coherency in its youth policy. Other countries are also working hard in this area. A vision on the ideal upbringing and education of young people, ideas on Healthy (and extended) Schools, and organizational questions on child and youth care also play a role.

To summarize the international comparison have lead to the following conclusions:

Dutch young people are predominantly healthy, but appropriate preventive care is needed to keep today's young people healthy in the future

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

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

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

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

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

References

- Ågren G. Sweden's new public health policy. National public health objectives for Sweden. Stockholm: Swedish National Institute of Public Health, 2003.
- Anciaux B, Redig G, vanhee J. Youth policy in the Flemish Community. Forum 21. European Journal on Youth Policy 2006;7- 8:82-94.
- Anciaux B. Vlaams Jeugdbeleidsplan 2006- 2009. http://www.wvc.vlaanderen.be/jeugdbeleid/beleid/vlaamsjeugdbeleidsplan/documenten/jbp2_def.doc (last visited 14 March 2007), 2006.
- Berg M van den. Jeugdzorg of jeugdhulp: een wereld van verschil? <http://arno.uvt.nl/show.cgi?fid=44412> (last visited 15 January 2007). Tilburg: Universiteit van Tilburg, Vakgroep Privaatrecht, 2007.
- Bremberg S (ed). New tools for parents. Proposals for new forms of parent support (http://www.fhi.se/upload/ar2006/Rapporter/r200615_toolsParents0604.pdf). Swedish National Institute of Public Health, 2006.
- Brummelkamp G. Approaches towards children at risk. A cross national analysis. Zoetermeer: EIM Business and Policy Research, 2005.
- Buijs G, Busch MCM. Wat zijn de effecten? In: volksgezondheid Toekomst verkenning, Nationaal Kompas Volksgezondheid. Bilthoven: RIVM, <<http://www.nationaalkompas.nl>> Preventie\ In verschillende settings\ School, 24 september 2005.
- Buijs G, Jong A de, Paulussen T, Wijngaarden J van. Landelijk Actieprogramma School-gezondheidsbeleid Nederland. Woerden: NIGZ, 2002.
- Buijs GJ. Werkdocument de Gezonde School Methode in Nederland. Woerden: Landelijke Werkgroep Gezonde School/NIGZ, 2005.
- CLB, Centra voor Leerlingenbegeleiding. CLB als draaischijf tussen onderwijs, welzijn- en gezondheidssector. http://www.ond.vlaanderen.be/clb/thema/organisatie_clb/net-werk.htm (last visited 5 december 2006), 2006a.
- CLB, Centra voor Leerlingenbegeleiding. Online brochure. <http://www.ond.vlaanderen.be/clb/brochure/> (last visited 5 december 2006), 2006b.
- CLB, Centra voor Leerlingenbegeleiding. Toelichting bij de overgang van de PMS- en MST-centra naar de centra voor leerlingenbegeleiding (CLB). http://www.ond.vlaanderen.be/clb/documenten/achtergrond/toelichting_bij_de_overgang.pdf (last visited 15 January 2007), 2007.
- Currie C, Roberts C, Morgan A, Smith R, Settertobulte W, Samdal O. Young people's health in context. Health Behaviour in School-aged Children (HBSC) study: international report from the 2001/2002 survey. Copenhagen: WHO-europe, 2004.
- DfES, Department for Education and Skills. Every Child Matters. http://www.everychildmatters.gov.uk/_files/eBe7ee-AC90382663e0d5BBF24C99A7AC.pdf. The Stationery Office, 2003.
- DfES, Department for Education and Skills. Every Child Matters: Change for Children. http://www.everychildmatters.gov.uk/_files/F9e3F941dC8d4580539ee4C743e9371d.pdf, 2004.
- DfES, Department for Education and Skills. Youth matters. Department for Education and Skills, 2005.
- DfES, Department for Education and Skills. Youth Matters: Next Steps. Something to do, somewhere to go, someone to talk to. Department for Education and Skills, 2006.
- DH, Department of Health. Choosing Health: Making healthy choices easier. London: The Stationary Office, 2004.
- DH, DfES, Department of Health, Department for Education and Skills. National Healthy School Status. A Guide for Schools. http://www.wiredforhealth.gov.uk/PDF/NHSS_A_Guide_for_Schools_10_05.pdf, 2005.
- EC, European Commission. Report on the state of young people's health in the European Union. A Commission Services Working Paper. European Commission directorate-General Health and Consumer Protection. Unit F3 - Health promotion, health monitoring, and injury prevention. http://ec.europa.eu/health/ph_information/reporting/ke01_en.pdf, 2000.

- EC, Europese Commissie. Witboek van de Europese Commissie: een nieuw elan voor Europa's jeugd. COM(2001) 681 definitief. http://ec.europa.eu/youth/whitepaper/index_en.html (last visited 14 March 2007). Brussel: EC, 2001.
- EC, European Commission. Amended proposal for a decision of the European Parliament and of the council establishing a second Programme of Community action in the field of Health (2007-2013). COM(2006) 234 final. Brussel: EC, 2006.
- Eijck SRA van. Sturingsadvies deel 1. Koersen op het kind. The Hague: Operatie Jong, 2006.
- Gennip EMSJ van. Subsidieaanvraag ZonMw. Keurmerk Gezonde en veilige school, 2006.
- Groen A, Erp S van. Review of Youth Policy in Europe. Tilburg: PON, Institute for Research and Social development Tilburg, 2005.
- Guldbrandsson K. Child Health Promotion. Analyses of Activities and Policy Processes in 25 Swedish Municipalities. Stockholm: Karolinska Institutet, department of Public Health Sciences, division of Social Medicine, 2005.
- Hallengren L. Shaping a new Youth Policy in Sweden. Forum 21. European Journal on Youth Policy, 2005;4:47-59.
- Healthy Schools. National Healthy Schools Programme Progress Report. <http://www.healthyschools.gov.uk/ProgressReports.aspx> (last visited 14 March 2007), 2007a.
- Healthy Schools. Aims. <http://www.healthyschools.gov.uk/About-Aims.aspx> (last visited 14 March 2007), 2007b.
- Hibell B, Andersson B, Bjarnason T, Ahlström S, Balakireva O, Kokkevi A, et al. The ESPAd Report 2003; Alcohol and Other drug use Among Students in 35 European Countries. Stockholm: The Swedish Council for Information on Alcohol and Other drugs (CAN) and the Pompidou Group at the Council of Europe, 2004.
- Hollander AEM de, Hoeymans N, Melse JM, Oers JAM van, Polder JJ (eindred.). Zorg voor gezondheid. Volksgezondheid Toekomst Verkenning 2006 [English: Care for health. The 2006 Dutch Public Health Status and Forecasts Report. RIVM report 270061003]. RIVM-rapportnr. 270061003. Houten: Bohn Stafleu van Loghum, 2006.
- Hurk K van den, dommelen P van, Wilde JA de, verkerk PH, Buuren S van, HiraSing RA. Prevalentie van overgewicht en obesitas bij jeugdigen 4-15 jaar in de periode 2002-2004. TNO-rapport KvL/JPB/2006.010. Leiden: TNO, 2006.
- Integrale Jeugdhulp. <http://www.jeugdhulp.vlaanderen.be> (last visited 5 december 2006), 2006.
- Kind & Gezin. Preventieve Gezinsondersteuning. http://www.kindengezin.be/KG/Algemeen/Over_Kind_En_Gezin/Wat_doet_kind_en_gezin/Preventieve.jsp (last visited 5 december 2006), 2006.
- Lanting LC, Stam C, Hertog PC den, Brugmans MJP. Hoe vaak komt het voor en hoeveel mensen sterven eraan? In: volksgezondheid Toekomst verkenning, Nationaal Kompas volksgezondheid. Bilthoven: RIVM, <<http://www.nationaalkompas.nl>> Gezondheid en ziekte\ Ziekten en aandoeningen\ Letsels en vergiftigingen\ verkeersongevallen, 13 March 2006.
- Leurs MTW, Jansen MWJ, Schaalma HP, Murveeman IM, Vries NK de. The tailored schoolbeat-approach: New concepts for health promotion in schools. In: Clift S, Jensen BB (eds.). The health promoting school: international advances in theory, evaluation and practice. danish university of Education Press, 2005.
- National Evaluation of Children's Trusts. National Evaluation of Children's Trusts Phase 1 Report. Realising children's trust arrangements. university of East Anglia, 2005.
- NESS, National Evaluation of Sure Start. Getting Sure Start started. London, UK: NESS, 2002.
- NESS, National Evaluation of Sure Start. National Evaluation Report. Early Impacts of Sure Start Local Programmes on Children and Families. Report of the Cross-sectional Study of 9-and 36-Month Old Children and their Families. NESS, 2005.
- NIZW. Jeugd op de Europese agenda. Factsheet over het beleidsterrein jeugd in de Europese unie (revised version April 2005), <http://www.nizw.nl/internationaal/docs/factsheetjeugd%20op%20de%20Europese%20agenda.pdf>, 2005.

- Operatie Jong. Proeve van de Jeugdagenda. The Hague: Gezamenlijke uitgave van de ministeries van BZK, Justitie, OCenW, SZW en VWS, 2003.
- Paulus P. Anshub.de - Mit Gesundheit gute Schule machen. Eine nationale Allianz für nachhaltige Schulgesundheit und Bildung. http://www.anshub.de/cps/rde/xbcr/SId0A000F0A-8C90AACd/anshub/Anshub.de-mit_Gesundheit_gute_Schule_machen1.pdf (last visited 28 November 2006), 2006.
- Paulus P. From the Health Promoting School to the Good and Healthy School: New developments in Germany. In: Clift S, Jensen BB (eds.). The health promoting school: international advances in theory, evaluation and practice. Danish University of Education Press, 2005.
- Pijll M van der, Konijn C. Jeugdzorg in Engeland. Grote Engelse beleids- en praktijkverschillen met Nederland. *Nederlands tijdschrift voor jeugdzorg* 2006;10(1):36-46.
- Pijll M van der, Konijn C. Jeugdzorg in Zweden. NIZW Jeugd/ Expertisecentrum Jeugdzorg (ongepubliceerd), 2007.
- Raad van Europa. Resolution on the priorities of the Council of Europe's youth sector for 2006-2008. <http://www.coe.int/T/E/Com/Files/Ministerial-Conferences/2005-Budapestjeunesse/Resolution.asp> (last visited 15 January 2007). Budapest, Hungary: 7th Conference of European Ministers responsible for Youth, 23-24 September 2005.
- Ross-van Dorp C. Youth Policy in the Netherlands. *Forum 21. European Journal on Youth Policy* 2006;5-6:70.
- Schoemaker C, Poos MJJC, Spijker J. Hoe vaak komt depressie voor? In: volksgezondheid Toekomst verkenning, Nationaal Kompas volksgezondheid. Bilthoven: RIVM, <<http://www.nationaalkompas.nl>> Gezondheid en ziekte\ Ziekten en aandoeningen\ Psychische stoornissen\ Depressie, 13 december 2005.
- Schokker DF, Visscher TLS, Nooyens ACJ, Baak MA van, Seidell JC. Prevalence of overweight and obesity in the Netherlands. *Obesity Reviews* 2006; 8:101-107. doi: 10.1111/j.1467-789X.2006.00273.x.
- Scottish Executive/SHPSU. Framework for the National Accreditation of Health Promoting Schools in Scotland. http://www.healthpromotingschools.co.uk/images/Nationalaccreditationofhps_tcm4-303668.pdf. Scottish Executive/Scottish Health Promoting Schools unit, 2006.
- SHPSU, Scottish Health Promoting Schools Unit. Being Well - Doing Well. A framework for health promoting schools in Scotland. Learning and Teaching Scotland, 2004.
- SHPSU, Scottish Health Promoting Schools Unit. Health Promoting Schools in Scotland: A partnership approach: Strategic Plan 2006-08. http://www.healthpromotingschools.co.uk/images/Healthpromotingschoolsinscotlandstrategicplan_tcm4-365411.pdf (last visited 6 March 2007), 2007.
- SHPSU, Scottish Health Promoting Schools Unit. National accreditation of Health Promoting Schools in Scotland. http://www.healthpromotingschools.co.uk/images/Nationalaccreditationfinalreport_tcm4-401864.pdf. Report on the Implementation of the National Framework, 2006.
- SNIPH, Swedish National Institute of Public Health. The 2005 Public Health Policy Report. Summary. Stockholm: SNIPH, 2005.
- Stewart-Brown S. What is the evidence on school health promotion in improving health or preventing disease and, specifically, what is the effectiveness of the health promoting schools approach? <http://www.euro.who.int/document/e88185.pdf> (last visited 5 December 2006). Copenhagen: WHO Regional Office for Europe/ Health Evidence Network report, 2006.
- Stewart-Burgher M, Barnekow Ramussen V, Rivett D. The European Network of Health Promoting Schools. The alliance of education and health (EuR/ICP/IvST 06 03 05). Copenhagen: WHO, 1999.
- Sure Start. Introduction. <http://www.surestart.gov.uk/surestartservices/settings/introduction/> (last visited 27 November 2006), 2006.
- Thomas Coram Research unit/National Foundation for Education Research. Evaluation of the Impact of the National Healthy School Standard - Research Summary. London: Thomas Coram Research unit, Institute of Education, University of London/National Foundation for Education Research, 2004.

- Tweede Kamer [Dutch House of Representatives]. Kamerstuk, 23-10-2006. Centrum voor Jeugd en Gezin. DJB/APJB2718401, 2006.
- Tweede Kamer [Dutch House of Representatives]. Aard en omvang van kindermishandeling in Nederland. Kamerstuk DJB/J2-2764361. 25 April 2007. The Hague: Tweede Kamer [Dutch House of Representatives], 2007.
- UNICEF, Child poverty in perspective: An overview of child well-being in rich countries, Innocenti Report Card 7. Florence: UNICEF Innocenti Research Centre, 2007.
- Vlaams Parlement. Maatschappelijke beleidsnota bijzondere jeugdzorg. Stuk 1354 (1998-1999) nr.1. http://www.jeugdhulp.vlaanderen.be/04_regelgeving/maatschappelijke_beleidsnota/stuk1354nr1.pdf. 1999b.
- Vlaams Parlement. Motie van aanbeveling bij de maatschappelijke beleidsnota Bijzondere Jeugdzorg. Stuk 1354 (1998-1999) nr.4 http://www.jeugdhulp.vlaanderen.be/04_regelgeving/maatschappelijke_beleidsnota/stuk1354nr4.pdf. 1999a.
- Vlaams Parlement. Voorstel van decreet betreffende de integrale jeugdhulp. Stuk 2056 (2003-2004) nr.8. http://www.jeugd-hulp.vlaanderen.be/04_regelgeving/de-creet_stuk2056/stuk2056nr8.pdf. 2004.
- VN, Verenigde Naties. Convention on the Rights of the Child. <http://www.ohchr.org/english/law/pdf/crc.pdf>. 1989.
- VWS, Ministry of Health, Welfare and Sport. Beleidsagenda 2004. Keuzes voor een houdbare en beter presterende zorg. The Hague: VWS, 2003a.
- VWS, Ministry of Health, Welfare and Sport. Living Longer in good health: also a question of healthy lifestyle. The Hague: VWS, 2003b.
- VWS, Ministry of Health, Welfare and Sport. Opting for a healthy life, 2007-2010. Kamerstuk 2006-2007, 22894, nr. 110. The Hague: VWS, 2006.
- WHO, World Health Organization. European strategy for child and adolescent health and development. Copenhagen: WHO-Europe, 2005a.
- WHO, World Health Organization. The European health report 2005: public health action for healthier children and populations. Copenhagen: WHO-Europe, 2005b.
- WHO, World Health Organization. What are the main factors that influence the implementation of disease prevention and health promotion programmes in children and adolescents? Copenhagen: WHO Regional Office for Europe's Health Evidence Network, 2005c.
- Wilk EA van der, Jansen J. Lifestyle-related risks: are trends in Europe converging? *Public Health* 2005 Jan;119(1):55-66.
- Wired for Health. National Audit Tool and guidance for local education and health partnerships on validating school achievement of national healthy school status. <http://www.wiredforhealth.gov.uk/PdF/audittool.doc> (last visited 5 december 2006), 2006.
- Young I. Conference Report: Education & Health in Partnership: a European Conference on linking education with the promotion of health in schools. International Planning Committee of the European Network of Health Promoting Schools. Woerden: NIgZ, 2002.

SCREENING

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

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

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

Compared to many other countries, the Netherlands carefully considers the advantages and disadvantages of screening tests before they are implemented. In many other countries, the decision to perform screening, apply new techniques or expand current screening programmes is made faster. The Netherlands faces the challenge of continuing its policy of carefully weighing up the advantages and disadvantages of screening tests whilst still ensuring that full use is made of the advantages that new technology offers.



8 SCREENING

Katia Witte, Matthijs van den Berg and Ingeborg Bovendeur

8.1 Introduction

8.2 International policy frameworks

8.2.1 WHO and the European Union

8.2.2 The policies of individual countries

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8.4.1 Chlamydia screening

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8.5 Discussion and conclusions

References

8.1 Introduction

Screening is the systematic detection of disease or risk factors associated with a certain disease at the earliest possible stage. Screening is performed in healthy people who do not yet have any complaints or perceivable symptoms of disease. The aim of screening is to improve the prognosis of a disease by its early detection and subsequent intervention. The therapy that is given for diseases detected at an early stage is usually less radical and the person's chance of survival and/or quality of life will be better.

Considerable health gains can be achieved with early detection. However, it should be remembered that there are also possible disadvantages attached to screening. For example, screening requires a large group of people to be tested to detect a small number of people with a disease. Whilst waiting for the test results, the whole group goes through a period of uncertainty regarding their health. Moreover, there are people who are wrongly diagnosed, whether positive or negative. People who are wrongly diagnosed with a positive result will have to undergo further tests that are sometimes quite stressful before a definitive diagnosis can be reached. People who are wrongly diagnosed with a negative result, will be falsely reassured about their health and think that they are disease-free. There are also some people who develop a disease in the intervening period between two screening tests.

The policies surrounding screening are determined by what decision is taken following a careful consideration of the health gains from screening weighed up against the demands and possible risks of the screening itself. In addition, other factors such as social, political, cultural and organizational aspects as well as the scale of a particular public health problem play an important role in whether or not screening programmes are implemented and how the screening test is offered. The various methods used for screening are: programmed detection, which is funded by the government, opportunistic screening funded by health care insurers, and self-testing which is usually offered by commercial parties.

Overview of this chapter

The question at the core of this chapter is: what can the Netherlands learn from other countries about screening policies at a national level and about policies in six specific screening areas in particular?

Firstly, the international and national screening policies of the different countries will be discussed. This will be followed by a look at the Dutch policies for breast cancer and cervical cancer screening, the heel prick test (also known as blood spot screening) and Down's syndrome, which will be compared with the policies of other countries. Then the screening tests for colorectal cancer and Chlamydia infection will be discussed. Screening programmes for these latter conditions have been implemented in some other countries but not yet in the Netherlands. The discussion will focus on how these programmes have been introduced in those countries and what the current situation in the Netherlands is. Finally, the most significant findings will be outlined in 'Discussion and Conclusions'.

8.2 International policy frameworks

Each country determines its national screening policies depending on the scale and preventability of a certain health problem, the expected health gains and the possible risks of the screening itself. In addition, social, political, cultural and organizational aspects influence whether or not the screening programme will be introduced and how the screening is offered to people. International agreements, international organizations and the international market can also influence the national policies that are finally implemented. For example, there are international guidelines on the quality monitoring of breast cancer and

cervical cancer screening. Also the policies applied in neighbouring countries can be significant. For example, Dutch citizens can apply for certain screening tests that are offered through the Internet and conducted in locations just outside the Dutch borders. One example that demonstrates this point is the German health check-ups that include screening for cancer. These comprehensive health check-ups are prohibited in the Netherlands by the legislation on population studies (Population Screening Act, WBO) because the benefits to public health as a whole have either not been investigated or are not yet evident. In Germany these check-ups are socially accepted and are reimbursed by insurers.

8.2.1 WHO and the European Union

Most countries apply WHO criteria for the introduction of screening

In 1968, the World Health Organization (WHO) drew up a set of general criteria that should be adhered to when screening is offered at population level. In most countries, screening programmes are checked against the Wilson & Jungner criteria before they are implemented (see Text block 8.1).

As well as setting up criteria for screening, WHO has also documented some more concrete viewpoints and advice on a number of screening areas. In 2005, for example, WHO adopted one resolution for all types of cancer. This resolution ranges from the prevention of exposure to risk factors and screening to early diagnosis, treatment and palliative care for cancer patients. One consequence of this resolution is that each country is expected to set up its own integral cancer programme. In 2003, it came to light that seventeen of these national programmes from EU Member States either did not cover prevention and early detection of disease at all or provided just limited cover (WHO, 2003). In 2004, the Dutch National Cancer Prevention and Control Programme for 2005-2010 was presented. Up until 2004, there had been no integrated approach to cancer prevention and control at a national level.

Other WHO advice applies to the areas of type 2 diabetes and osteoporosis. In the area of type 2 diabetes, there is currently insufficient scientific evidence on which to base a decision about whether screening should be introduced. However, policymakers are being advised to formulate policies for this condition. In the Netherlands, the Health Council has advised against the introduction of a general screening programme for diabetes because there is still insufficient evidence available on the effectiveness of screening for this disease (GR, 2004a).

Text block 8.1 The Wilson-Jungner criteria for appraising the validity of a screening programme

- The condition being screened for should be an important health problem
- The natural history of the condition should be well understood
- There should be a detectable early stage
- Treatment at an early stage should be of more benefit than at a later stage
- A suitable test should be devised for the early stage
- The test should be acceptable
- Intervals for repeating the test should be determined
- Adequate health service provision should be made for the extra clinical workload resulting from screening
- The risks, both physical and psychological, should be less than the benefits
- The costs should be balanced against the benefits

World Health Organisation 1968

Additional national criteria in the United Kingdom

The National Screening Committee in the UK has formulated a set of 22 extra criteria. For example:

- There should be a plan for managing and monitoring the screening programme and an agreed set of quality assurance standards

- All other options for managing the condition should have been considered (e.g. improving treatment, providing other services), to ensure that no more cost effective intervention could be introduced or current interventions increased within the resources available.
- Evidence-based information, explaining the consequences of testing, investigation and treatment, should be made available to potential participants to assist them in making an informed choice.

Source: Wilson & Jungner, 1968

In 2006, WHO published an advisory report on osteoporosis that advised against screening at population level. There is some positive evidence regarding the effectiveness of selective screening of women over the age of 65 years, although many questions remain unanswered for this population group (WHO, 2006a). Other areas of screening have not been placed within a broader WHO programme.

European Union complements national policies from EU Member States

Each Member State of the European Union (EU) is responsible for the protection and promotion of the health of its citizens. Consequently, each Member State formulates its own screening policies. One of the tasks of the EU is to complement the policies from the Member States and to draw up further recommendations and guidelines for this purpose. The EU's commitment to screening is part of a general strategy aimed at an integrated and effective approach towards health problems in various sectors. In addition, the following items are at the core of the European Community's Health Strategy for 2003 to 2008: information and knowledge about health, a rapid response to health threats, and addressing health determinants. A more integrated approach has been proposed however, by the 'Programme of Community Action in the field of Health and Consumer Protection 2007-2013'.

Text block 8.2 Self-tests

Increasing number of self-tests on the market

More and more products are available on the market, which enable people to test themselves for (potential) diseases using a sample of their own blood, urine or faeces. Self-tests are available from pharmacists and drug stores, and increasingly via the Internet. Such tests may be designed to show whether someone is at elevated risk (e.g. from a raised cholesterol level) or to show whether someone already has a medical condition (such as HIV infection). In addition, on-line questionnaires and checklists are widely available, intended to help people decide whether they should consult a doctor about problems they have been experiencing or about their lifestyles.

Although the early detection of risk and illness is generally a good thing in terms of facilitating treatment and improving a patient's prognosis, a critical look needs to be considered at the increasing availability and use of self-tests. The reliability of a test depends on it being performed correctly, at the right time and directed to someone from the right target group. For example, the HIV self-test (which enables the user to test for the presence of antibodies against the virus, again by testing a fingerprick blood sample) is unreliable until three months after unsafe sex, since it takes some time for the body to produce sufficient antibodies to be detected. An HIV test carried out sooner is liable to give a false negative outcome. Furthermore, self-tests are not backed up by professional support for those who test positive, which is potentially problematic, particularly where life-threatening illnesses such as cancer and HIV-AIDS are concerned. It is open to question whether people whose test results are positive do always seek the help of a doctor, as the product manufacturers advise.

Insurers offer health checks

Encouraged by changes to the health care system, insurers are launching all sorts of initiatives to win new clients and to manage their costs. Two large Dutch insurers, Ohra and Delta Lloyd, intend the provision of annual health checks for their clients. These checks involve a questionnaire, a physical examination and lab testing of blood, urine and faeces samples. On the basis of the findings, the insured

person may be advised to take preventive action, or may be referred for further testing or treatment. The intention is to promote the early detection of common illnesses, such as cancer, diabetes and cardiovascular disease. This is expected to improve the scope for treatment and result in reduced care consumption and therefore lower costs for the insurers. The companies are initially providing checks for their own personnel; if these trials prove successful, checks will be made available to people insured through their employers' company schemes or under private policies. Where testing is made available for commercial reasons, it is important to look critically at the implications for insured individuals: is early detection actually in the interest of the client and is his or her privacy adequately protected? The Minister of VWS has expressed criticism of this initiative and has pointed out that any programme that involves systematic screening for cancer has to be licensed under the Population Screening Act.

Self-tests require EU certification

As of December 7, 2005, the EU-Directive (98/79/EG) on In-Vitro Diagnostics requires that all IVD products, including accessories, have CE marking. Other certifications are not necessary and not allowed. An In Vitro Diagnostic Medical Device (IVD) is defined in Directive (98/79/EC) as: any medical device which is a reagent, reagent product, calibrator, control material, kit, instrument, apparatus, equipment, or system, whether used alone or in combination, intended by the manufacturer to be used in vitro for the examination of specimens, including blood and tissue donations, derived from the human body, solely or principally for the purpose of providing information, concerning for example a physiological or pathological state.

Source: De Hollander et al., 2006

8.2.2 The policies of individual countries

WHO has formulated criteria for the assessment of screening programmes before they are actually implemented. The EU supports countries by providing them with general information, recommendations and guidelines on screening (WHO, 2006c). The advice and guidelines given by the EU and WHO are based on the latest practice and in this respect are usually forthcoming from the front-running countries. The policies surrounding screening are stipulated by each individual country. Each country differs regarding the scale of separate health problems and the organization of preventive health care. This means that policies differ between the various countries and, in some cases, within a country as well because policies are sometimes formulated at provincial levels. As far as the Netherlands is concerned, the policies of immediately neighbouring countries are important because Dutch citizens may decide to use their services at their own initiative.

Belgium

In 2003, the Flanders area of Belgium adopted new legislation on preventive health policy that also included national screening programmes. With this legislation, the Flemish government wants to protect the population against examinations that have not proven their use yet – therefore offering a guarantee that screening tests would be of high quality. This step also leads to the prevention of unnecessary wasting of government funding and ensures that resources are deployed where they can bring the most health gains. Consequently, screening programmes cannot be implemented without the approval of the Flemish government. The law on preventive health policy is currently enacted as a form of legislation only valid for Flanders (decree) but preparations are being made to transform it into legislation for the wider Belgian area of Flanders and Wallonia (Vlaams Agentschap Zorg & Gezondheid, 2006). Therefore screening policies in Flanders and Wallonia might differ temporarily.

United Kingdom

In the United Kingdom, screening programmes for cancer have been embedded into a larger public health programme. The National Health Service Cancer Plan describes the strategy taken on investments and

changes taking place within the National Health Service (NHS). In 1996 a national organization was set up in the United Kingdom – the UK National Screening Committee (NSC) – that advises the government on screening policies and monitors screening programmes to ensure that standard guidelines are implemented and adhered to.

In its advice, the NSC takes into account both scientific evidence and aspects concerning the feasibility and acceptance of a screening programme (Screening Policy Team, 2005). The criteria adhered to by the NSC are based on the Wilson & Jungner criteria and supplemented with a few other criteria (see Text block 8.1).

Following the advice from the NSC, officials from the four UK countries (England, Wales, Scotland and Northern Ireland) advise and inform their respective governments. These governments can deviate from this advice – as is clear from the following. In Wales screening is carried out for Duchenne muscular dystrophy whilst it is an untreatable disorder and therefore does not meet the Wilson & Jungner criteria. The legislation pertaining to the whole area of screening has not been documented together in one article of a law. For example, the use of radiation in screening programmes has been included in the legislation concerning the use of ionic radiation (Crown Copyright, 2000). In the area of genetic material, there is at present a complicated system of legislation that also affects genetic screening (NCB, 2006).

Despite this centralized policy, in practice the policy around screening is not always clear. For example, the NHS has determined that screening for prostate cancer does not yet meet the criteria set for screening. However, because of pressure from the general public to screen for prostate cancer, the NHS decided to allow men a free Prostate-Specific Antigen (PSA) test even though much is unclear on the effectiveness of early treatment for this disease. One condition included in the test is that the men concerned are sufficiently informed about the risks (Donavan et al., 2001). This action has opened up opportunities for screening tests that do not meet the criteria that need to be met by other screening tests.

Germany

In Germany, the costs for screening for breast cancer, cervical cancer, prostate cancer, colorectal cancer and skin cancer are covered by the insurance policies for specifically described target groups (Deutsche Krebshilfe, 2007). In addition, a general check-up that consists of blood and urine tests, blood pressure measurement and physical examination of heart and lungs, carried out every two years from the age of 35 years, is advised by the government and reimbursed by the insurers. The aim of this is to provide patients with good information on their general health. A wide-ranging package of investigations is available to people at their own initiative in Germany. However, only 50% of women and approximately 17% of men in Germany actually have these tests performed. In 2002, approximately 17% of insured persons had the general medical check-up (BS, 2007). In Germany, these tests are organized per federal state and not at national level. Furthermore, there is no national legislation covering the criteria that have to be met before a screening programme is implemented. However, there are national guidelines for the implementation and performance of the screening (GB, 2007). In the case of breast cancer, for example, the institutions that perform mammography have to be accredited according to national guidelines.

The Netherlands

The Population Screening Act (WBO) was introduced in the Netherlands in 1996. The objective of the WBO is to protect the population against screening programmes that could be dangerous to either the physical or mental health of a person. A licence is required for performing screening programmes that use ionic radiation, tests for cancer and tests for serious diseases or disorders for which no treatment or prevention is possible. The Health Council of the Netherlands has to deliver a recommendation on the relevant issue before the Minister of Health, Welfare and Sport Affairs (VWS) issues permission. The Ministry decides whether there is a licensing obligation for a certain screening programme – this decision is usually based on the planned testing methods or the nature of disease. This has to be approved by the Dutch House of Representatives. The Dutch Health Care Inspectorate (IGZ) supervises compliance with the WBO. For example, in 2006, the IGZ started a campaign against providers of medical check-ups that

included tests for cancer. In 1995, how people were asked for consent to participate in scientific studies and receive information on them, was legislated in a WBO decree. This stipulates that any person who agrees to participate in scientific research must be able to reach their decision following careful consideration of all the facts.

8.3 New developments in existing screening programmes

The following section will focus on four screening programmes that are currently in use in the Netherlands. The four screening areas are: breast cancer, cervical cancer, Down’s syndrome and the neonatal screening test known as the heel prick. Many different aspects come to light when comparing international policies on screening. In this report we have chosen to concentrate on a number of developments relevant to policymaking and not to go into great detail concerning the characteristics of the screening tests as they are now implemented. See Table 8.1 for a summary of the developments relevant to policymaking that have been compared at international level for each screening area.

Table 8-1 Internationally compared developments that are relevant for policy, by screening

Screening	Policy relevant developments compared
Breast cancer screening	<ul style="list-style-type: none"> ▪ Screening policy ▪ Organization of the screening ▪ Shifting of age limits ▪ Screening of high-risk-groups within the programme
Cervical cancer screening	<ul style="list-style-type: none"> ▪ Screening policy ▪ New technique: thin layer cytology ▪ HPV screening ▪ HPV vaccination
Neonatal screening	<ul style="list-style-type: none"> ▪ Screening policy ▪ Diseases that are screened ▪ Education and informed consent ▪ Carriership information
Prenatal screening	<ul style="list-style-type: none"> ▪ Informed decision-making ▪ Routinization

8.3.1 Breast cancer screening

Since 1990, a national breast cancer screening programme for women between the ages of 50 and 75 years has been gradually introduced. Women in this age category are invited to have mammography screening in specialized research centres once every two years. This population screening aims to prevent mortality from breast cancer by detecting the disease in an early stage. From an international perspective, the incidence and mortality from breast cancer in the Netherlands is high (Van der Wilk, 2005). However, there was a clearly visible decrease in death from breast cancer during the period 1994-2004 amongst women in the age group 65-74 years. This decrease is largely attributed to the screening programme (Voogd et al., 2005; Otto et al., 2003; Fracheboud & De Koning, 2005).

The aim of the EU is to decrease mortality from breast cancer and reduce policy differences between countries

The objectives formulated by the European Parliament in 2003 for breast cancer are as follows: to decrease mortality due to breast cancer by 25% and to decrease the differences between the EU countries by 5%. For this purpose, the fourth quality guideline for breast cancer screening and diagnosis were formulated by the

European Breast Cancer Network (EBCN) of the EU in collaboration with the International Agency for Research on Cancer (IARC). Standards and protocols are outlined in this guideline for all the steps involved in the process of screening up to the moment of diagnosis. Eighteen European Member States as well as Norway, Switzerland, Israel Canada and the United States have worked together on this guideline (Perry et al., 2006). To what extent the EU objectives have been reached and whether the guidelines have been implemented and are adhered to in the various Member States is not evident yet.

The organization of screening differs greatly at international level

The organization of breast cancer screening varies widely between countries. In many countries, there was a long tradition of opportunistic screening before a national project was initiated (Broeders et al., 2005). Countries with national programmes in place often work along the principles of centralization where the responsibilities for and the control of the screening programmes are brought together under a central body. The screening is then financed by the central government. Countries with federal states usually place the responsibility for screening with decentralized organizations. The evaluation of the screening is usually centrally organized. The role of the central coordinator – as far as monitoring the quality of the programme is concerned – is usually much more active because the implementation is not always uniform. According to expectations, the costs are higher in a decentralized system. Moreover, it is more usual to see a decentralized system characterized by more opportunistic screening outside the programme. There are also countries that only screen opportunistically. Austria has a system of opportunistic screening which gives the impression of results being no worse (as far as mortality from breast cancer is concerned) than in countries with a centrally organized system (Vutuc, 2006). In Austria, women are advised to have themselves screened, the tests are free and client-friendly and having a mammography is generally accepted as normal in Austrian society. Austrian women do not receive a specific invitation for the test.

Organization does not appear to influence screening outcomes for women

For breast cancer screening, the EU has set the desired rate of attendance at 75% or higher (Perry et al., 2006). Some countries including the Netherlands do meet this standard rate (Appendix 4, Table A4.1). In many countries, including the Netherlands, the numbers of people attending screening tests are higher in rural areas than urban ones (Lynge et al., 2003). Research has shown that attendance numbers are generally lower in those countries where the screening is organized decentrally (Broeders et al., 2005). This difference is however, not always visible, as is shown in Appendix 4 (Table A4.1) in which some studies have been compared. Also, no differences were found between research conducted in countries with central and decentralized systems regarding the rates for and the characteristics of cancer that was detected through testing. It seems that as long as women take part in the screening, the methods of organization do not influence the outcomes, and that outcomes are indeed comparable. At the public health level, differences will be found. Countries with a higher rate of attendance will detect more women with cancer and the effect of screening at population level will be higher.

Should the age limit be lowered to 45 or 40?

Some countries screen the population in younger age groups than the Netherlands does. For example, Japan (from 40 years), Iceland (40-69 years), some areas of Sweden and the US screen from the age of 40 years (OECD, 2006b). In Hungary, women of 45 to 65 years are screened (OECD, 2006b). The Health Council of the Netherlands has indicated that screening women under the age of 50 years is a controversial subject because the evidence for the beneficial effect on the mortality rate is still not convincing (GR, 2006a). The Council advises waiting for the results of British research before announcing any decisions on lowering the age for screening.

A detailed study was conducted in 2005 in Belgium on whether or not the Belgian screening programme should be extended to the age group of 40-49 year-olds (Puddu & Iafforeau, 2005). This study concluded that there was insufficient evidence on the specificity, sensitivity and the frequency with which subjects should be screened. Early detection in people aged 40-49 years does not necessarily have an influence on how the disease progresses. However, the screening does lead to more treatments being given and women

know that they are ill earlier. Extending screening in Belgium to women between 40-49 years has therefore not been recommended (Puddu & Iafforeau, 2005). Taking into account the results from countries that now screen amongst 40-49 year-olds, would be a valuable addition to the scientific information that is currently available.

New medical technology methods are also an influencing factor for lowering the age of screening programmes. For example, digital mammography is very suitable for testing women under the age of 50 years, women in menopause and women with dense breast tissue (GR, 2006a). The effects of using new test methods such as digital mammography, ultrasound in combination with a mammography and MRI scans, for a screening programme have not yet been determined.

No consensus on screening methods for women at genetic high risk

Besides a population based screening programme for breast cancer, in many countries women at genetic high risk for breast cancer are screened; these include women from families with hereditary breast cancer types BRcA1 and BRcA2. The treatment options available to such high-risk patients can vary considerably from country to country (Bouchard et al., 2004). In the Netherlands, this screening is carried out in specialized cancer centres or university medical centres and consists of six-monthly breast examinations, a yearly mammography and, wherever necessary, an MRI scan. No guidelines are in place for the screening of high-risk groups (GR, 2006a).

Cultural factors are important when making comparisons between countries. For example, in Anglo-Saxon countries an individual's own responsibility for his/her health is a significant factor whilst in France the doctor has a much more authoritative position. Further, the context in which preventive therapies are offered – through a cancer centre versus a clinical genetic centre – and the degree of collaboration between treating professionals can influence the final treatment that women at genetic high risk receive (Bouchard et al., 2004). Other factors that determine treatment options between the various countries are: the degree to which new scientific insight is applied in daily practice, the freedom given to innovative procedures and the way in which care is organized in each country. At international level, there is no agreement on what the best treatment options are for women at increased risk. For example, opinions are sharply divided on the scientific evidence for carrying out screening mammographies in women at increased risk, mainly due to the inevitable exposure to radiation (Puddu & Iafforeau, 2005).

Conclusions

Seen from the international point of view, the Netherlands has a good nationally organized programme for breast cancer screening. The attendance rate for these screening tests is high. The international literature on this subject shows that the way the screening is organized does not influence the outcome for women who take part in the screening programme. However, it is essential that all steps in the screening process are carried out carefully according to guidelines. In those countries where there is a high rate of attendance, more women with cancer will be detected and the effect of screening at public health level will be higher. Discussions are currently being held about merging the 18 screening organizations in the Netherlands to form 5 organisations that could then also assume responsibility for the implementation of new screening programmes. The treatment options for women at increased genetic risk are determined by more than one factor including that of the location where the screening takes place. If the treatment setting for this group of women (including that for the screening) changes, then the consequences that may result from any such shift will first of all have to be examined. Before changes in the Netherlands can be implemented, research will need to be done on the effects of these changes. For developments such as the implementation of digital mammography, the use of combined screening techniques or the lowering of the age for screening, results from research in progress will need to be known.

8.3.2 Cervical cancer screening

In the Netherlands, women between the ages of 30 and 60 years are called up for a smear test once every five years. A cytological test, carried out as a cervical smear test, can detect early stages of cancer and cervical cancer itself. When abnormalities such as precancerous symptoms or very early stages of cancer are treated early, then there is a good chance that the disease can be cured. In 2003, the attendance rate for screening in the Netherlands was 66%; 2.3% of these women required follow-up examinations. As it is not known what percentage of women with a treatable form of precancerous disease actually go on to develop cancer, it is not possible to directly measure how much cancer can be prevented by screening. One rough estimate shows that half of the decrease in mortality due to cervical cancer is attributed to the introduction of screening tests and the other half to the decreasing trend that had emerged before the introduction of screening (GR, 2006b). A prerequisite for developing cervical cancer is an infection with the human papilloma virus (HPV), although other causes are possible. In other words, not everyone who gets an HPV infection will actually go on to develop cervical cancer (Davies et al., 2006, WHO, 2006b). Other risk factors for cervical cancer are: smoking, long-term hormonal contraceptive use, HIV-infection and many full-term pregnancies (Muñoz et al., 2006). More than 100 types of HPV are circulating from which HPV-16 and HPV-18 cause approximately 70% of cases of cervical cancer (Muñoz et al., 2006).

Most EU countries screen for cervical cancer

Nearly all EU countries screen for cervical cancer and have formulated policies for this purpose (Appendix 4, Table A4.2). The advice from the EU is to only offer cervical cancer screening through well-organized, population-based screening programmes that guarantee quality. Women between the ages of 30 and 60 years are recommended for screening programmes at intervals of three to five years (Raadgevend comité voor de kankerpreventie, 1999). At present, the smear test is the only test that has provided sufficient evidence for its use at population level and is therefore an appropriate test to offer to women who are symptom-free. There are clear differences between countries concerning the number of smear tests taken during a person's lifetime. This varies from seven in Finland, Lithuania and the Netherlands up to more than fifty in Luxemburg and Germany. The interval between the screening tests is between three and five years in most countries. The target groups vary from fifteen-year olds and older in Luxemburg to 50-69 year-olds in some parts of France. In many countries the target group is between the ages of 25 and 64 years (Antilla et al., 2004).

Implementation of new technology in existing screening programmes

A few new techniques are available that could improve the effectiveness of current cervical smear screening. One of these is the analysis method of the smear test through the thin layer cytology method known as liquid based cytology (LBC). Tests carried out with this method can apparently detect more abnormalities without creating more false positive outcomes. It has been shown that fewer smear tests are rejected due to inadequate quality, the processing takes less time and more tests can be carried out on the same sample (GR, 2005a). The costs for LBC are however, higher than the traditional technique. To date, little research has been conducted on the effects of LBC when used at population level. Despite this lack of evidence, LBC has been implemented at population level in some countries. This could be seen as a market-driven development (GR, 2006b). In England, the introduction of LBC has led to a decrease in the number of inadequate smears by 80%. Some countries, such as Denmark, Finland, England, Scotland, the Netherlands and the United States, are already applying this technique (GR, 2005a; Kitchner et al., 2006). In the Netherlands, the use of this technique partly falls under regulations for scientific research and is done with a licence. However, the part carried out until December 2006 was done without a licence but was, nevertheless, allowed (GR, 2006b). Research is now being conducted on the effects of using LBC within the Dutch context. The expected gains from using LBC in the Netherlands are smaller than in other countries because the quality of the traditional techniques already in use was good. In the Netherlands and Iceland only 1% of the smears needs to be repeated because of inadequate quality; in Norway the percentage is 4% and in England 9%. LBC has been introduced in Denmark because of the high number of false negative results. Good results have also been booked in the cervical cancer screening programmes following the implementation of LBC (Schledermann et al., 2006).

No large-scale implementation of HPV screening

Screening women for HPV has not been introduced as a national programme anywhere in Europe. However, a number of countries are currently conducting pilot studies on the subject. In the Netherlands, the United Kingdom (two studies) Finland, Canada, Sweden and Mexico, HPV screening combined with cytology tests – either LBC or traditional tests – are being compared with results from cytology alone. In Italy and Finland, HPV screening is being compared with cytology tests (Cuzick et al., 2006; Davies et al., 2006). Cytology is the standard method used in Europe and policies will only be revised following good results from studies in progress. In the United States, the use of cytology and an HPV test has been approved for women of 30 years and older (Arbyn & Temmerman, 2002). It would be interesting to introduce an HPV test into the screening programme both for countries with a national programme as well as for those countries that screen opportunistically. This is because the HPV test has a higher sensitivity and therefore more women with precancerous symptoms will be detected. However, the specificity will be lower as there are more women without precancerous signs of cervical cancer who will get a false-positive result compared with cytology alone (Cuzick et al., 2006). The introduction of the HPV test could be cost-effective in many European countries if the HPV test were offered first (most sensitive test) and then if the results warranted this, the cytology test (most specific test) (Davies et al., 2006). The cost-effectiveness largely depends on the duration of the interval and the design of the screening process (Vijgen et al., 2005).

Women will need to be well informed on the relation between HPV and cervical cancer before deciding whether or not to participate in HPV screening. Several studies conducted in the United Kingdom (UK) and the US have shown that few women are aware of this relationship (Cuzick et al., 2006; Anhang et al., 2004). If an HPV screening is introduced, there will be more women with a false positive result. This could give rise to a number of issues: anxiety, anxiety for cancer, sexual problems, changing body self-image and worry about reproduction issues, anxiety for necessary interventions and treatments. Support and guidance for these women will therefore be an important component of the screening programme (Anhang et al., 2004). Other issues such as the right age at which to screen and the interval between tests are also controversial (Cuzick et al., 2006).

It is highly likely that the implementation of HPV screening programmes will vary from country to country depending on the screening currently in place and the policy choices that have to be made. In the US, the HPV test has been recommended in some protocols for specific cases and not initially as the first test method. To raise the attendance rate of the screening, tests are also being carried out with HPV self-testing kits (see Text block 8.2). The Health Council of Flanders has advised the organization of screening programmes to be investigated every few years and then revised accordingly so that the results of scientific research can be implemented (VGR, 2006).

HPV vaccination will possibly interfere with screening

At present there are no European countries that offer HPV vaccination. In the European Union, the United States, Mexico, Canada and New Zealand, one of the two vaccines developed for use has been approved, the other has been submitted for approval (BBC, 2006). The level of protection that the HPV vaccine offers is high and its quick introduction in many countries is therefore expected. However, information on how long the protection offered by the vaccine lasts is lacking (Wright et al., 2006). The best age for introducing the vaccination in Europe would be between 9 and 13 years. In those countries where a vaccination is already given at this age, such as Belgium, Croatia or the Netherlands, the introduction of the vaccination would be slightly easier than in those countries where this is not the case, such as France, Germany, Italy or the United States (Wright et al., 2006). Before this vaccination programme is implemented there are other aspects that need to be studied – the high costs of the vaccine (360 euro for three jabs), the political willingness in the various countries (effects are only visible in the long-term and the screening programme will have to be continued as well as vaccination) and the advice of scientific committees on the possible implementation of the vaccine (does it fit in with existing vaccination schedules, will there have to be a new vaccination moment, will the organizational structure have to change?).

Moreover, the different work areas now operating separately, such as those for vaccinations, prevention of sexually transmitted disease, health care for young people and cancer prevention, will need to be brought together to work in a more intense collaborative effort (WHO, 2006b). In countries where the present screening policy is cost-effective, such as in the Netherlands, the uncertainties surrounding the effectiveness of the vaccine will weigh heavier than in countries where the present screening policy has proved to be less cost-effective (De Melker, 2005). The introduction of the HPV vaccination programme will in all probability lead to frequent revision of the screening policy for cervical cancer being necessary as more insight is gained into the effects of the vaccination itself. The Flemish Health Council has already issued a recommendation on the vaccination in which they indicate that revision of the current screening practices will only be necessary ten or twenty years after the introduction of the vaccine. At present there is insufficient evidence on the effect of the vaccine at population level and the results of research will only be known around 2012. For this reason, vaccination is not recommended at present (VGR, 2006).

Conclusions

Many countries are now revising their policies around cervical cancer screening because of current advances in new techniques and detection methods; these include thin-layer cytology, the HPV test, the HPV home test and the HPV vaccine. At present there is still a lot of uncertainty regarding the effectiveness of these new methods and techniques. Some of them look very promising and are already being used in some countries. The current screening programmes will need to be frequently revised due to the introduction of new technology, even if this means breaking down the current infrastructure surrounding the screening. This could be the case, for example, if the efficiency and cost-effectiveness of the screening programmes were to decrease sharply as a result of the implementation of an HPV vaccination programme. All countries appear to be looking for ways in which they can fit the various new technologies into their policies. It appears that the Netherlands is taking the lead with respect to the infrastructure for vaccinating teenagers, trial studies in the areas of HPV screening and initiatives towards implementing a future structure for all screening programmes.

One special area that needs careful attention when introducing new methods aimed at vaccination or screening for HPV, is that women need to be informed about the relationship between HPV and cervical cancer.

8.3.3 Neonatal screening

Expanding the scope of the heel prick test in the Netherlands

In the Netherlands, parents of all newborn babies are offered neonatal screening through the heel prick test. The purpose of this test is to detect certain serious congenital disorders. Nearly all parents (99.8%) agree to have their babies tested (Lanting & Verkerk, 2005). In the Netherlands, information on the heel prick test is given to parents during pregnancy and when they register the birth of their child. The heel prick test is performed within one week of birth.

Up until the end of 2006, the heel prick in the Netherlands screened for three conditions: phenylketonuria (PKU), congenital hypothyroidism (CHT) and androgenital syndrome (AGS) However, the introduction of new techniques, such as tandem mass spectrometry (MS/MS) means that many more conditions can now be detected. Consequently, in 2005, the Health Council of the Netherlands recommended extending the scope of the heel prick test to screen for more diseases. Since 1 January 2007, the blood sample from the heel prick test has been tested for seventeen disorders – and as soon as the screening method for cystic fibrosis has been refined – the number of diseases screened will be eighteen (see Table 8.2) (GR, 2005b). In principle, even more rare congenital diseases could be detected by applying the MS/MS test method. The Health Council of the Netherlands adheres to the international criteria of Wilson & Jungner to determine whether or not a disease should be included in the screening package (Wilson & Jungner, 1968). One of the most important criteria is whether or not there is an effective treatment for the disease in question. On this

point, the Health Council of the Netherlands states: will the child have clear health gains from screening for a certain disease either directly by being given immediate treatment or indirectly through improved diagnostics and care? If the answer to this question is no, then there is no point in screening for the disease and it will not be included in the heel prick test.

International frameworks

No international guidelines are available either from the EU or WHO that specifically cover neonatal screening. In many countries, however, the WHO set of Wilson & Jungner criteria is seen as the guiding framework for the decision-making process regarding neonatal screening (see Text block 8.1). Twenty-five recommendations have been made in one report from the European Commission concerning the ethical, legal and social implications of genetic tests. The advice is that the EU Member States implement a universal programme as priority instrument for a general examination among newborn babies to screen for rare but chronic and treatable disorders (McNally, 2004). This proposal is in line with the guidelines of the International Society for Neonatal Screening' (ISNS). The ISNS guidelines recommend only screening for conditions where there is a demonstrated benefit from early diagnosis, the benefit is balanced against financial and other costs, there are suitable tests, and follow-up services are available for management (ISNS, 2002).

Table 8-2 Expansion of neonatal screening in the Netherlands (Bolhuis & Page-Christiaens, 2005)

The Health Council of the Netherlands has published an advisory report on neonatal screening in view of developments in diagnostics, therapy and the prevalence of neonatal diseases. Currently it involves screening for phenylketonuria, congenital hypothyroidism and congenital adrenal hyperplasia. Because screening may lead to considerably better outcomes in affected newborns, the council recommends expanding current screening to include medium-chain acyl-CoA dehydrogenase deficiency, sickle-cell disease and 12 other rare disorders:

1. biotinidase deficiency
2. galactosaemia
3. glutaricaciduria type I
4. HMG-CoA lyase deficiency
5. holocarboxylase-synthetase deficiency
6. homocystinuria
7. isovaleric-acidaemia
8. long-chain hydroxyacyl-CoA dehydrogenase deficiency
9. maple syrup urine disease
10. 3-methylcrotonyl-CoA carboxylase deficiency
11. tyrosinaemia I
12. very-long-chain acyl-CoA dehydrogenase deficiency

A better detection method for cystic fibrosis must be developed before it is included in screening to restrict the number of sweat-test referrals of unaffected newborns. The council recommends providing information on neonatal screening during pregnancy and gives special attention to the possibility of detecting carriership in the parents.

The recommendations have been implemented. On 1 January 2007 neonatal screening was expanded to 17 neonatal diseases.

The guidelines proposed during a WHO conference on the ethical aspects of medical genetics go one step further than the guidelines named above: 'neonatal screening should be compulsory and free of charge if early diagnosis and treatment holds health benefits for newborn babies' (WHO, 1998). One recent report on screening in Europe from the European Observatory on Health Systems and Policies, sums up a whole

gamut of components required for an effectively organized screening programme (based on the Wilson & Jungner criteria) and recommends heel prick screening for a number of disorders: PKU, CHT, CF and sickle cell disease (Holland et al., 2006).

Table 8-3: Overview of neonatal diseases that are screened in 2004, in a number of European countries (Loeber, 2006)

Country	PKU	CHT	AGS	CF	SCZ	GAL	BIOT	MCAD (ms/ms)	G6PD ¹	Others
Austria	L	L	L	L		L	L	L		
Belgium	L	L	L	P	P	P	P	P	P	
Denmark	L	L								
Germany	L	L	L	P		L	L	L	P	2
France	L	L	L	L	P					
Greece	L	L							L	
Ireland	L	L				L				2
Italy	L	L	P	L		P	P		P	2
Luxembourg	L	L	L							
Netherlands	L	L	L					P		
Portugal	L	L						P		
Russia	L	L	P	P						
Scotland	L	L		L						
Spain	L	L	P	P	P		P			2
United Kingdom (excl. Scotland)	L	L		L	P					
Sweden	L	L	L							
Switzerland	L	L	L			L	L	L		

¹ Glucose 6-phosphate dehydrogenase deficiency

² MSUD, HCU

L National Screenings programme

P Pilot screening in parts of the country

Many international differences in screened diseases

It is clear from Table 8.3 that although most European countries do screen for PKU and CHT, there are still many differences between programmes (Loeber, 2006). From this, we can conclude that with the new screening programme which includes seventeen diseases, the Netherlands has suddenly taken the lead in Europe (note, Table 8.3 refers to the situation prior to 2007).

The degree of coverage also differs strongly: in Western Europe nearly 100% of newborn babies are screened while in some countries in Eastern Europe this percentage is 50% or less. In the United Kingdom all babies are screened for PKU and CHT and in some regions screening for cystic fibrosis, sickle cell disease, and medium-chain acetyl-CoA dehydrogenase deficiency (MCAD) also takes place. Work is ongoing for the phased implementation of this programme throughout the whole country. In Wales boys are also screened for Duchenne muscular dystrophy (DMD). The UK Newborn Screening Programme Centre, is responsible for safeguarding the high quality of a national screening programme. In Belgium, this test screens for between three to six disorders and includes Duchenne muscular dystrophy in the province of Antwerp alone. The only countries that screen for DMD are some parts of the United Kingdom and Belgium. The screening for DMD is performed separately from that for other disorders – this means that separate permission is asked and as a separate heel prick test has to be done. It is striking to note that both countries indicate that they adhere to the Wilson & Jungner criteria. One of these criterion is that the disease which is to be screened must be treatable. However, this is not the case for DMD and there is also

no direct health benefit for the newborn baby. The main arguments in favour of still introducing screening for this disease are family related and linked to such issues as reproductive choices and diagnostic delay. Screening is not performed in the Netherlands for diseases that cannot be treated. In accordance with the Population Screening Act (WBO), this would not be allowed without a licence.

In the United States it is the various states who independently decide for which conditions screening will take place – this varies from 4 to 44 different disorders (Tarini et al., 2006). The number of screening tests in the United States has increased enormously during the last ten years. In 1995, for example, screening covered 5 conditions and in 2005 this figure had risen to 24. Further, in 40% of the states the number of conditions covered in screening programmes is 40 or more. There is no treatment available for some of the diseases for which screening takes place in the United States.

Participation in screening: from compulsory to freedom of choice

In the Netherlands, the heel prick test is voluntary and parents can refuse to have their child tested if they choose to do so. The information leaflet on the heel prick (also known as blood spot screening) clearly indicates the importance of taking part in the test: “a small amount of blood will be taken from your baby’s heel in his first week of life. This blood will be examined in a laboratory for seventeen rare but serious conditions. This is in the interest of your child’s health - that is why it is important for your child to have the test performed. Participation is strongly recommended but not compulsory. If you do not want your baby screened, please let the person who wants to make an appointment with you know at this time.” In the UK, parents receive an information leaflet from their midwife so that they are able to make an informed decision on whether or not to have their baby screened. Parents maintain the right to withhold permission for screening although it is strongly recommended. In France, neonatal screening is seen as a natural part of the care surrounding birth and the newborn baby for which the newborn is entitled regardless of the parents’ opinion. In Germany, where the blood spot test has recently been expanded to include fourteen conditions, parents are required to sign a form when they give permission for screening. In the United States, neonatal screening is, in principle, compulsory for all newborn babies. However, in many states exceptions are allowed to be made, for example, on religious grounds. In three-quarters of American states, parents are not asked for their permission for their baby’s heel prick test but are merely informed about the test (Mandl et al., 2002). In ten American states, parents are not even informed that the heel prick test will be or has been done. In almost all states, information leaflets are available but these are not given to all parents as standard practice (Fant et al., 2005).

One of the criterion stipulated by the Health Council of the Netherlands in its recommendation for expanding the heel prick test, was that clear information must be given to parents and that they must give their express permission in the form of an informed consent. On an international level, parents are rarely provided with good detailed information well in advance of the heel prick test. During an international workshop organized by the Research Institute TNO Quality of Life, and the Centre for Bioethics on this subject, one point that emerged was that informed consent is hardly possible because it implies that parents know exactly what they are giving permission for (Detmar, 2006). In the case of a comprehensive heel prick test, it is almost impossible to inform parents sufficiently on all the relevant aspects of all the diseases screened in the test. A proposal was made during the workshop to ask parents for a form of basic consent. This form of consent concentrates less on the actual disease and more on the benefits of screening as well as the question on how, as a parent, you regard this issue (Detmar, 2006). This is also the point of departure in the new information material in the Netherlands, as introduced from 1 January 2007 in line with the expanded programme.

The question of carriership information

Expanding the scope of the heel prick test in the Netherlands means that screening for sickle cell disease (SCD) will now also take place. The difference between this disease and others is that screening will also provide information on carriership – incidentally, this is also the case with CF screening. Carriers of SCD are not ill and may never have any discomfort or hindrance from the disease but if the child is a carrier,

then one of the parents must also be a carrier and possibly other children in the family. This leads to the question of whether or not parents should be informed when their child is found to be a healthy carrier or only when the child actually has the disease.

The policies on revealing carriership information differs both inter-regionally and from country to country (Oliver et al., 2004). The information is either given to parents as standard procedure, not given as part of standard procedure or the parents are allowed to choose whether they are given the information or not. One of the countries that screens for SCD is the United Kingdom where information on carriership of SCD is given to parents. In France, SCD screening is only offered to high risk groups of people. The parents of carriers are given a detailed information leaflet on what the screening entails. To date, there is little known on the psychological and social consequences of providing carriership information (De Wert, 2005). One recent Cochrane review could not even include a single study that had studied the effects of carriership information related to neonatal screening (Oliver et al., 2004). It would therefore seem clear at this point that further research needs to be done in this area. In the Netherlands, it has been decided not to provide carriership information as part of standard practice, but to offer people the choice of whether or not to receive the carriership information.

Conclusion

There are considerable differences between Western countries regarding their neonatal screening programmes. These differences concern not only the number of conditions covered by screening programmes but also the information and freedom of choice in participation. By expanding the scope of the heel prick test, the Netherlands no longer lags behind the rest of Europe but takes the lead instead.

8.3.4 Prenatal screening

Relatively little prenatal screening in the Netherlands

Prenatal screening tests that estimate the risks of an unborn child having Down's syndrome or neural tube defects such as spina bifida have been available for several decades. These tests may be done through testing maternal serum (blood test) nuchal translucency (ultrasound) or a combination of both. Prenatal screening for these conditions is standard in many Western countries and offered to all pregnant women, many of whom decide to have one or more tests carried out. However, in the Netherlands, the government has been quite reticent about offering prenatal screening, and only a limited number of pregnant women undergo such a test. Up until the end of 2006, the official policy was that only pregnant women older than 35 years would be offered a prenatal test (chorionic villus sampling, CVS or amniocentesis) and younger pregnant women would not be offered prenatal testing. Since 1 January 2007, all pregnant women in the Netherlands receive information on prenatal screening. All pregnant women older than 35 years will be reimbursed for the screening test for Down's syndrome; the ultrasound examination for neural tube defects and other conditions will be reimbursed for all pregnant women (VWS, 2005). Prenatal screening must comply with the national quality requirements that have been set with regard to information, counselling, ultrasound and laboratory testing. A recent study completed prior to 1 January 2007 amongst a large group of pregnant women in the Netherlands revealed that less than half of the pregnant women who were offered prenatal testing actually took up the offer (Van den Berg et al., 2005). Other studies in the Netherlands have concluded that a higher percentage (more than 80%) of pregnant women in the Netherlands would take up an offer of prenatal screening (Muller et al., 2006).

From an international perspective, there has been a continuous increase in the percentage of congenital disorders that have been detected through prenatal screening since these tests became available. The European registration of congenital abnormalities (EUROCAT) shows, for example, that there has been a continuous increase in the percentage of fetuses with Down's syndrome detected and later aborted that were found through prenatal tests. The percentage of 5% in 1980 rose to approximately 30% in 1990 and approximately 55% in 2003 (EUROCAT website). A similar trend can be seen for neural tube defects: from

less than 20% in 1980 to approximately 45% in 1990 and a further rise to more than 70% in 2003. The intensity of these trends differs per country and largely depends on the national policies that are in place.

Diversity of policies for prenatal screening in European countries

One recent EUROCAT report shows that there is great diversity in Europe regarding prenatal screening policies (EUROCAT, 2005). For example, in the United Kingdom, France and Denmark, prenatal screening is offered to all pregnant women as part of a standard package. Germany and Sweden, however, do not have general screening policies although screening in these countries is widespread. In Norway screening is limited to women over the age of 37 years. Ireland has no prenatal screening programme although pregnant women can request a test. Ultrasound examinations appear to be more widely used; in nearly all European countries, pregnant women routinely undergo one or more scans in which congenital abnormalities can also be detected. The variation among policies is related to such factors as legislation in the area of pregnancy termination, availability of resources and social and cultural aspects (EUROCAT, 2005). The differences in policies between the European countries is clear from another study based on the EUROCAT data (Garne et al., 2005). In this study it appeared that almost 65% of the structural congenital abnormalities (including neural tube defects) were diagnosed with prenatal tests. This then resulted in an average of 66% of those pregnancies being terminated. It should be noted that these percentages greatly differ for each country and sometimes per region. For example, in Croatia only 24% of these conditions are detected through prenatal screening while in the Paris region of France the percentage is 88%. The percentage of pregnancy terminations for abnormal foetuses detected through prenatal tests with a structural congenital abnormality also exhibits considerable differences between the Member States: in the German region of Mainz it is 23% whilst in the Italian region of Campania, 82%.

One study on the guidelines for prenatal care among the EU Member States, showed that 20 out of 25 Member States had official guidelines for prenatal care in place. In fourteen out of twenty cases, there were specific recommendations for prenatal screening for Down's syndrome by a maternal serum test. The researchers concluded that it would be advisable to formulate one European guideline that included a minimum of criteria for prenatal care. However, it is not clear whether recommendations for prenatal screening should also be included in this guideline (Bernloehr et al., 2005).

Choice for screening often not based on well-informed decision-making

The aim of offering prenatal screening is not to test as many people as possible or indeed to prevent as many births of children with a disability as possible. The choice of whether or not to undergo prenatal testing depends on the personal values and standards of the individuals concerned. When prenatal screening is offered to pregnant women they should be able to make a well-considered and informed decision on whether or not they want to take part in the screening (GR, 2004b). This means that when a prenatal screening programme is evaluated, one important indicator should be the extent to which pregnant women are able to take an informed decision on participation in the screening (Essink-Bot et al., 2005). Research from other countries shows that many women do not think they have been informed sufficiently and that the offer of testing was presented – not as a matter of choice – but as a self-evident part of the care process (GR, 2004b). One review article that analysed studies from twelve different countries regarding the psychosocial aspects of prenatal screening, showed that many pregnant women had insufficient information on the relevant aspects of prenatal screening (Green et al., 2004). In fact, many pregnant women do not take a well-informed decision on their participation in a screening programme. This is confirmed by a recent study in the Netherlands that concluded that approximately half of the pregnant women studied did not take well-informed and consistent decisions on prenatal screening (V an den Berg et al., 2006). Incidentally, this point was studied prior to the policy changes that were enforced on 1 January 2007 in the Netherlands. Now concrete agreements have been made on the quality of information and counselling and further research will need to demonstrate whether or not this leads to better decision-making by the women concerned.

The routinization of prenatal screening

A process of normalization and routinization for prenatal screening has emerged in many countries where prenatal screening is offered to all pregnant women. This means that it has become both normal and self-evident to have prenatal screening performed during pregnancy – no longer a matter of explicit decision-making. However, this routinization violates the aim of informed decision-making where a conscious and well-informed choice is made. In the American state of California, research concluded that screening is no longer something that involves making a conscious choice (Press & Browner, 1997). Other studies in France, the United Kingdom and Australia also point to such developments (Tsianakas & Liamputtong, 2002; Williams et al., 2002; Vassy, 2005). To prevent routinization and uninformed decisions from taking place, the decision aids can be implemented. One example of such a decision-aid is an interactive website where people are stimulated to weigh up the advantages and disadvantages and possible consequences of a test and subsequently apply their own values and standards. Research from abroad has shown that such decision aids can be effective in improving the process of decision-making for people (O'Connor et al., 1999). However, it is still not clear whether these instruments can actually be applied on a large scale in these countries. In the Netherlands, decision aids are being developed for prenatal screening.

Conclusion

The policies and practice of prenatal screening for congenital abnormalities show much diversity between countries. This variation is related to the political and cultural differences of each country. For a long time the Netherlands has operated a rather cautious policy regarding prenatal screening although this has now changed – since 1 January 2007, all pregnant women (regardless of their age) are informed about the possibilities of prenatal screening. Various studies have shown that in countries where prenatal screening has been part of standard prenatal care procedure for some time, a process of routinization has taken place. This, in turn, means that undergoing prenatal screening is no longer preceded by a conscious and well-considered choice – it is now a self-evident test belonging to the prenatal care period. The implementation of aids that support the process of decision-making could help to prevent this situation from occurring in the Netherlands.

8.4 New screening programmes

As far as new policy is concerned, a decision will have to be made in the Netherlands in the near future regarding the implementation of two screening programmes at a national level. These screening programmes are for Chlamydia infection and colorectal cancer. In the next section, we will look at the policies in place in other countries for these two areas of screening.

8.4.1 Chlamydia screening

Chlamydia the most frequently occurring STD in the Netherlands

An infection with *Chlamydia trachomatis* is the most frequently occurring bacterial sexually-transmitted disease (STD) in the Netherlands. The diagnosis of Chlamydia infection was made on 5145 occasions in 2005 by the municipal health services (GGD) and the STD outpatient departments belonging to the Sentinel Surveillance Network that monitors the incidence of sexually-transmitted infections in the Netherlands. This data shows an increase of 15% compared to the number of diagnoses in 2004 (De Boer & Laar, 2006). At present, no national screening programme is in place in the Netherlands for Chlamydia because not all of the Wilson & Jungner criteria can be met (GR, 2004c; Wilson & Jungner, 1968). There is still much uncertainty regarding the natural course of Chlamydia infection and the occurrence of complications (Dekker, 2005). However, in 2007 a pilot scheme was started for Chlamydia screening amongst sexually active persons of 16-29 years in three areas of the Netherlands (SOA Aids Nederland, 2006). This

screening programme is a follow-up to the successful pilot study of 2002-2003 into a systematic Chlamydia screening conducted by postal survey of urine samples. From this first national study into Chlamydia infections, it appeared that in large Dutch cities 3.2% of the participants had a Chlamydia infection – a considerably higher number than in sparsely populated areas where 0.6% of the participants were found to be infected with Chlamydia (Van Bergen, 2005; SOA Aids Nederland, 2006). Chlamydia infections occur particularly in the population groups of young women (15-19 years) and young adult men (25-29 years) living in densely urban areas. Those affected are usually young people and young adults with a low educational level, of Surinamese or Antillean origin who have STD symptoms and non-monogamous sexual relations (Van Bergen et al., 2005).

Chlamydia infection usually runs its course without symptoms so that people are often unaware that they are infected. An infection is easy to treat with antibiotics. However, if the Chlamydia infection is not treated then in women it can lead to serious health consequences such as reduced fertility and ectopic pregnancies. In men, Chlamydia infections can lead to inflammation of the prostate and epididymis (SOA AIDS Nederland, 2006).

Few European countries have policies for Chlamydia screening

A number of European countries have formulated policies for Chlamydia screening. One remarkable point here is that these screening programmes are mainly opportunistic in structure (Holland, 2006).

United Kingdom proceeds with phased implementation of a national screening programme

In 2002, as part of the National Strategy for Sexual Health and HIV, the English Ministry of Health started to phase the implementation of a national Chlamydia screening programme. This concerned opportunistic screening of sexually active men and women under the age of 25 years. The partners of people found to be infected with Chlamydia are also to be traced (DH, 2004). From a qualitative study into barriers for opportunistic screening for Chlamydia in the United Kingdom, it was shown that doctors found it difficult to raise the subject of Chlamydia infection during a consultation that had nothing whatsoever to do with sexuality (McNulty et al., 2004; Dekker, 2005). Within the framework of this screening programme, young people between the ages of 16 and 24 years were able to collect a Chlamydia test kit free of charge from certain chemists and pharmacies in London and Cornwall. This intervention started in November 2005. It is expected that this intervention will lead to more screening in the target population. The free service is part of a pilot scheme that is financed by the Department of Health to determine whether or not pharmacies and chemists are the right setting for people to access Chlamydia screening. The pilot scheme will be evaluated after two years. If it is shown to be successful, it will be implemented nationwide (DH, 2006).

Large-scale opportunistic screening in Sweden

Opportunistic screening for Chlamydia takes place on a relatively large scale in Sweden. Since 1988, doctors have been obliged to examine both those patients who are possibly infected with Chlamydia as well as the sexual contacts of those patients. However, the doctors are not checked to see whether they comply with this legislation. Moreover, screening in Sweden is organized at local level which means that the intensity of the screening varies across the country. Some regions have guidelines on who should be screened while other regions follow the general Swedish recommendations. Screening in Sweden is aimed at sexually active women between the ages of 15 and 29 years who visit a doctor either for contraceptives or an abortion (Low, 2004).

Some countries are considering Chlamydia screening programmes

The United States upholds a recommendation to screen all sexually active women of 25 years and under as well as other asymptomatic women who are at increased risk of exposure to infection (USPSTF, 2001).

Denmark and France are investigating the best ways of organizing Chlamydia screening (Pavlin et al., 2006). The situation in these countries is the same as that of the Netherlands – they do not offer active Chlamydia screening yet, partly because research results from abroad cannot always be adapted to fit into

the country-specific situation. Denmark is considering the implementation of a systematic screening system in which all young people in the age category of 16-25 years are offered a yearly self-testing home kit (Holland et al., 2006). An earlier pilot study showed that screening that is combined with a home test is associated with a lower prevalence of Chlamydia infections at one year follow-up compared to the traditional screening method where the test is performed by a professional (Østergaard et al., 2000).

A number of pilot studies are currently being run in France. The French organization, l'Agence National d'Accréditation et d'évaluation en Santé' (ANAES) has recommended setting up opportunistic screening for people in risk groups who visit certain care institutions. Men and women under the age of 30 years, who are sexually active, have changed partners within the last year or people whose partner could be infected with an STD, fall into risk groups eligible for Chlamydia screening according to this advice. Portugal, Spain and Italy are encouraging opportunistic screening directed at young people. At present, other countries do not seem to have concrete policies in place concerning Chlamydia screening (Holland et al., 2006).

Conclusion

Only a few countries currently have organized screening programmes aimed at the early detection of Chlamydia infection, although some countries are in the process of developing initiatives for this purpose. Such programmes can be structured in different ways according to the country concerned. For example, selective, opportunistic or systematic screening may be chosen – the choice depending on differences in both the prevalence and the occurrence of risk factors inter-regionally and between countries. Most countries appear to be in favour of opportunistic screening and have given priority to research aimed at raising the cost-effectiveness of such screening programmes. Considering that Chlamydia infections in the Netherlands do not occur in all places at the same rate and that there are clear distinctions in risk factors, selective screening is recommended in this country. Selective screening in sexually active target groups that is based on risk profiles will deliver a higher background prevalence, which may increase cost-effectiveness (SOA Aids Nederland, 2006). The prevalence rates in the UK are clearly higher than in the Netherlands. This could explain why the United Kingdom is more positive about the idea of screening than the Netherlands (Pimenta et al., 2003; Dekker, 2005).

8.4.2 Colorectal cancer screening

Three pilot population studies have started in the Netherlands

At present, periodic preventive testing into colorectal cancer is only being done in those people who are at increased risk of developing this disease. This concerns persons with genetic abnormalities, people with a family history of colorectal cancer and people with certain conditions that could lead to an increased risk (Signaleringscommissie Kanker van KWF Kankerbestrijding, 2004). The number of new patients in the Netherlands diagnosed with colorectal cancer in 2003 was 0.64 per 1000 men and 0.58 per 1000 women – this translates into 5157 men and 4741 women (Kampman et al., 2006). There is no national screening programme aimed at the early detection of colorectal cancer. Because colorectal cancer is one of the most commonly occurring types of cancer, its early detection or prevention is an important issue. In 2006, three trial pilot screening studies started that focussed on various techniques that can be applied for the very early detection (precancerous stage) of colorectal cancer and the way in which such population studies can be implemented. In addition, following advice from the Health Council of the Netherlands, the Ministry of Health has granted a licence for a scientific study into selective screening (stepped care approach) into colorectal cancer (GR, 2006c).

FOBT screening reduces the risk of mortality from colorectal cancer

At present, only the two-yearly standard faecal occult blood (FOBT) screening test has shown to have an increased chance of diagnosing colorectal cancer in an earlier stage of the disease. This then leads to less radical treatment being needed as well as a reduction in the risk of death from colorectal cancer by 15% to 20% (Faivre et al., 2004; Jørgensen et al., 2002; Kronborg et al., 1996; Mandel et al., 1999). This test can determine the presence of traces of blood in the faeces (Schrijvers & Ballegooijen, 2006). There are several

types of FOBT tests: the standard FOBT Hemoccult II and the immunochemical FOBTs. The FOBT is patient-friendly and easy to perform at home. One disadvantage, however, is that its sensitivity is limited.

The percentage of patients with colorectal cancer who are found to test positively for this disease through the standard FOBT is approximately 50% (De Visser et al., 2005). Polyps, the precancerous stage of colorectal cancer are hardly ever detected through this test. Approximately 2% of the people who have the standard FOBT screening test have positive results – this is in accordance with expectations. Any FOBT test result that is false positive will need further investigation through a colonoscopy – this is a demanding procedure for someone to undergo. During colonoscopy, the whole of the large bowel is inspected with a small camera that is attached to a flexible tube (Schrijvers & Ballegooijen, 2006). In approximately half of the people who undergo this further test, no colorectal cancer is present – this means that they were false positive to start with (Pronk, 2005).

In contrast to the FOBT test, polyps can be detected by colonoscopy and lead to a diagnosis of cancer in an early stage. Polyps can lead to cancer within a period of approximately ten years (ZonMw, 2005; Segnan et al., 2002). Polyps can usually be immediately removed on detection during the colonoscopy procedure (GR, 2006d). However, it should be remembered that this is a demanding procedure for patients to undergo – they do need to have an anaesthetic and there is a risk of complications. There is also always a risk of haemorrhage or even perforation of the bowel after polyps have been removed. The worst-case scenario results in death (Pronk, 2005). One other technique that is used to detect polyps is that of sigmoidoscopy. In this procedure, only the last part (= 60 cm) of the large bowel and the rectum is examined – similar to the colonoscopy procedure (GR, 2006d; Schrijvers & Ballegooijen, 2006). The risk of perforating the intestinal wall during a sigmoidoscopy is about 2 to 3 per 100,000 procedures (Segnan et al., 2002; UK, 2002; GR, 2006c,d). People who undergo a colonoscopy because of a positive screening result (either through FOBT or sigmoidoscopy) are at risk of intestinal wall perforation – this occurs in 10 per 10,000 procedures. For the same people, there is also a risk of haemorrhage that requires hospitalization occurring in 14 per 10,000 procedures (Segnan et al., 2002; UK, 2002; GR, 2006 a,d).

It is expected that sigmoidoscopy will be more effective than the standard FOBT screening for the detection of colorectal cancer. As is the case with a colonoscopy, people undergoing sigmoidoscopy are at risk for certain conditions that do not apply to the standard FOBT test. At present, the real health gains of sigmoidoscopy procedures are still being studied in pilot studies in Italy, the United States, the United Kingdom and the Netherlands. In addition, multiple pilot studies have been started both in the Netherlands and other countries that focus on the immunochemical variant of the FOBT (with a sensitivity around 70% to 80%), imaging technology tests and DNA tests (Federici et al., 2005; Crotta et al., 2004).

European Commission recommendation aimed at the FOBT

A recommendation on colorectal cancer screening was issued in 2000 at a European level. The Advisory Committee on Cancer Prevention of the European Commission has advised all people between the ages of 50 and 74 years to be screened for the time being using the standard FOBT, followed by a colonoscopy procedure in cases of a positive FOBT result. The interval between the screening tests has been set at one to two years (Neuhaus, 1999; Advisory committee on cancer Prevention, 1999). Other screening methods such as the immunochemical variants of the FOBT, sigmoidoscopy and colonoscopy are not recommended yet.

The Netherlands upholds a cautious policy on colorectal cancer screening compared to other countries

Some countries are currently conducting activities in the area of screening programmes. The Netherlands is one of the countries with pilot studies in progress and is, compared to other countries, quite hesitant about offering colorectal cancer screening (GR, 2006c,d). In 2005, a Dutch consensus group concluded that screening with the standard FOBT either did comply with all the Wilson & Jungner criteria or will do so

within the next two to three years (Visser et al., 2005; Pronk, 2005). According to the consensus group, a national screening programme aimed at preventing colorectal cancer should be set up as soon as possible.

The United Kingdom, France, Finland and Australia have already started the phased implementation of a national screening programme using the standard FOBT (Classen, 2006; GR, 2006d). In the United Kingdom, France and Finland, screening does take place in a number of provinces and will be extended to all provinces during the next few years. The intended target groups for screening varies from country to country. In France, people between the ages of 50 and 74 years are screened while in the United Kingdom and Finland, the target is people between the ages of 60-69 years. At present, Australia only offers screening to people who will reach the age of 55 years or 65 years between 2006 and 2008 to suitably tune the supply to the demand (NBCSP, 2006). Here, the screening takes place on a national scale. In countries such as Germany, the United States and Italy, screening for colorectal cancer also takes place, although this is not through organized programmes. Here, the screening activities mostly take place at regional level (GR, 2006d). In Germany preventive colonoscopy is recommended at the age of 55 years to be repeated at the age of 65 years (Neuhaus, 1999). In the United States, colorectal cancer screening is recommended for people of 50 years and older (ACS, 2006). For this purpose, various diagnostic techniques are possible: a yearly FOBT, a periodic sigmoidoscopy (once every five years), (Cokkinides et al., 2003), a combination of both of the above, a periodic colonoscopy (once every ten years) or a periodic contrast barium meal test (once every five years). A pilot study has started in Italy, which offers a single sigmoidoscopy to people between the ages of 55 and 64 years. If the result is positive then a colonoscopy will subsequently be performed. The aim of this pilot study is to show that the number of deaths from colorectal cancer can be reduced by sigmoidoscopy screening (Segnan et al., 2002).

The organization of screening programmes differs per country

In the United Kingdom and Finland, colorectal cancer screening is organized outside the regular primary care services. General practitioners are informed when the screening programme is about to take place in their region. The special screening centres take care of the invitation letters, the distribution of the FOBT toolkits and the reporting of and feedback on the results. People who receive an FOBT toolkit can perform the test at home and send the sample material to the laboratory. In the United Kingdom, any colonoscopy that is deemed necessary following a positive FOBT result is performed in one of the screening centres. If colorectal cancer is diagnosed following these tests then the person concerned is referred to the regular care services (NHS-BCSP, 2006).

In Finland people are referred to their local care institutions for a colonoscopy procedure. Here it is the local authority that decides whether or not to implement colorectal cancer screening and they bear the costs for these tests (Malila et al., 2004). In some countries, such as France and Australia, general practitioners play a much greater role. In France for example, it is the general practitioners (providing they followed further training) who perform the screening. Their tasks include inviting people to take part and maintaining contact with them regarding the screening procedure (Classen, 2006). In Australia people are advised to contact their general practitioner if they have a positive FOBT result (NBCSP, 2006). In Germany, preventive colonoscopy is performed by a network of gastrologists. An electronic protocol is currently being developed for the implementation of a standard colonoscopy procedure (Classen, 2006; Brenner et al., 2006). In the United States, screening tests are performed by the Preventive Services Task Force, the American Cancer Society and the Centers for Disease Control and Prevention (ACS, 2006). The Italian pilot study is mainly being conducted in the regular care services – a screening centre has been set up for inviting the target group (Segnan et al., 2002).

Conclusion

Compared to other countries, the Netherlands is still quite cautious in offering colorectal cancer screening. Screening for colorectal cancer already takes place in a number of countries. These screening programmes are either carried out as national population programmes or organized as a regional activity. For example, Italy, Germany and the United States conduct their screening regionally. Other countries, such as Australia,

Finland, the United Kingdom and France have started with the phased implementation of national screening programmes using the standard FOBT test (GR, 2006c). The Dutch consensus group has concluded that screening with the standard FOBT either did comply with all the Wilson & Jungner criteria or will do so within the next two to three years. As far as colorectal cancer screening is concerned, it seems that the FOBT (HCII) is currently the most suitable method of diagnosis – whilst waiting for further research results on immunogenic FOBTs and sigmoidoscopy testing. People in the age category of 50 to 74 years would be eligible for this screening (De Visser et al., 2005; Pronk, 2005).

The Dutch consensus group concluded that a national screening programme for the prevention of colorectal cancer should be started as soon as possible. Before a screening programme is implemented in the Netherlands, the positive health benefits should be weighed up against the negative effects. In particular, the physical and psychological demands on the participants should be carefully considered as well as the danger of over-diagnosing and over-treatment, possible complications and demands on the regular care services. This means that all parties involved in the population studies – including those in the target groups and the relevant professional groups – must be well informed about the screening procedure (Schrijvers & Ballegooijen, 2006).

8.5 Discussion and conclusions

Comparison of developments limited to those relevant for policymaking

This chapter has focussed on the following question: what can the Netherlands learn from policies in other countries regarding screening? We have tried to answer this question satisfactorily by comparing screening policies at national level for the following conditions: breast cancer, cervical cancer, neonatal screening (heel prick test), Down's syndrome, Chlamydia infection and colorectal cancer. In the comparison of the various screening programmes, not all the characteristics of each screening test have been included. Only those developments that will be relevant for Dutch policy in the near future have been studied.

Unfortunately, the scope of this project did not allow for a comparison of more separate screening aspects to be made.

We have collected and studied information on policies and relevant policy aspects by conducting a review of relevant articles, reports and websites of ministries and institutes. This has enabled us to gather information on the various policies as they have been officially formulated by the Member States. One limitation of the sources used was that they do not provide sufficient information on the degree to which the policies have actually been implemented in daily practice. Unfortunately, it has not been possible to find out – for example, through interviews – how the policies described in the literature have been implemented in daily practice.

The comparisons made in this chapter provide insight into how Dutch policymakers could learn from other countries regarding the area of screening. One thing that still needs to be studied however, is the degree to which these aspects of screening can be applied to the Dutch system.

Countries differ strongly on the conditions for which they screen

The policies surrounding screening are based on the weighing-up of the health gains from screening and the demands and possible risks to the people concerned. In 1968, WHO formulated criteria that could be used for the assessment of new screening procedures or to adjust and revise those already in place. Most countries have indicated that they use these Wilson & Jungner criteria. It seems there is international consensus on applying the Wilson & Jungner criteria. The phrasing of the criteria, however, allows for different interpretations: when is a screening test a good test? What is an acceptable treatment? Despite the same set of criteria being used, there are many differences between countries concerning: the conditions for which screening takes place, how the screening is organized and the information that people receive on the

subject. There are also countries that have formulated additional criteria. For example, the United Kingdom has added the criterion that prior to a screening, which is secondary prevention, everything that falls under primary prevention must already have been performed. This integrated approach towards prevention is not explicitly applied in other countries, including the Netherlands. It should be noted that it can be a valuable addition for various health problems to ensure that everything has been done in the area of primary prevention before moving on to secondary prevention.

Screening policies are also influenced by a combination of public opinion, both national and international, political and commercial interests, the public health problems in a particular country and the way in which health care systems are organized. These aspects determine the final decision that is taken on whether or not to implement a national screening programme and how it is implemented.

Other countries perform screening, apply new techniques or expand current screening programmes earlier than the Netherlands.

Compared to many other countries, the Netherlands carefully considers the advantages and disadvantages of a screening test before new programmes are implemented or existing ones revised. In many other countries, the decision to perform screening, apply new techniques or expand current screening takes place earlier. This is evident for example, from the fact that the Netherlands has not introduced screening for colorectal cancer because research results are still awaited. In contrast, other countries introduce screening programmes without having all the information on the advantages and disadvantages at hand. This careful attitude on the part of the Netherlands does mean that some Dutch developments are lagging behind those of other countries. However, whilst the Netherlands waited for a long time before expanding the scope of the heel prick test, it now takes the lead regarding the number of conditions that are screened. Current developments in technology will require screening programmes, for example, for cervical cancer to be frequently adjusted. This will be a challenge for the Netherlands, bearing in mind that the country's careful consideration regarding screening must not be lost from view.

The Netherlands and Belgium belong to the few countries that protect their citizens through legal measures. Whilst other countries do take certain measures to safeguard the quality of screening that is offered, these are often not legally secured and therefore not obligatory. This can lead to undesired screening tests being offered. One example of this is the implementation of the screening for Duchenne muscular dystrophy in Wales, considering that the National Screening Committee does not support this screening test being offered.

In Germany a much broader screening package is offered that includes screening tests that are not allowed to be offered by the Netherlands. People's attention is drawn to these screening tests in Germany through the Internet. It is also possible to order self-testing kits over the Internet. The quality and safety of these tests is not guaranteed and there is no supervision involved when performing the test. Legislation in the Netherlands does not offer any help on either the prohibition or the regulation of these screening tests that are offered through Internet and/or are offered just outside Dutch borders.

Most important conclusions per screening test

In this chapter an international comparison has been made of developments that are relevant for policies on screening tests for breast cancer, cervical cancer, the heel prick test, Down's syndrome and screening for colorectal cancer and Chlamydia infection. From this comparison, the following conclusions can be drawn:

- For breast cancer screening, it is evident that the way in which screening is organized does not necessarily influence the outcome for women who take part in the screening programme. What is important is that all steps in the screening process are carried out carefully and according to guidelines.
- For cervical cancer screening, many countries are looking for ways to introduce various new techniques (such as the HPV home test and the HPV vaccine) into their policy procedures. With the arrival of new technologies, frequent revision of the current screening programme will be needed in the Netherlands.

- By expanding the scope of the heel prick test, the Netherlands no longer lags behind the rest of Europe but instead takes the lead. Western countries differ greatly regarding the number of conditions for which neonatal screening takes place as well as the information provided to parents and their freedom of choice regarding participation.
- It has been shown that in countries where prenatal screening has been part of standard prenatal care for some time, a process of routinization for the screening has taken place. The result is that undergoing this screening has become a natural part of prenatal care. This means that undergoing prenatal screening is no longer preceded by a conscious and well-considered choice – it is now a self-evident test belonging to the prenatal care period. If possible, this routinization should be prevented from occurring in the Netherlands.
- Only a few countries currently have organized screening programmes aimed at the early detection of Chlamydia infection, although some countries are in the process of developing initiatives for this purpose. Differences in both the prevalence and the occurrence of risk factors, both inter-regionally and between countries may influence how a screening programme is organized and implemented. Most countries appear to be in favour of opportunistic screening. The Netherlands will probably choose selective screening among sexually active target groups that is based on risk profiles.
- Compared to other countries, the Netherlands is still quite cautious in offering colorectal cancer screening. Screening for colorectal cancer does already take place in a number of countries. In these countries the screening is carried out either as a national screening programme or is organized as a regional activity. The Dutch consensus group has concluded that screening with the standard FOBT either complies with all the Wilson & Jungner criteria or will do so within the next two to three years.

In summary, the following general conclusions can be drawn from the international comparisons described in this chapter:

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

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

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

Compared to many other countries, the Netherlands carefully considers the advantages and disadvantages of screening tests before they are implemented. In many other countries, the decision to perform screening, apply new techniques or expand current screening programmes is made faster. The Netherlands faces the challenge of continuing with its policy of carefully weighing up the advantages and disadvantages of screening tests whilst at the same time making full use of the advantages that new technology offers.

References

- ACS, American Cancer Society. http://www.cancer.org/docroot/PED/content/PED_2_3X_AcS_cancer_Detection_Guidelines_36.asp (last visited October 2006), 2006.
- Advisory Committee on Cancer Prevention. Recommendations on cancer screening in the European union. December 1999.
- AIHW, Australian Institute of Health and Welfare. Breast Screen Australia; monitoring report 2002-2003. Canberra: 2006.
- Anhang R, Goodman A, Goldie SJ. HPV communication review of existing research and recommendation for patient education. *Cancer J Clin*, 2004;54:248-259.
- Anttila A, Ronco G, Clifford G, Bray F, Hakama M, Arbyn M, et al. Cervical cancer screening programmes and policies in 18 European countries. *British Journal of cancer*. 2004; 91:935-941.
- Arbyn M, Temmerman M. Belgian Parliament calls for organised cervical cancer screening and HPC research throughout Europe. *The Lancet Oncology*; 2002.
- BBC News. EU approves cervical cancer jab. <http://news.bbc.co.uk/1/hi/health/5370504.stm>. (last visited 22 November 2006), 2006.
- Berg M van den, Timmermans DR, Kleinveld JH, Garcia E, vugt JM van, Wal G van der. Accepting or declining the offer of prenatal screening for congenital defects: test uptake and women's reasons. *Prenat Diagn*, 2005 Jan;25(1):84-90.
- Berg M van den, Timmermans DR, ten Kate LP, van vugt JM, van der Wal G. informed decision making in the context of prenatal screening. *Patient Educ Couns*, 2006 Oct;63(1-2):110-117.
- Bergen J van, Götz HM, Richardus JH, Hoebe CJPA, Broer J, Coenen AJT. Prevalence of urogenital chlamydia trachomatis increases significantly with level of urbanisation and suggests targeted screening approaches; results from the first national population based study in the Netherlands. *Amsterdam: Sex Transm Infect*, 2005;81:17-23.
- Bernloehr A, Smith P, Vydellingum V. Antenatal care in the European Union: a survey on guidelines in all 25 member states of the community. *Eur J Obstet Gynecol Reprod Biol*. 2005 Sep 1;122(1):22-32.
- Boer IM de, Laar MJW van de. Voorlopige soacijfers 2005: Toename van chlamydia en hiv. *Infectieziekten Bulletin*, 2006;17:129-131.
- Bolhuis PA, Page-christiaens GC. The advisory report 'Neonatal screening' from the Health council of The Netherlands. *Ned Tijdschr Geneesk*, 2005; 149(51):2857-2860.
- Bouchard L, Blancquaert I, Eisinger F, Goulkes WD, Sobol H, Julian-Reynier C. Prevention and genetic testing of breast cancer: variations in medical decisions. *Social Science and Medicine*, 2004:1085-1096.
- Brenner H, Chang-Claude J, Seiler CM, Stürmer T, Hoffmeister M. Does a negative screening colonoscopy ever need to be repeated? *Gut*, 2006;55:1145-1150.
- Broeders MJM, Scharpantgen A, Ascunce A, Gairard B, Olsen AH, Mantellini P, et al. Comparison of early performance indicators for screening projects within the European Breast Cancer Network. *Eur J Cancer Prev*, 2005;14:107-116.
- BS, Bunderministerium für Gesundheit. <http://www.die-praevention.de/frueherkennung/index.html?param=> (last visited 16 January 2007), 2007.
- Classen M. Colorectal Cancer Screening is Gaining Ground in Europe. *Long-Term Healthcare*. <http://www.touchbriefings.com/pdf/1956/classen.pdf#search=%22preventive%20colonoscopy%20germany%22> (last visited 9 October 2006), 2006.
- Cokkinides VE, Chao A, Smith RA, Vernon SW, Thun MJ. Correlates of underutilization of colorectal cancer screening among US adults, age 50 years and older. *Preventive Medicine*, 2003;36(1):85-91.
- Crotta, S, Castiglione G, Grazzini G, Valle F, Mosconi S, Rosset R. Feasibility study of colorectal cancer screening by immunochemical fecal occult blood testing: results in a northern Italian community. *Eur J Gastroenterol Hepatol* 2004;16(1):33-37.
- Crown copyright. Statutory instrument 2000 No. 1059; The ionising Radiation (Medical Exposure) Regulations 2000. <http://www.opsi.gov.uk/si/si2000/20001059.htm>. 2000.

- Cuzick J, Mayrand MH, Ronco G, Snijders P, Wardle J. chapter 10: New dimensions in cervical cancer screening. 2006.
- Davies P, Arbyn M, Dillner J, Kitchener HC, Meijer C, Ronco G, et al. A report on the current status of European research on the use of human papillomavirus testing for primary cervical cancer screening. *Int J Cancer*, 2006;118:791-796.
- Dekker JH. Gezondheidsraadadvies 'Screenen op chlamydia' te terughoudend. *Ned Tijdschr Geneesk*, 2005;149(16):850-852.
- Detmar SB. Verslag van expert meeting: informed consent bij neonatale screening. Leiden: TNO Kwaliteit van Leven, 2006.
- Deutsche Krebshilfe. <http://www.krebshilfe.de/54.0.html> (last visited 17 January 2007), 2007.
- DH, Department of Health. National Chlamydia Screening Programme (NCSP) in England. Programme Overview Core Requirements Data collection. London: DH, 2004 (2nd edition).
- DH, Department of Health. 2006 Chlamydia screening evaluation - interim report. Wave One Report prepared by TNS Healthcare for: The Department of Health, 2006.
- Donovan JL, Frankel SJ, Neal DE, Hamdy FC (eds.). Screening for prostate cancer in the UK; seems to be creeping in by the back door. *BMJ* 2001;323:763-674.
- Essink-Bot ML, Fracheboud J, Laudy JAM, Wild-schut HIJ, de Koning HJ. Landelijke evaluatie van een programma voor prenatale screening op Down syndroom - voorstel voor kernindicatoren, meetprocedures en monitoring. Rotterdam: ErasmusMC, 2005.
- EUROCAT. Prenatal screening policies. Ulster: University of Ulster, 2005.
- Fabri V, Remacle A, De Gauquier K, Mertens R. Programma borstkankerscreening; periodes 2001-2002 en 2003-2004. Rapport nr. 4 van het intermutualistisch Agentschap. Brussel: Intermutualistisch Agentschap, 2006.
- Faivre J, Dancourt V, Lejeune C, et al. Reduction in colorectal cancer mortality by fecal occult blood screening in a French controlled study. *Gastroentrol* 2004;126:1674- 1680.
- Fant KE, Clark SJ, Kemper AR. completeness and complexity of information available to parents from newborn-screening programs. *Pediatrics* 2005;115(5):1268-1272.
- Federici A, Giorgi RP, Borgia P, Bartolozzi F, Farchi S, Gausticchi G. The immunochemical fecal occult blood test leads to higher compliance than the guaiac for the colorectal cancer screening programmes: a cluster randomized controlled trial. *J Med Screen* 2005;12(2):83-88.
- Fracheboud J, Koning HJ de. Wie doet wat? In: Volksgezondheid Toekomst Verkenning, Nationaal Kompas Volksgezondheid. Bilthoven: RIVM, <<http://www.nationaalkompas.nl>> Preventie\ van ziekten en aandoeningen\ Kanker\ Borstkanker, 5 december 2005.
- Frelih T. Chlamydia screening project starts in Nova Gorica, Slovenia. <http://www.eurosurveillance.org/ew/2005/050609.asp> (last visited 12 October 2006). *Eurosurveillance* 2005;10(6).
- Game E, Loane M, Dolk H, De Vigan C, Scarano G, Tucker D, et al. Prenatal diagnosis of severe structural congenital malformations in Europe. *Ultrasound Obstet Gynecol* 2005 Jan;25(1):6-11.
- GB, Gemeinsamer Bundesausschuss. http://www.g-ba.de/cms/front_content.php?idcat=109&start=3. (Last visited 17 January 2007), 2007.
- GR, The Health Council of the Netherlands: commissie Screening erfelijke en aangeboren aandoeningen. Genetische screening. GR-publicatienr. 1994/22. The Hague: GR, 1994.
- GR, The Health Council of the Netherlands. Screening op type 2 diabetes. The Hague: GR, 2004a.
- GR, The Health Council of the Netherlands. Prenatale screening (2); Downsyndroom, neuralebuisdefecten. GR-publicatienr. 2004/06. The Hague: GR, 2004b.
- GR, The Health Council of the Netherlands. Screenen op chlamydia. GR-publicatienr. 2004/07. The Hague: Gezondheidsraad, 2004c.
- GR, The Health Council of the Netherlands. Wet bevolkingsonderzoek: dunnelaagcytologie en geautomatiseerde screening op baarmoederhalskanker. The Hague: GR, 2005a.
- GR, The Health Council of the Netherlands. Neonatale screening. GR-publicatienr. 2005/11. The Hague: GR, 2005b.
- GR, The Health Council of the Netherlands. Jaarbericht bevolkingsonderzoek 2006. The Hague: GR, 2006a.

- GR, The Health Council of the Netherlands. Wet bevolkingsonderzoek: thuishest voor niet-deekneemsters aan de screening op baarmoederhalskanker. The Hague: GR, 2006b.
- GR, The Health Council of the Netherlands. Wet bevolkingsonderzoek: screenen op darmkanker via individuele risicoprofielen. The Hague: GR, 2006c.
- GR, The Health Council of the Netherlands. Wet bevolkingsonderzoek: screening op darmkanker met sigmoidoscopie of FOBT. The Hague: GR, 2006d.
- Green JM, Hewison J, Bekker HL, Bryant LD, Cuckle HS. Psychosocial aspects of genetic screening of pregnant women and newborns: a systematic review. *Health Technol Assess* 2004 Aug;8(33): iii, ix-x, 1-109.
- Holland WW, Stewart S, Masseria C. Policy Brief; screening in Europe. WHO on behalf of the European Observatory on Health Systems and Policies. Brussels, 2006.
- Holland, W. Screening for disease, considerations for policy. *Euro Observer, the Health Policy Bulletin of the European Observatory on Health Systems and Policies* 2006;8(3).
- Hollander AEM de, Hoeymans N, Melse JM, Oers JAM van, Polder JJ (eindred.). *Zorg voor gezondheid. Volksgezondheid Toekomst Verkenning 2006* [English: Care for health. The 2006 Dutch Public Health Status and Forecasts Report. RIVM report 270061003]. RIVM-rapportnr. 270061003. Houten: Bohn Stafleu van Loghum, 2006.
- ISNS. General Guidelines for Neonatal Screening. 2002.
- Jørgensen OD, Kronborg O, Fenger C. A randomised study of screening for colorectal cancer using faecal occult blood testing: results after 13 years and seven biennial screening rounds. *Gut* 2002;50:29-32.
- Kampman E, Nagengast FM, Poos MJJC. Hoe vaak komt dikkedarmkanker voor en hoeveel mensen sterven eraan? In: *Volksgezondheid Toekomst Verkenning, Nationaal Kompas Volksgezondheid*. Bilthoven: RIVM, <<http://www.nationaalkompas.nl>> Gezondheid en ziekte\ Ziekten en aandoeningen\ Kanker\ Dikkedarmkanker, 13 March 2006.
- Kelley E, Hurst J. Health care Quality indicators Project; initial indicators Report. Paris: OEcD, 2006.
- Kitchener HC, Castle PR, Cox JT. chapter 7: Achievements and limitations of cervical cytology screening. *Vaccine* 2006;24S3:63-70.
- Kronborg O, Fenger C, Olson J, et al. Randomised study of screening for colorectal cancer with faecal occult-blood test. *Lancet* 1996;348:1467-1471.
- Lanting CI, Verkerk PH. Evaluatie van de screening AGS/CHT/PKU bij kinderen geboren in 2003. Leiden: TNO Kwaliteit van leven, 2005.
- Loeber JG, namens de iSNS Europese regio. 2006.
- Low N, McCarthy A, Macleod J, Salisbury C, Horner PJ, Roberts TE, et al. and for the Chlamydia Screening Studies Group The chlamydia screening studies: rationale and design. *Sex Transm Inf* 2004;80:342-348.
- Low N. current status of chlamydia screening in Europe. *Eurosurveillance weekly* 2004;8(41).
- Lynge E, Olsen AH, Fracheboud J, Patnick J. Reporting of performance indicators of mammography screening in Europe. *Eur J Cancer Prev* 2003;12.
- Malila N, Anttila A, Hakama M. colorectal cancer screening in Finland: details of the national screening program implemented in Autumn 2004. *Journal of medical Screening* 2004; 12(1):28-32.
- Mandel JS, Church TR, Ederer F, et al. Colorectal cancer mortality: effectiveness of biennial screening for fecal occult blood. *J Natl Cancer Inst* 1999;91:434-437.
- Mandl KD, Feit S, Larson C, Kohane IS. Newborn screening program practices in the United States: notification, research, and consent. *Pediatrics* 2002;109(2):269-273.
- McNally E. 25 Aanbevelingen inzake de ethisch, juridische en maatschappelijke implicaties van genetische tests. Brussel: Europese commissie, 2004.
- McNulty CAM, Freeman E, Bowen J, et al. Barriers to opportunistic chlamydia testing in primary care. *Br J Gen Pract* 2004;54:508-514.
- Melker HE de (red.). *Het Rijksvaccinatieprogramma nu en in de toekomst*. RIVM-rapportnr. 210021004/2006. Bilthoven: RIVM, 2005.
- Muller MA, Bleker OP, Bonsel GJ, Bilardo CM. Women's opinions on the offer and use of nuchal translucency screening for Down syndrome. *Prenat Diagn* 2006 Feb;26(2):105-111.

- Muñoz N, castellsagué X, Berrington de González A, Gissmann L. chapter 1: HPV in the etiology of human cancer. Vaccine 24S3 (last visited 1 October 2006), 2006.
- NBcSP, National Bowel cancer Screening Program. Australian Government, Department of Health and Ageing. <http://www.cancerscreening.gov.au/internet/screening/publishing.nsf/content/bowel-1lp> (last visited 12 October 2006), 2006.
- NCB. Genetic Screening: a Supplement to the 1993 Report by the Nuffield Council on Bioethics. [http://www.nuffieldbioethics.org/fileLibrary/pdf/Genetic_Screening_-_a_Supplement_to_the_1993_Report_\(2006\).pdf](http://www.nuffieldbioethics.org/fileLibrary/pdf/Genetic_Screening_-_a_Supplement_to_the_1993_Report_(2006).pdf). 2006.
- Neuhaus N. Screening for colorectal cancer in Germany: Guidelines and Reality. Endoscopy New York 1999;31(6):468-470.
- NHS-BCSP, Bowel Cancer Screening Program. <http://www.cancerscreening.nhs.uk/bowel/> (last visited 4 October 2006), 2006.
- O'Connor AM, Rostom A, Fiset V, Tetroe J, Entwistle V, Llewellyn-Thomas H, et al., Decision aids for patients facing health treatment or screening decisions: systematic review. BMJ 1999Sep18;319(7212):731-734.
- OECD. Cervical cancer screening. OECD HEALTH DATA 2006. OECD. October 2006a.
- OECD. Mammography screening - Breast cancer screening. <http://www.irdes.fr/eco-sante/ocde/370010.html> (last visited 3 August 2006), 2006b.
- Oliver S, Dezateux C, Kavanagh J, Lempert T, Stewart R. Disclosing to parents newborn carrier status identified by routine blood spot screening. Cochrane Database Syst Rev 2004; (4):cD003859.
- Østergaard L, Andersen B, Møller JK, Olesen F. Home sampling versus conventional swab sampling for screening of chlamydia trachomatis in woman: A cluster-randomised 1-year follow-up study. clinical infectious diseases 2000;31:951-957.
- Østergaard L, Andersen B, Møller JK, Olesen F. Screening for klamydia med hjemmetest - en medicinsk teknologivurdering. Medicinsk Teknologivurdering - puljeprojekter 2002;2(4).
- Otto SJ, Fracheboud J, Looman CWN, Broeders MJM, Boer R, Hendriks JHCL, et al. initiation of population-based mammography screening in Dutch municipalities and effect on breast-cancer mortality: a systematic review. Lancet 2003;361:1411-1417.
- Pavlin NL, Gunn JN, Parker R, Fairley CK, Hocking J. Implementing chlamydia screening: what do women think? A systematic review of the literature. BMC Public Health 2006;6:221.
- Perry N, Broeders M, de Wolf C, Törnberg S, Holland R, Von Karsa L. European guidelines for quality assurance in breast cancer screening and diagnosis. Luxembourg: EC, 2006.
- PHAC, Public Health Agency of Canada. Organized Breast Cancer Screening Programs in Canada; Report on Program Performance in 2001 and 2002. Ottawa: PHAC, 2005.
- Pimenta JM, catchpole M, Rogers PA, Hopwood J, Randall S, Mallinson H. Opportunistic screening for genital chlamydia infection. ii: prevalence among healthcare attenders, outcome, and evaluation of positive cases. Sex Transm Infect 2003;79(1):22-7.
- Press N, Browner CH. Why women say yes to prenatal diagnosis. Soc Sci Med 1997 Oct;45(7):979-89.
- Pronk E. Bevolkingsonderzoek darmkanker discutabel. Medisch contact 2005;60(36):1424-1426.
- Puddu M, Tafforeau J. Opportuniteit van borstkankerscreening bij vrouwen tussen 40-49 jaar; stand van zaken in België. Elementen voor een gezondheidsbeleid. Brussel: Wetenschappelijk Instituut Volksgezondheid, 2005.
- Raadgevend comité voor de kankerpreventie. Aanbevelingen voor kankerscreening in de Europese Unie. Wenen, 1999.
- RVZ, Raad voor de Volksgezondheid & Zorg. Advies t.a.v. zelftest. Zoetermeer: RvZ, 1999.
- Schledermann D, Ejersbo D, Hoelund B. improvement of diagnostic accuracy and screening conditions with liquid base cytology. Diagnostic cytopathology 2006;34(11).
- Schrijvers cTM, Ballegooien M van. Dikkedarmkanker samengevat. in: volksgezondheid Toekomst verkenning, Nationaal Kompas volksgezondheid. Bilthoven: RivM, <<http://www.nationaalkompas.nl>> Preventie\ van ziekten en aandoeningen\ Kanker\ Dikkedarmkanker, 7 September 2006.

- Screening policy team. Commissioning and managing screening programmes in the NHS in England. DH, August 2005.
- Segnan N, Senore c, Andreoni B, Aste H, Bonelli L, crosta c, et al. Baseline findings of the italian multicenter randomized controlled trial of 'once-only sigmoidoscopy'-ScORE. *J Natl cancer inst* 2002, 94(23):1763-1772
- Signaleringscommissie Kanker van KWF Kankerbestrijding. Vroege opsporing van dikkedarmkanker; Minder sterfte door bevolkingsonderzoek. KWF Kankerbestrijding, 2004.
- Soa Aids Nederland. Programmavoorstel Proefimplementatie chlamydia Screening. www.soaids.nl (last visited 12 October 2006), 2006.
- Tarini BA, christakis DA, Welch HG. State newborn screening in the tandem mass spectrometry era: more tests, more false-positive results. *Pediatrics* 2006;118(2):448-56.
- Tsianakas v, Liamputtong P. Prenatal testing: the perceptions and experiences of Muslim women in Australia. *J Reprod infant Psychol* 2002 Feb;20(1):7-24.
- UK Flexible Sigmoidoscopy Screening Trial investigators. Single flexible sigmoidoscopy screening to prevent colorectal Cancer: baseline findings of a UK multicenter randomized trial. *Lancet* 2002;359(9314):1291-1300.
- USPSTF, US Preventive Services Task Force. Screening for chlamydial infections. Recommendations and Rationale. *Am J Prev Med* 2001;20(suppl 3):90-93.
- Vassy C. How prenatal diagnosis became acceptable in France. *Trends Biotechnol* 2005 May;23(5):246-249.
- Verhoeven v, Avonts D, Meheus A, Goossens H, ieven M, chapelle S, et al. Chlamydial infection: an accurate model for opportunistic screening in general practice. *Sex Transm inf* 2003;79:313-317.
- Verhoeven V, Avonts D, Royen P van, Denekens J. implementation of a pilot programme for screening for chlamydial infection in general practice. *Eur J Gen Pract* 2004 Dec;10(4):157-161.
- VGR, Vlaamse Gezondheidsraad. Advies van de Vlaamse Gezondheidsraad Preventie van baarmoederhalskanker, 2006.
- Vijgen SMc, Busch McM, Wit GA de, Zoest F van, Schuit AJ. Economische evaluatie van preventie; Kansen voor het Nederlandse volksgezondheidsbeleid. RIVM-rapportnr. 270091001/2005. Bilhoven: RivM, 2005.
- Visser M de, Ballegooijen M van, Bloemers SM, Deventer SJH van, Jansen JBMJ, Jespersen J, et al. Report on the Dutch consensus development meeting for implementation and further development of population screening for colorectal cancer on FOBT. *cellular Oncology* 2005;27:17-29.
- Vlaams Agentschap Zorg & Gezondheid. <http://www.zorg-en-gezondheid.be/bevolkingsonderzoek.aspx> (last visited 19 december 2006), 2006.
- Voogd AC, Rutgers E J Th, Leeuwen FE van, Poos MJJc. neemt het aantal mensen met borstkanker toe of af? in: volksgezondheid Toekomst verkenning, nationaal Kompas volksgezondheid. Bilthoven: RivM, <[http:// www.nationaalkompas.nl](http://www.nationaalkompas.nl)> Gezondheid en ziekte\ Ziekten en aandoeningen\ Kanker\ Borstkanker, 13 december 2005.
- Vutuc C, Waldhoer T, Haidinger G. Breast cancer trends; opportunistic screening in Austria versus controlled screening in Finland and Sweden. *Eur J cancer Prev* 2006;15:343-346.
- VWS, Ministry of Health, Welfare and Sport. Brief Staatssecretaris over organisatie van prenatale screening. 2005.
- Wert GM de. neonatal screening: dynamics and ethics. *ned Tijdschr Geneesk* 2005;149(51):2841-2843.
- WHO, World Health Organization. Proposed international guidelines on ethical issues in medical genetics and genetic services. Geneva: WHO, Human Genetics Program-me, 1998.
- WHO, World Health Organization. Screening for Type 2 Diabetes; report of a World Health Organization and international Diabetes Federation meeting. Geneva: WHO, 2003.
- WHO, World Health Organization. What evidence is there for the prevention and screening of osteoporosis? copenhagen: WHO-Europe and Health Evidence network, 2006a.
- WHO, World Health Organization. Preparing for the introduction of HPV: vaccines: Policy and programma guidance for countries. Geneva: WHO, 2006b.

- WHO, World Health Organization. cancer. <http://www.who.int/mediacentre/factsheets/fs297/en/index.html> (last visited 5 March 2006), 2006c.
- Wilk EA van der. Zijn er verschillen tussen Nederland en andere landen? in: volksgezondheid Toekomst verkenning, nationaal Kompas volksgezondheid. Bilthoven: RivM, <<http://www.nationaalkompas.nl>> Gezondheid en ziekte\ Ziekten en aandoeningen\ Kanker\ Borstkanker, 16 June 2006.
- Williams C, Alderson P, Farsides B. What constitutes 'balanced' information in the practitioners' portrayals of Down's syndrome? *Midwifery* 2002;18(3):230-237.
- Wilson JMG, Junger G. Principles and practice of screening for disease. Geneva: WHO, 1968.
- Wright TC, Bosch XF, Franco EL, Cuzick J, Schiller JT, Garnett GP, et al. Chapter 30: HPV vaccines and screening in the prevention of cervical cancer; conclusions from a 2006 workshop of international experts. *Vaccine*; 24S3 (2006); S3/251-S3/261.
- ZonMw. <http://test.zonmw.org/nl/program-mas/preventie/themas/informatie-over-kanker/screening-op-dikkedarmkanker-is-mogelijk.html?type=98> (last visited 11 december 2006), 2005

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APPENDIX 2 SMOKING

Table A2.1: EU-countries ranked by the Tobacco Control Scale in 2006 (Joossens & Raw, 2006^a).

	Price (30)	Public Place Bans (22)	Public info campaign spending (15)	Advertising campaign	Health warnings (10)	Treatment (10)	Total (100)	Order of rank
Ireland	23	21	3	12	6	9	74	1
United Kingdom	30	1	15	11	6	10	73	2
Norway	26	17	5	13	6	4	71	3
Iceland	25	11	13	13	6	2	70	4
Malta	19	17	3	9	7	7	62	5
Sweden	19	15	2	13	6	5	60	6
Finland	18	12	1	13	7	7	58	7
Italy	16	17	2	10	6	6	57	8
France	23	6	4	11	6	6	56	9
Netherlands	16	9	4	12	6	5	52	10
Cyprus	21	6	1	12	6	5	51	11
Poland	16	10	0	12	6	6	50	12
Belgium	16	8	2	12	7	5	50	13
Slovakia	18	8	0	11	6	6	49	14
Hungary	17	6	1	10	6	7	47	15
Bulgaria	19	6	0	9	6	6	46	16
Estonia	14	9	2	1	1	8	45	17
Denmark	17	3	2	10	6	7	45	18
Portugal	17	5	-	10	6	1	39	19
Greece	17	7	0	4	6	4	38	20
Czech Republic	12	6	0	9	6	5	38	21
Germany	20	2	0	4	6	4	36	22
Slovenia	13	6	0	7	6	4	36	23
Switzerland	15	5	4	4	3	4	35	24
Lithuania	11	6	1	9	6	1	34	25

Spain	12	3	3	3	6	4	31	26
Austria	14	4	0	4	6	3	31	27
Latvia	9	6	1	6	6	1	29	28
Romania	13	6	0	0	3	5	27	29
Luxembourg	7	4	0	5	7	3	26	30

^aJoossens L, Raw M. The Tobacco Control Scale: a new scale to measure country activity.
Tob control 2006; 15:247-253. doi: 10.1136/tc.2005.015347.

APPENDIX 3 OVERWEIGHT

Table A3.1: Prevalence of overweight in percentages in EU-countries (adults) (WHO Nutrition Policy Database, 2006a)

	Age	Overweight v	Obesity	Overweight m	Obesity	Period	S/Mb
Austria	20+	30.4	9.1	63.4	9.1	1999	S
Belgium	18+	37.8	13.4	50.6	11.9	2004	S
Bulgaria	15+	4.3	13.5	50.1	11.3	2001	S
Czech Republic	16+	47.4	16.3	56.7	13.7	2002	S
Cyprus	15+	38.7	11.8	53.9	12.9	2003	S
Denmark	16+	34.0	9.1	49.6	9.8	2000	S
Estonia	16-64	40.6	14.9	45.7	13.7	2004	S
Finland	15-64	40.2	13.5	59.7	14.9	2005	S
France	15+	36.3	13.0	47.4	11.8	2006	S
Germany	18+	41.2	12.3	57.7	13.6	2003	S
Greece	20-70	48.1	18.2	67.1	26.0	2003	S
Hungary	18+	49.5	18.2	58.9	17.1	2003-2004	S
Ireland	18-64	48.4	15.9	66.4	20.1	1997-1999	M
Italy	18+	34.5	8.7	51.4	9.3	2003	S
Latvia	15-64	43.4	19.5	42.0	11.9	2004	S
Lithuania	20-64	46.2	16.9	52.5	14.2	2004	S
Malta	20-64	49.4	20.4	68.2	26.6	2002	S
Netherlands	20+	39.6	11.4	50.4	9.9	2005	S
Poland	19+	48.6	19.9	56.7	15.7	2000	M
Portugal	18-64	45.2		52.9		2003-2004	M
Romania	15+	38.1	9.5	45.8	7.7	2000	S
Slovenia	25-64		13.8		16.5	2001	S
Slovakia	15-64	37.4	15.0	57.8	13.5	2002	S
Spain	16+		13.6		11.9	2001	S
Sweden	16-84	37.0	11.0	53.0	12.0	2005	S
United Kingdom ^c	16+	59.7	26.0	65.4	22.4	2003-2004	M

a WHO Nutrition Policy Database. <http://data.euro.who.int/nutrition>, 2006.

b S; self-reported data, M: measured data

c No national data

Table A3.2: Prevalence of overweight in percentages in EU-countries (children) (WHO Nutrition Policy Database, 2006^a)

	Age (years)	Overweight	Obesity	Period	S/M ^b
Belgium	2-9	19.0	7.8	2004	S
Bulgaria	5-9	13.5	4.5	2004	M
Cyprus	2-6	14.1	5.5	2004	M
Germany ^c	5-6	12.6		2001-2002	M
France	7-9	18.1	3.8	2000	M
Ireland	4-9	25.8	6.6	2001-2002	M
Italy ^c	6-11	27.2	6.5	2000-2002	M
Netherlands	2-9	14.5	3.4	2005	S
Poland	1-9	22.0	6.7	2000	M
Portugal	7-9	31.5	11.3	2002-2003	M
Slovakia	7-9	15.2	4.6	2001	M
Spain	2-9	31.3	10.4	1998-2000	M
Sweden	5	22.4	5.8	2001-2002	M
United Kingdom ^c	4 + 8	19.1	3.0	2003	S

a WHO Nutrition Policy Database. <http://data.euro.who.int/nutrition>, 2006.

b S; self-reported data, M: measured data

c No national data

APPENDIX 4 SCREENING

Table A4.1: Overview of breast cancer screening in different countries

Country	Organization method	Age (years)	Interval	Attendance	Remark	Source
Australia	National programme	50-69	2 year	56.1% (2002/2003)		AIHW, 2006
Belgium	Opportunistic screening & regional national covered screenings programme	50-69	2 year	56.0% (2003/2004)		Fabri et al., 2006 Kelley & Hurst, 2006; PHAC, 2005
Canada	In 12 of the 13 provinces (2000-2001)	50-69	2 year	70.6% (2003)	Survey	Kelley & Hurst, 2006; Holland et al., 2006)
Czech Republic	Screening is advised for this group	45-69	2 year			Kelley & Hurst, 2006; Holland et al., 2006)
Denmark	Regional programmes in 2 of the 14 provinces	50-69				Kelley & Hurst, 2006; Lyng et al., 2003)
Finland	National programme	50-69	2 year	87.7% (2003) 38.6% (2002/2003) over 1 year, 72.8% over 2 years	Survey	Kelley & Hurst, 2006; Puddu & Tafforeau, 2005
France	National programme Screening will be implemented in phases, from 2004 onwards	50-69	2 year			Kelley & Hurst, 2006
Germany	National programme	40-69	2 year	61.0% (2004)		Kelley & Hurst, 2006
Iceland	Regional programme, national data will be imported	50-64	2 year	79.5% (2003)		Kelley & Hurst, 2006 Kelley & Hurst, 2006; Lyng et al., 2003)
Ireland	Regional programme in 3 regions	55-69	2 year	28.0% (2000) 2.6% (2003) for 1 year interval	Survey	Kelley & Hurst, 2006 Lyng et al., 2006)
Japan	National programme	50-69	2 year	61.0% (2004)		Fracheboud & De Koning, 2005
Luxembourg	National programme	50-75	2 year	79.0% (2002)		Kelley & Hurst, 2006
Netherlands	National programme	50-64	3 year	63.0% (2002)		Kelley & Hurst, 2006
New Zealand	Regional programme	50-69	2 year	98.0% (2003)		Kelley & Hurst, 2006
Norway	Regional programme in 1 region	50-69	2 year	60.1% (2003)	Not generalizable for the whole of Portugal	Kelley & Hurst, 2006
Portugal	No national programme					Kelley & Hurst, 2006
Slovakia	National programme	50-69		84.0% (2004)	No national data available	Kelley & Hurst, 2006; Vutuc et al., 2006
Sweden						

Switzerland	National programme	50-69	2 year	27.0% (2002)	Survey	Kelley & Hurst, 2006
United Kingdom	National programme	53-64	3 year	74.9% (2003/2004)	No national data available	Kelley & Hurst, 2006; Lynge et al., 2003)
United States		>40	2 year	69.5% (2003)	Survey	Kelley & Hurst, 2006

Table A4.2: Overview of cervical cancer screening in different countries (OECD, 2006)

Country	Organization	Age	Interval	Attendance	Remark
Australia	National programme	20-69 year	2 year	60.5% (2003)	
Belgium	National programme	25-64 year	3 year	63.1% (2004)	
Canada	Opportunistic screening	18-69 year	3 year	74.9% (2003)	Survey
Czech Republic	Opportunistic screening	15+ year	1 year		Survey
Denmark	National programme	23-59 year	3 year	45.2% (2004)	
Finland	National programme	30-60 year	5 year	71.5% (2003)	
France	Opportunistic screening	20-69 year	2 year	74.9% (2003)	Self-reporting, Survey
Germany	Opportunistic screening	20-49 year	5 year	55.9% (2002)	Annual smear test is insured for all women aged 20+
Hungary	National programme from 2003 onwards	25-65 year	3 year	28.1% (2004)	
Iceland	National programme	20-69 year	2 year	73.0% (2004)	
Ireland	National programme	25-60 year	5 year	70.1% (2003)	
Italy	Opportunistic screening	25-69 year	3 year	45.1% (2000)	Survey
Japan	Opportunistic screening	20-69 year	1 year	23.7% (2003)	
Mexico	National programme	25-64 year	3 year		Combined with screening on high blood pressure, diabetes and breast cancer
Netherlands	National programme	30-60 year	5 year	67.9% (2003)	
New Zealand	National programme	20-69 year	3 year	72.0% (2003)	
Norway	National programme	25-67 year	3 year	72.5 % (2004)	
Sweden	National programme	23-60 year	23-49 year: 3 year 50-60 year: 5 year	72.0% (2002)	
United Kingdom	National programme	25-69 year	3 year	69.7% (2005)	Survey
United States	Opportunistic screening	18-69 year	3 year	82.6% (2003)	Survey