PREVENTIVE HEALTH PATHWAYS

TRANSITIONS TOWARDS A HEALTHIER 2040

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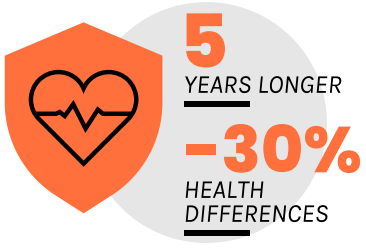
EWUU INSTITUTE FOR PREVENTIVE HEALTH

The EWUU institute for Preventive Health (EWUU i4PH) was established to support and accelerate the transition towards a prevention-oriented society in the Netherlands. As part of the EWUU Alliance, comprising Eindhoven University of Technology, Wageningen University & Research, Utrecht University, and University Medical Center Utrecht, EWUU i4PH brings together expertise from across disciplines to address complex societal challenges.

"We believe that keeping people healthy is just as important as treating disease."

Recent advances in knowledge and research have improved our understanding of health. Yet, the many factors that shape health today are too complex to address through gradual improvements and adjustments. Systemic change is needed. EWUU i4PH contributes to this transformation by fostering collaboration between researchers, policymakers, healthcare professionals, businesses, and citizens to accelerate the transition to a healthier Netherlands.

The ambitions of the EWUU institute for Preventive Health align with the central mission of the VWS Knowledge & Innovation Agenda for Health & Care to increase the number of healthy years people live by five years, and to reduce health inequalities between population groups by 30%. We aim to contribute to these national goals.



Transitions Towards a Healthier 2040

Preventive health is shaped by many factors throughout life: where we grow up, what we eat, the air we breathe, the opportunities we have, and the care we receive. It encompasses the prevention of disease and the active promotion of health. Furthermore, it adopts a life-course perspective in which health is understood as a dynamic trajectory shaped by lifelong exposures, environments, and biological responses.

"Transforming preventive health is therefore not a matter of a single intervention or policy change."

It involves long-term, systemic change across healthcare, education, housing, mobility, food systems, governance, and public space. Actors with different roles, responsibilities, and priorities involved in these sectors are likely to have diverse perspectives on what changes are necessary. Yet, the systemic transformation of preventive health requires shared future goals and visions, to guide alignment and collective action.

To support this process, the EWUU institute for Preventive Health has conducted a qualitative exploratory study into preventive health transitions. This document introduces the four preventive health pathways developed through this research. These pathways are not predictions of the future. Instead, they describe alternative strategic directions for change, intended to support decision-making, structure policy debate, and align action across sectors. They were developed using scientific evidence, policy analysis, interviews with stakeholders, and input from citizens and experts.

PREVENTIVE HEALTH CHALLENGES

The largest historical gains in human health have come from public health measures — clean water, sanitation, vaccination, safer housing, improved nutrition, and access to education — rather than from clinical medicine. Yet in recent decades, gains in life expectancy have not been matched by gains in healthy life expectancy, and the burden of ill health has shifted towards chronic conditions, multimorbidity, and progressive loss of function (Mierau & Demaria, 2026; OECD, 2025).

The Netherlands is facing a set of interconnected health challenges. Healthcare expenditure now exceeds €100 billion per year and continues to rise (CPB, 2025). Around ten million people live with one or more chronic conditions, including cardiovascular disease, diabetes, respiratory illness, and mental-health conditions (RIVM, 2022). At the same time, persistent health inequalities remain: Dutch citizens with lower educational attainment continue to live, on average, six years less, and experience up to twenty fewer years in good health, than their higher-educated peers (WRR, 2019; RIVM, 2022).

These pressures are increasingly compounded by environmental and climate-related developments, which contribute both to acute health events and to long-term physiological decline (PECCH, 2026; Romanello et al., 2023).

Taken together, these trends challenge the long-term sustainability of the current healthcare system, and underscore the need to address what the literature describes as the “causes of the causes” of ill health. They strengthen the case for systemic changes to ensure that preventive approaches address not only biological, but also social, economic, commercial, and environmental determinants of health. In line with a Health in All Policies approach, health is integrated into decision-making across sectors such as housing, education, urban planning, employment, food systems, and social policy, reflecting the evidence that wellbeing is shaped by the everyday environments in which people live, work, learn, and travel.

Achieving this requires more than incremental change. It calls for a broader transition in how health is understood, organised, and supported across all sectors.

TENSIONS IN THE CURRENT SYSTEM

Our analysis of the current preventive health system in the Netherlands identifies a number of structural tensions that constrain progress. These are not the failings of any single actor, but rather structural characteristics that emerge from the complex interaction of policy, science, industry, and society:

- **Individual vs. Collective:** A tension between individual responsibility for health and the collective conditions that shape it. We advise people to make healthy choices, while many unhealthy choices remain the easiest and cheapest options.
- **Commercial vs. Public Interest:** A tension between commercial interests and public health objectives, including the influence of the commercial determinants of health, for example, ultra-processed foods, tobacco, alcohol, and pollution-related exposures, which disproportionately affect people living in vulnerable circumstances (Gilmore et al., 2023).
- **The Evidence Base:** A tension in the evaluation methods. Randomised controlled trials are the gold standard for evaluating interventions, but the measures most likely to improve population health at scale — changes in policy, food environments, infrastructure, and urban design — are often the hardest to test this way.
- **Fragmentation:** Fragmentation of governance and funding across ministries, municipalities, and providers, with distinct mandates and budgets that limit cross-sector action. Across the European Union, only around 5.5% of health expenditure was directed toward prevention in 2022 (OECD, 2024), a share that remains small relative to the scale of the challenge. Health is everyone’s responsibility, but often nobody is truly accountable.
- **Time Horizons:** A mismatch between the short horizons of political and financial decision-making and the long horizons over which preventive measures are implemented and produce results.

Recognising these tensions is a necessary step in identifying where coordinated action can have the greatest impact.

UNDERSTANDING TRANSITIONS

To study how preventive health is currently organised in the Netherlands, we applied the Multi-Level Perspective (MLP), a framework widely used for analysing societal transitions (Geels, 2024). The MLP examines how systems change across three interacting levels.

Landscape level

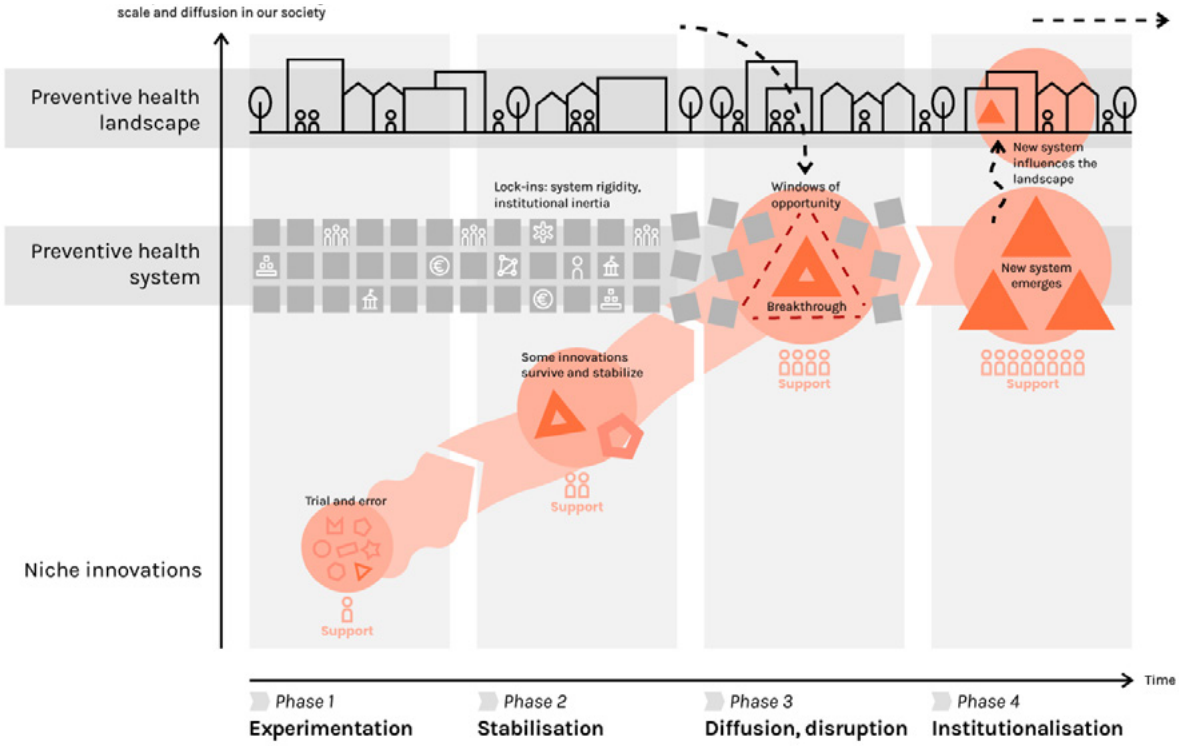
Long-term societal developments such as demographic ageing, labour-market pressures, climate change, digitalisation, and rising health inequalities. But also sudden shocks, such as pandemics and wars. These pressures shape the system but cannot be directly controlled.

Regime level

The dominant structures and practices informing how preventive health is currently organised: its technologies, rules, norms, institutions, professional routines, and networks of actors. These elements together provide stability and continuity.

Niche level

Protected spaces in which new ideas, technologies, and ways of working can develop. Examples include community-based initiatives, healthy-neighbourhood pilots, digital health platforms, integrated data infrastructures, and new professional roles. Over time, successful niche innovations can challenge and reshape elements of the regime.



Within this framework, transitions tend to unfold through four broad phases.

Phase 1 — Experimentation in niches

Groundbreaking preventive health ideas emerge in small pilot settings, often developed by entrepreneurs, researchers, municipalities, or civil-society organisations. They respond to specific needs but are typically at an early stage of development. The existing system continues to operate largely as before. Only a limited number of these innovations mature sufficiently to move beyond the niche.

Phase 2 — Early adoption and structural resistance

Promising innovations begin to operate in one or a few early markets. Their design becomes more stable and clearer standards begin to emerge. However, they continue to face barriers to entering the mainstream, including regulatory frameworks, funding structures, established networks, and deeply ingrained habits and routines that favour incremental adjustment of the existing system.

Phase 3 — Windows of opportunity

Broader landscape developments, whether gradual trends such as ageing or digitalisation, or sudden events such as pandemics or economic shocks, can place the existing regime under pressure and create openings for change. This phase is often characterised by debate and competition between established actors and new entrants, and by active discussion of regulations, priorities, and solutions.

Phase 4 — Consolidation of a new regime

A new system gradually becomes established. New institutions, policies, professional practices, and standards consolidate. For preventive health, this would mean that prevention is embedded as a standard framework for organising policies and services, rather than as an alternative approach to the dominant model.

Transitions of this kind are non-linear. Their development depends heavily on proper timing, alignment between innovations and broader societal change, and the willingness and varying abilities of different actors to adapt (Geels et al., 2016).

OUR FOUR PREVENTIVE HEALTH PATHWAYS: A SHARED VISION FOR 2040

Drawing on our analysis of the current preventive health system, its structural tensions, and the broader societal pressures driving change, we developed four transition pathways. Each addresses the same overarching question:

"What should preventive health in the Netherlands look like by 2040?"

The pathways are neither mutually exclusive, nor concrete predictions. Instead, they describe contrasting but plausible directions in which preventive health could develop, each grounded in different priorities and values.

The first two pathways (*'Making preventive health with all, for all'* & *'Making preventive health the easy choice'*) align closely with established Dutch policy directions, and may feel familiar, though their implementation will still require substantial change. The remaining two (*'Making preventive health planetary-centred'* & *'Making preventive health investable'*) are more exploratory in character, reflecting emerging debates in the literature and the visions articulated by participants in our research. They are included because long-term systemic change is often informed by perspectives that currently lie outside the current mainstream.

The four pathways are different routes toward a shared aspiration: a Dutch preventive health system that is effective, just, inclusive, and empathetic. Each pathway reflects a distinct direction for change, together pointing towards a 2040 in which:

- **Health is a shared public responsibility,** co-designed with communities and built on inclusive governance across sectors.
- **Healthy living is the default**, embedded in the design of food systems, built environments, mobility, and digital spaces.
- **Human and planetary wellbeing are inseparable**, and preventive health policy reflects that interdependence.
- **Preventive health has its own institutional home and long-term funding**, evaluated on what it contributes to society, not only on what it saves the healthcare system.

PATHWAY I — MAKING PREVENTIVE HEALTH WITH ALL, FOR ALL

This pathway describes a future in which preventive health is equitable, accessible, and embedded across society. By 2040, health is approached as a shared public responsibility rather than primarily an individual one. Government, citizens, healthcare organisations, and businesses co-design preventive services. Health inequalities are addressed through inclusive governance, community participation, and structural cross-sector cooperation. Evidence from across Europe indicates that some of the most effective and durable preventive interventions are those co-designed with the communities most affected (PECCH, 2026).

Illustrative initiatives

- Community centres such as Het Klokhuis Wijkcentrum (Amersfoort) and Austerlitz Zorgt, which combine meals, social support, and practical assistance.
- "Caring neighbourhoods" such as Zorgvrijstaat (Rotterdam), which build informal support networks and neighbourly help.
- Citizen panels co-organised with EWUU i4PH that contribute lived experience to research priorities.

Phase 1 — Building partnerships and reforming the rules.

Cross-sectoral partnerships are established. Legislation is adjusted to make Health Impact Assessments standard across all policy areas, and to reduce financial barriers to preventive services. Funding shifts from siloed budgets to cross-ministerial arrangements. The GGDs serve as transition brokers between healthcare, social services, urban planning, and local communities.

Phase 2 — Embedding prevention in everyday environments.

Schools, workplaces, neighbourhoods, and public spaces are physically and structurally designed to support health and wellbeing. Communal spaces, including parks, libraries, and neighbourhood centres, receive structural investment. Participation is at the core of this phase: citizens gain access to publicly co-funded preventive health budgets they can apply to community activities of their choosing. This phase refers to physical environments design as well as to changes and improvements in how educational curricula and work are structured and organised.

Phase 3 — Universal preventive health coverage.

Preventive health is institutionalised as a public good. Reductions in inequalities in healthy life expectancy serve as headline performance indicators. Public health data infrastructures successfully integrate scientific evidence with community-generated insights.

Barriers and enablers.

Key barriers include fragmented governance, differences in organizational capacity between municipalities, resistance to the redistribution of mandates and resources, and differing health preferences among citizens. Enablers include the existing and robust GGD network, high levels of civic participation and volunteering, growing employer interest in workforce wellbeing, and a long term political commitment to prevention as a societal priority.

PATHWAY II — MAKING PREVENTIVE HEALTH THE EASY CHOICE

This pathway describes a future in which healthy living is the most affordable, and most accessible option. By 2040, health is built directly into the design of physical, social, and digital environments. Information-based approaches are complemented by structural prevention: housing, food systems, mobility, public space, and digital platforms are strictly aligned with public health objectives, while unhealthy options become less visible, less affordable, and less socially normalised.

Illustrative initiatives

- Fiscal measures on sugar-sweetened beverages and tobacco, informed by WHO and OECD evidence.
- Municipal experiments with zoning that limits fast-food outlets near schools.
- National and local investment in cycling infrastructure, safe walking routes, and accessible green public spaces.

Phase 1 — Building the evidence base and political legitimacy.

Research institutes and academic public-health centres expand the evidence base on environmental, fiscal, and regulatory interventions. Targeted measures are introduced in domains with strong empirical support, such as food environments and physical activity.

Phase 2 — Scaling structural prevention across sectors.

Measures expand to additional domains, including alcohol, digital marketing, and active mobility. Investments in cycling infrastructure, green public spaces, and affordable healthy food address health disparities. Behavioural insights are used in carefully evaluated ways to complement, rather than substitute for, structural measures.

Phase 3 — Institutionalising healthy environments.

Health Impact Assessments become standard in urban and regional planning. A strengthened supervisory authority monitors compliance with marketing and product standards. Digital tools support healthy behaviour within strong privacy and data-protection safeguards.

Barriers and enablers.

Key barriers include industry resistance, regulatory complexity, and behavioural lock-ins. Enablers include a strong evidence base on environmental determinants of health, existing local experiments, as well as increased political recognition of prevention as a societal priority.

PATHWAY III — MAKING PREVENTIVE HEALTH PLANETARY-CENTRED

This pathway describes a future in which preventive health is fundamentally aligned with planetary health. By 2040, preventive health supports not only human wellbeing but also ecological sustainability and the wellbeing of other species. Climate, biodiversity, and environmental quality become integral to public health policy and practice.

Evidence from the Lancet Countdown and the Pan-European Commission on Climate and Health demonstrates that climate-related exposures including heat, air pollution, and food-system instability contribute both to acute health events and to long-term physiological decline (PECCH, 2026; Romanello et al., 2023). The pan-European region is heating at approximately twice the global average rate, and in 2024 an estimated 63,000 people died from heat-related causes across the region (PECCH, 2026). The pathway also recognises the climate dimensions of mental health, including eco-anxiety and the psychological consequences of extreme weather events, which are particularly relevant for children and young people.

Furthermore, it acknowledges that healthcare systems themselves contribute to environmental impact: globally, health systems are estimated to account for 4–5% of greenhouse gas emissions, and reducing this footprint is part of building climate-resilient health systems (PECCH, 2026). The pathway therefore implies both institutional integration of health and environmental domains and a broader societal recognition of the interdependence between human and planetary wellbeing.

Phase 1 — Developing shared planetary-health goals.

Planetary health objectives are integrated into preventive health policies and strategic assessment frameworks. Universities and research institutes develop unified methodologies that combine environmental, health, and equity indicators.

Phase 2 — Building integrated systems and pilots.

Regional and local actors develop pilot programmes combining environmental and health datasets. Education, public communication, and updated regulations strengthen awareness and action across human and planetary health. Insurance models begin experimenting with rewarding consumer behaviours with a positive environmental impact.

Phase 3 — Institutionalising planetary-health governance.

Planetary health indicators are structurally embedded in public governance, urban planning, and corporate reporting. Digital systems support joint environmental and health decision-making, while the environmental footprint of these digital systems is actively monitored and minimized.

Barriers and enablers.

Key barriers include fragmented governance between separate environmental and health sectors, limited integration of cross-domain data systems, and competing short-term policy priorities. Enablers include growing societal awareness of climate–health links, strong interdisciplinary research capacity, and continued digital and institutional innovation.

Illustrative initiatives

- Updated national dietary guidelines that incorporate environmental impact alongside human nutrition.
- Regional pilots combining environmental sensing with health data to identify areas of compound risk.
- Cartesius Utrecht: a future-focused neighbourhood designed to help people live longer, healthier, and happier lives.

PATHWAY IV — MAKING PREVENTIVE HEALTH INVESTABLE

This pathway describes a future in which preventive health is approached as a core, long-term societal investment. By 2040, preventive health is structurally funded and evaluated on its total contribution to health, equity, wellbeing, and social participation. Justification for preventative funding is no longer based primarily on the reduction of short-term healthcare costs, but on broader societal returns. These include long-term outcomes such as functional capacity, cognitive health, and independence in later life, alongside educational attainment, labour-market participation, and social cohesion. A coordinated investment framework links national, regional, and local actors across healthcare, education, housing, and infrastructure.

This pathway aligns with the international shift towards "beyond-GDP" and well-being economy approaches, in which societal progress is measured through indicators that reflect health, equity, and environmental sustainability alongside economic output (PECCH, 2026; OECD, 2025). Embedding such indicators in budgeting and decision-making provides a stronger basis for sustained investment in prevention.

Illustrative initiatives

- Joint preventive-health budgets co-financed by municipalities, employers, insurers, and community organisations.
- Value-based insurance experiments that reward sustained preventive behaviours.
- Workplace mental-health and wellbeing programmes co-funded by employers and public authorities.

Phase 1 — Building institutional and financial foundations.

Governance structures are centralized under a dedicated national preventive health authority. Economic evaluation methods are modernized to capture the broader societal returns of prevention, drawing on emerging wellbeing and beyond-GDP frameworks. Specialized, ring-fenced preventive health funding mechanisms are introduced.

Phase 2 — Scaling cross-sector investments.

Joint investment models are operationalised between governments, private insurers, employers, and local communities. Preventive health measures expand rapidly across workplaces, physical environments, and targeted population programmes.

Phase 3 — Institutionalising preventive-health investment systems.

Preventive health is permanently embedded in long-term macroeconomic budgeting and public governance, with outcome-based indicators — including healthy life expectancy, socio-economic equity, and holistic wellbeing — serving as the primary metrics guiding decision-making.

Barriers and enablers.

Key barriers include short-term political and financial cycles, fragmented governance, healthcare-oriented funding structures, and differing health preferences. Enablers include increased political recognition of prevention as a societal priority, growing employers and insurers interest in preventive health, and efforts to improve methods for measuring long-term societal returns.

FROM PATHWAYS TO ACTION

These pathways are not rigid, finished blueprints. Their realisation depends on the active contributions of many different actors and on the fruitful connections forged between them. The EWUU Institute for Preventive Health serves as a vital connector: bringing together the knowledge, institutional relationships, and long-term perspective needed to turn shared visions into coordinated action.

We actively seek collaboration with:

National government and ministries, to embed health considerations across policy domains, develop cross-sectoral preventive-health budgets with long-term horizons, and strengthen the regulatory conditions for healthier environments.

Municipalities and GGDs, to scale what works locally, act as connectors between healthcare, social services, planning, and communities, and ensure that national ambitions translate into meaningful change at the level where people live.

Research and funding organisations, to broaden the evidence base for prevention, support long-horizon and transdisciplinary research, and bridge the gap between scientific knowledge and practice.

Employers and insurers, to develop joint investment models that share both the costs and benefits of preventive action, and to embed health and wellbeing into workplaces and insurance practices.

Civil-society organisations and communities, because lived experience is a legitimate and necessary source of knowledge. We want communities to help shape, not merely respond to, the interventions that affect them.

Commercial actors, to develop business models and products aligned with public-health objectives, with transparent collaboration and clear safeguards against conflicts of interest.

HOW THE EWUU INSTITUTE FOR PREVENTIVE HEALTH CONNECTS SCIENCE AND SOCIETY

The EWUU Institute for Preventive Health connects scientific research and societal practice in pursuit of preventive health. Together with partners in the EWUU Alliance, we bring researchers, policymakers, professionals, and citizens together to develop and apply preventive health knowledge. Our activities include citizen panels, co-creation workshops, transdisciplinary research programmes, transition dialogues across sectors, and the translation of findings into policy, practice, and education.
The four pathways set out in this document are intended as a shared point of reference for these activities, supporting collective reflection and coordinated action across science and society.

The full white paper is available for download on the **EWUU website**. These pathways are intended as an invitation to think together. We welcome your reflections, questions, and contributions.
Please reach out at **i4PH@ewuu.nl**

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