

Organization of Public Health in the Netherlands

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Abstract

The institutional architecture of public health in the Netherlands is regulated by the *Public Health Act* (2008), based on the principle of state responsibility for collective prevention. Increasingly, responsibilities for public health are laid down at the level of municipalities, making their Community Health Services (CHS's) the central pillar in Dutch public health organization. From the national level municipalities and their CHS's are supported by a National Institute of Public Health and several health promotion knowledge institutes. The implementation of interventions at the local level is orchestrated by the CHS's and requires ample knowledge and organisational skills to collaborate with a large number of stakeholders such as schools and primary health care for positive effects on health risk factors/health determinants. In addition municipalities do influence those health risk factors/health determinants with their local health policies and CHS's with their public health basic tasks as youth health care, infectious disease control, vaccination and health promotion.

Actual policy is the alignment of public health with cure, care and social welfare for prevention, and health and social action on well-known spearheads of lifestyle such as smoking, harmful alcohol consumption and overweight.

Key words: health systems, public health, Netherlands

Słowa kluczowe: Holandia, system zdrowotny, zdrowie publiczne

Introduction

The institutional architecture of public health in the Netherlands is regulated by the *Public Health Act* (2008) (paragraph 1). It is the state, represented by the Ministry of Health, Welfare and Sports that makes public health services available to the public. Basically these services concern primary and secondary prevention in the following areas: Infectious disease control, Youth health care, Health promotion, Health protection and Screening. This collective prevention in the Netherlands however is organised, implemented or facilitated predominantly by 25 regional Community Health Services (CHS's) under the authority of the nearly 400 municipalities (paragraph 2). To implement the statutory tasks of municipalities and to play their role in public health, CHS's have the support of a National Institute of Public Health and health promotion institutes (paragraph 3).

Increasingly, responsibilities for public health are laid down at the level of municipalities, nearly 400, with about 17.000.000 inhabitants in total. As stated in the *Public Health Act*, municipalities have the task to protect, monitor and promote the health of their citizens. Therefore they need to develop local health policy. Every four years they have to produce a Health Policy Plan to demonstrate their commitment, results, goals and actions (paragraph 4).

Paragraph 5 gives a schematic overview of the Dutch public health system as a whole. Paragraph 6 summarizes some general developments regarding the health status of the Dutch population, including lifestyle factors. It brings up the question of the relation between the public health system and the health care sectors of cure, care and social welfare and actual Dutch health policy: health as a societal effort.

1. Public Health in the Netherlands

In the *Dutch Public Health Act*, public health is described as “health protection and health promotion measures for the population as a whole or for specific groups, including the prevention and early detection of diseases”. As collective prevention public health is state responsibility and a government task in terms of policy, organisation and funding. The implementation of collective prevention programmes, however, is not necessarily restricted to public services. For example, in the Netherlands there is a role of general practitioners in cervical cancer screening (secondary prevention) and home care in the National Immunisation Programme (primary prevention). So, in the context of Dutch health care, public health is defined as the sector of health care and public administration that focuses on disease prevention and health protection and promotion of the general population or groups within that population. Medically the sector can count on about 1000 doctors registered ‘society and health’ and about 600 doctors for specific tasks as youth health care, infectious control, Tuberculosis control and forensic medicine. About 2500 social nurses are involved.

As a specific work field public health has been described recently in the Netherlands in ten core tasks: the most important activities, defined on the basis of the objective they contribute [1]:

1. Monitoring and reporting on health and identifying developments.
2. Detection and prevention of diseases or health risks.
3. Health promotion (population or environmental oriented).
4. Health in all policies.
5. Health protection.
6. Research and innovation of public health care.
7. Ensuring sufficient and competent professionals.
8. Quality assurance.
9. Medical assistance by and prevention of disasters.
10. Safety net function.

These core tasks transcend institutional and professional domain limits; the execution takes place within various sectors of health care and beyond. Core task number 9 for example asks the involvement of general practitioners and emergency departments of hospitals, number 10 of private organizations like the Salvation Army. However, the 25 CHS’s, regional organized under the authority of the municipalities are present dominantly in the fields of core tasks 1, 2, 3, 4, 9 and 10. They are supported by specific knowledge institutes (paragraph 3). Core task 5, health protection like monitoring water and air quality and food and traffic safety, is a task for the ministry of Health, Welfare and Sports and the ministries of Agriculture and Infrastructure and Environment; workplace safety is a task for the ministry of Social Affairs. Core task number 6 is executed by universities and some specific research/knowledge institutes. Core task 7 is executed by universities, the Netherlands School of Public and Occupational Health and, specifically on continuing education (refresher courses), professional asso-

ciations. Together with the Inspectorate of the ministry of Health, Welfare and Sports the professional associations are active on quality assurance like developing guidelines and protocols (core task 8).

2. Community Health Services (CHS’s)

Municipalities are by law, the *Public Health Act* (2008), responsible for the implementation of a number of collective-preventive tasks. They are obliged to use therefore the services of an intermunicipal Community Health Service (CHS). Historically the CHS’s are the pivot of the Dutch public health system at the local level, but it took a long time the last century before a national coverage was reached with 54 CHS’s in 1997 [2]. National policy urged for such a national coverage and afterwards for scale enlargement in 25 regions. It took the more than 400 municipalities till 2015 to reach that number by merging their CHS’s. Their aldermen are the supervisory authority of the CHS’s.

Besides the municipalities there is financing from the National Budget and from so called market tasks as for example travelers vaccination. CHS’s must be accountable to the City Council.

A CHS executes at least one set of uniform tasks as defined in the *Public Health Act*. These basic tasks are:

1. epidemiological research;
2. data collection on health status;
3. monitoring health aspects in administrative decisions;
4. promoting environmental medical care;
5. promoting technical hygiene care;
6. psychosocial disaster relief;
7. youth health care (basic package);
8. general preventive measures;
9. TB and STD control and source- and contact detection;
10. prenatal education to expectant parents.

CHS’s make agreements about a so called basic- and a plus-package of services. About the basic package, the package that municipalities are obliged to take from their CHS in the framework of a common arrangement on a regional level, both long-term agreements as annual ones are made. About the plus-package mainly annual arrangements are made.

Apart from collective prevention, the CHS’s take care for specific groups such as addicts, homeless people, asylum seekers and illegal immigrants; for these specific tasks they have created so-called safety nets: provisions for people who fall through the cracks when it comes to health. This is the domain of the Public Mental Health (PMH). PMH concerns the social responsibility for vulnerable people who do not make use of available facilities on their own initiative or voluntarily. Because of the *Social Support Act* (2015), it is the responsibility of municipalities to organise PMH services. The actual work is conducted by mental health institutions and CHS’s, playing a key role in crisis intervention and social support. In addition to these organisations, other non-governmental institutions, such as the Salvation Army, are of great importance in this field.

Besides these basic tasks, CHS's can provide private market tasks. Examples are forensic medicine, vaccination for travellers and emergency transport.

Finally, the CHS's play an important role in the development of municipal health policy plans, which is a statutory obligation of municipalities by the *Public Health Act*. In paragraph 4 on national and local health policy the role of the CHS's will be specified.

Together the CHS's have about 10,000 employees, of which about half in youth health care (2011). 20% of the employees concerns nurses (excluding youth health care), staff health promotion, policy officers and epidemiologists [3]. The number of FTE's is about 7,600 (2011) [4].

The funding of CHS's comes for about 2/3 from municipalities. In addition CHS's receive funding from the State (11%) and third parties (other clients, project grants and private activities like for example traveler's vaccination) (25%) (2009) [5].

3. National support system

To implement the statutory tasks of municipalities and to play their role in the public health, the CHS's are supported by the National Institute for Public Health and the Environment (RIVM). Historically there is a role still for the Royal Dutch Association for the Control of Tuberculosis, supporting the CHS's for tuberculosis control.

In general RIVM does scientific research for the benefit of public policies and monitoring in the field of public health, the environment and nature. It is a knowledge institute of the Government that is acting as a consultant for issues around infectious diseases, vaccinations, population surveys, lifestyle, nutrition, pharmaceuticals, environment, sustainability and safety. In this context, it may also be involved in management and implementation, such as the national immunization program and the population screening programs (a.o. cervical-, breast- and coloncancer).

More specific support for the local/regional level comes from the following Centers of the National Institute:

- Centre for Infectious Disease Control. Part of this centre is the National Hygiene and Safety Centre, helping local health authorities to perform technical hygiene care;
- Centre for Population Screening, realizing and monitoring the consistency in tasks, responsibilities, and operations of all parties involved in a population screening;
- Centre for Environment, Health and Environmental Quality, helping local health authorities with environmental health problems. To this end they develop guidelines supporting community health service staff in dealing with environmental health problems as mobile phone base stations, low frequency noise, odours and smog;
- Centre for Healthy Living, equipped to support municipalities and community health services in the development and implementation of municipal health policy (see paragraph 4).

Besides the RIVM, the national and local governments and their CHS's get support from several national health promotion institutes:

- Nutrition Centre, for food and nutrition;
- Trimbo's Institute, for mental disorders and alcohol, smoking and drugs;
- Netherlands Institute for Sport and Physical Activity, for physical activity;
- AIDS Netherlands Foundation and Rutgers, for safe sex;
- SafetyNL, for safe behaviour;
- Ivory Cross, the specific organisation for the promotion of oral health. It is an association of dentists;
- Centre for Youth Health, an institute under the auspices of the Netherlands Community Health Services Association and Actiz (representing home care organisations delivering youth health care);
- Pharos, targeting vulnerable groups as low-skilled, homeless and asylum-seekers.

In the adjacent area of public health, social care, there are the Dutch Youth Institute, Vilans (for the elderly) and Movisie (including domestic and sexual violence, informal care and voluntary services and vulnerable groups). The above mentioned health promotion institutes and these welfare enhancing institutions are so-called knowledge institutes, because they pool all the knowledge in their field and make that publicly available. They often have a combination of tasks and products such as information, research, consultancy, expertise and implementation of preventive activities. For example, Rutgers has an Information Centre in the area of sexuality, it performs research and it also develops educational programmes.

All national institutes receive (project) grants from the Ministry of Health, Welfare and Sport to carry out their tasks, but they are also market oriented and raise funds from private companies and public organisations, like the CHS's.

4. National and local health policy

According to the Public Health Law the Government presents every four year a national policy paper on public health defining priorities. The so-called national *Public Health Status and Forecast* report of the RIVM is on the basis of this paper. This publication provides a quantitative overview of diseases, health, influencing factors, health care, and public health policy. The municipalities follow with a local health policy paper connecting their health policy to the national priorities as defined in the national paper. Actually they describe their own effort on long standing national priorities such as smoking, harmful alcohol consumption and overweight (lifestyle factors) and prevention of chronic diseases such as diabetes and depression. In addition they describe their own priorities and approach to, for example, social-economic health differences. This is their role as policy maker. Their priorities are based on analyses of the health situation in their municipalities and regions. These analyses are provided by their CHS in a regional or local *Public Health Forecast*. CHS's have an executive role in local

or regional health policy also, and therefore in the implementation of the policy paper, but not as the only one. Characteristic of local health policy is the participation of local health care and its professionals in determining the local health problems and the way to tackle them. They also participate in the implementation phase of the policy. For that reason at the start of the policy process municipalities organize meetings to give care institutions and practices of health care the possibility to get their own problems and needs on the municipal agenda, including their collaboration with public health care. The focus is specifically on primary health care and the ax general practitioner – district nurse for district-specific prevention.

The involvement of the local health services in the design and implementation of local and regional health policy concerns also other sectors such as welfare, sport, education and business. In the first place the relevant own municipal policy departments, but like the Government in the national prevention plan, municipalities are looking for direct involvement by welfare organizations, sports associations, schools and companies in their health policy to realize their objectives.

This involvement of the local community in the development and implementation of local health policy is the third role of municipalities in the municipal health policy. Besides their role as policy maker and policy executioner it is the role of Director. This role is also based on the Public Health Law. Municipalities are expected to

manage the coordination and cooperation between all the different local parties involved. It is necessary in order to combine efforts and to avoid unnecessary overlap in activities and any gaps in the approach of the health and care problems.

5. The Dutch Public Health System in scheme

When we bring the four main actors or ‘players’ in public health described so far together in a scheme, **Figure I** appears. It is the ministry of Health, Welfare and Sports that sets the public health priorities, informed and advised by the National Institute for Public Health and the Environment (RIVM) as the state health agency for research and information, and by the health promotion institutes as non-profit knowledge institutions on specific health risk factors. The relation between the ministry of Health, Welfare and Sports, the RIVM and health promotion institutes is based and maintained on regulation and funding. For specific areas of collective prevention, the RIVM has established Centres to professionally support local public health practices, in particular the Community Health Services. The Community Health Services identify the regional health problems for their municipalities and advise them on health policy, interventions and programmes, primarily on national priorities. Together with setting priorities, the ministry of Health, Welfare and Sports provides funding to the municipalities for their mandatory tasks. Regulation is part of the relation

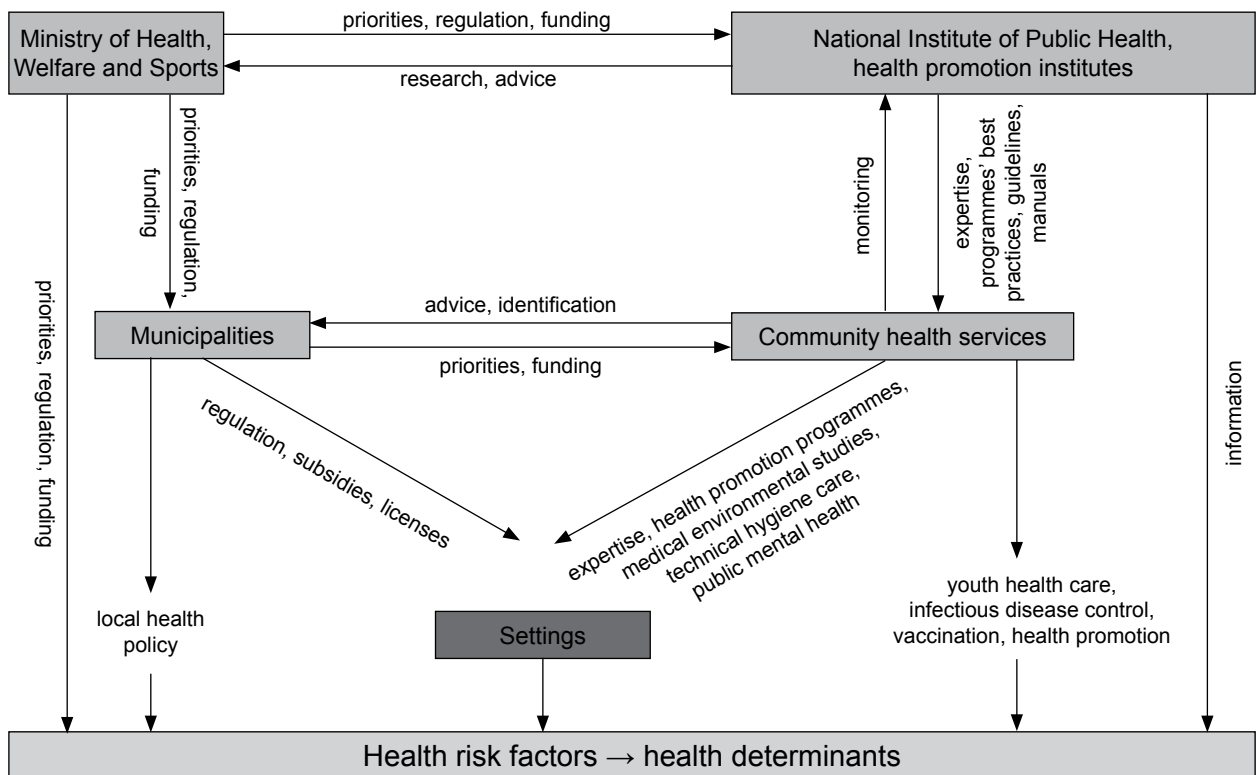


Figure I. Dutch Public Health System.

Source: Authors' own elaboration.

between the Ministry and the municipalities. Besides maintaining a Community Health Service as the central pillar of a regional public health infrastructure with youth health care, infectious disease control, vaccination and health promotion, each municipality has its own (inter-sectoral) health policy and implementation plan on risk factors and determinants of health (Figure I). Take notice in Figure 1 that at the national level the ministry of Health, Welfare and Sports and RIVM/Health Promotion Institutes have with priority setting, regulation, funding and information their own contribution on health risk factors and determinants. Locally we see the contribution of so called settings like schools, sport, pubs and primary health care based on policy instruments of municipalities and expertise and activities of their CHS's.

6. Dutch public health status, health policy and institutional change

Extra years of life that have been added in recent years will be largely in good health and without somatic restrictions. On the other hand there are large and persistent health inequalities. There are in the Netherlands considerable differences in health to socio-economic status (ses), in terms of education, income or professional level. For men in the lowest educational class, the life expectancy at birth is 75,3 years, for men in the highest educational class 81,8 years. For women the difference in life expectancy between lowest and highest educational class is 6,1 years (80,0 vs 86,1 years). For healthy life expectancy the differences between the lowest and highest educational groups are even bigger: both for men and women the difference in life expectancy in as (very) good perceived health is about 19 years. Also for life expectancy without physical limitations and the life-expectancy without chronic conditions there are large differences between the lowest and highest educational classes. The trends in lifestyle factors such as smoking, alcohol consumption and obesity, are stabilized, but the level is far too high still. The reduction of unhealthy lifestyle habits is stagnant, especially among low-skilled workers [6].

As a response on these figures the national and local health policy in Netherlands now applies the alignment of the public health system and health care [7, 8]. There should be a stronger physical, organisational and substantive connection between public health and the cure, care and social welfare, which all have in the Netherlands their own legal framework of financing. This implies the cooperation of competitive insurance companies (cure), non-competitive regional Care Offices (care) and ca. 400

municipalities (social support). When it comes to lifestyle, there is specific attention for youth. In addition to promotion of (teaching) a healthy lifestyle there is early detection of risks. People make choices. Those choices have to be made in an environment in which the healthy choice is the easy choice.

However, the National Programme Prevention 2014–2016 goes a step further than the alignment of the public health system and health care. Prevention and health are an effort of society. As a consequence health policy is a range of structured social initiatives and activities that should lead to targeted and effective health gains, in particular through the well-known spearheads of lifestyle such as smoking, harmful alcohol consumption and overweight. To this end, a Programme Office is established with the task to launch a social movement to get a healthier and more vital Dutch population [9].

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