university of groningen

Prof. dr. J.O. Mierau

The Value of Health



Inaugural lecture

April 4th 2025

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Chair

Public Health Economics

at the

Faculty of Economics and Business

University of Groningen

university of groningen

Published by University of Groningen Presss
Broerstraat 4
9712 CP Groningen
https://ugp.rug.nl/

First published in the Netherlands ©
https://orcid.org/0000-0002-9968-8807/

Design and layout: LINE UP boek en media bv | Riëtte van Zwol
Illustrations: see images.
Portret photo: Marieke Kijk in de Vegte (https://www.mariekekijkt.com/)
Cover photo: Jochen Mierau and his brother on their first school day.

DOI: https://doi.org/10.21827/67616d301dd8f

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Madam Rector,
Members of the Board of the University,
dear Guests,



Photographer: Stephan Keereweer

Erik, thank you very much for your kind words.[1] I remember very well your enthusiastic roadshow ten years ago to show how important healthy ageing is not just for the medical faculty but for the entire university. While the medical field is sometimes closed and protective, you were very welcoming and helped me over the threshold into the field. Our collaboration over the years has brought many adventures for which I am very grateful.

Many more people have helped me get here but you will excuse me if I highlight only three. Viola, Aurora and Jacopo, without you I would not be able to be here. Through joy and stress, ups and downs you are always there. Regardless of any success that I may have, my greatest joy is to be part of our family. Aurora and Jacopo it is a joy to see you becoming bigger, stronger and independent. And Viola you are my constant source of inspiration in all aspects of life – ogni giorno con te e un regalo.

For all you here today, if you find anything that I say clear, it's because Viola helped in creating the lecture. Just like Schelto and my brother, thanks to both of you. All errors are, of course, my own.

1 See laudation by Prof. dr. E. Buskens, added as appendix.

It is often said that health has an intrinsic, inalienable value. I will not attempt to challenge that notion. What I will do, is offer a broader perspective – one that views health through an economic lens.

I will argue that health is crucial for economic development, yet economic development can also impede health. The central objective of health policy is therefore to overcome any contradictions between health and economic development. If we succeed in doing so, protection and promotion of health will no longer feel like an uphill battle – it will be common sense policy.

1.1 Health as a production factor

Health is a fundamental factor of production. Regardless of how well educated we are or how advanced our technology is, we can only be productive if we are healthy.[2]

But health is not just crucial for commercial activity. Every aspect of societal involvement requires us to be healthy enough to participate. A sports club depends on healthy volunteers and informal care can only be delivered if family, friends and neighbours are sufficiently healthy.

2 Mierau, J. O., van der Pol, S., Sandhu, A., & Jansen, D. E. (2024). Performance assessment to improve public health systems. Bulletin of the World Health Organization, 102(7), 541.

In this sense, health is the most important resource that we have as individuals and society. Without health, society comes to a halt – just as we experienced during the COVID-19 pandemic.

While it is hard to quantify how much economic growth can be attributed to health; it is clear that an unhealthy workforce reduces our economic potential.

Consider obesity. It is on track to beat smoking as the most important avoidable risk factor.[3] Obesity contributes to a wide range of health problems, from the well-known link with type-2 diabetes and its complications such as kidney disease and necrosis, to its increasingly well-established relationship with various cancers.

Over the past half century obesity rates soared world-wide. In 1980 only 5 percent of the Dutch population were considered obese; today it has tripled to over 15 percent. In the United States it has sky-rocketed to 40 percent. The World Health Organization now refers to it as an epidemic. But as we will explore later; this epidemic was not caused naturally – it is man-made; it's an outcome of our economic process.

3 WHO European Regional Obesity Report 2022. Copenhagen: WHO Regional Office for Europe; 2022.

The impact of obesity poses a substantial threat to our economy. The Organisation for Economic Cooperation and Development estimates that obesity stands to claim as many as 92 million lives in the coming decades and that 8.4 percent of healthcare budgets will be absorbed by costs associated with overweight and obesity.[4]

While the economic burden of such large, avoidable healthcare expenditures is already significant, the main impact of bad health is due to lost economic activity.

Unhealthy people are more likely to be unemployed, when employed are more prone to disease leading to absenteeism and presenteeism. For obesity and overweight alone, the OECD estimates a potential loss of 3.3 percent of economic output. In other words, we are suffering from an obesity recession.

Preventing obesity doesn't only make health sense – it is sound economic policy. Bram Wouterse, Sander Boxebeld and I show that stabilizing obesity rates in the Netherlands at their current level, could boost economic output by two billion euro.[5] Just imagine the economic boom if we succeed in turning the obesity tide.

4 OECD (2019), The Heavy Burden of Obesity: The Economics of Prevention, OECD Health Policy Studies, OECD Publishing, Paris

5 Wouterse, B., Boxebeld, S., & Mierau, J.O. (2024). Preventie is goed voor de gezondheid en voor de portemonnee. Economisch Statistische Berichten - 109(4838) 440 - 442.

1.2 Differences in health – Age

While population health measures like obesity rates provide valuable insights, understanding how health as a production factor can be enhanced requires us to look beneath the surface at health differences. Among the many reasons for differences, two stand out: age and social class.

Most conditions show a clear increase in prevalence with age – cancer and cardiovascular disease, for example, share one important risk factor: aging. In fact, age is such an important risk factor that preventing birthdays may well be one of the most effective public health interventions – instead we celebrate them!

Mental health problems, however, have a markedly different pattern. They tend to develop much earlier in life and exhibit age patterns that do not display the typical increase with age. Some scholars have suggested that mental health is at its worst at midlife, but Hermine Dijk and I have demonstrated this to be a methodological artefact.[6] The true trajectory remains unclear – a question we hope to address with Rob Alessie soon.

Let's be clear: the atypical life-cycle pattern of mental health is not just a puzzle for statistical connoisseurs – it shapes the impact that mental health has on individuals and society.

6 Dijk, H., & Mierau, J. (2023). Mental health over the life course: Evidence for a U-shape?. *Health Economics*, *32*(1), 155-174.

Unlike cancers and cardiovascular disease, which mainly affect individuals who are near or after retirement, mental health problems affect people over their entire life-cycle.

According to the OECD, the costs of mental health problems run to 3.3 percent of economic output, driven largely by lower economic activity rather than healthcare expenditures.[7] Viewing health as a production factor, therefore, implies a much more prominent focus on prevention and treatment of mental health.

1.3 Differences in health – social class

Looking beyond age; social class is a critical determinant of health disparities. Engels already observed the dire state of the working class in England in the mid-nineteenth century. He argued that the health disadvantage of the working class was not due to personal failure but that the circumstances they were exposed to at work, at home and in society amounted to nothing less than social murder.[8]

In contrast to actual murder, social murder appears to be a perpetrator-less crime. No one was prosecuted for workers' lives that were nasty, brutish and short.

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7 OECD (2014), Mental Health and Work: Netherlands, Mental Health and Work, OECD Publishing, Paris.

8 Engels, Friedrich. The condition of the working class in England (1845). Penguin UK, 1987.

What was true then, remains true today. While individuals with a lower education in the Netherlands live 5 years shorter than people with a higher education and 14 years shorter in good health, no one has been prosecuted for this loss of life and well-being.[9]

We owe to Michael Marmot much of our modern understanding of health differences across social classes. Especially his seminal work from the 1970s, which provided two key insights.[10]

The first is that health disparities do not just affect the least advantaged groups. Instead, there is a gradient running from the least to the most advantaged groups and each successive increase on the social ladder is associated with better health.

The second is that health disparities across social classes are not fully explained by common health threats such as smoking and poor diets. Social class in and of itself is a determinant of health.

Building on Marmot's work, Viola Angelini, Dan Howdon and I have been able to extend these insights across the life-cycle to show that even if you climb the social ladder, your childhood

9 https://www.cbs.nl/nl-nl/cijfers/detail/84842NED

10 Marmot, M. G., Rose, G., Shipley, M., & Hamilton, P. J. (1978). Employment grade and coronary heart disease in British civil servants. Journal of Epidemiology & Community Health, *32*(4), 244-249.

social position is a crucial factor shaping your physical and mental health in late adulthood.[11]

Moreover, with Laust Mortensen, Anna Vera Pallesen and Frederik Christensen we have established that the class pattern in health is not limited to a selected number of diseases. Instead, for virtually all communicable and non-communicable diseases a higher socioeconomic position is associated with a lower prevalence of disease.[12]

1.4 Measuring health

If you've been paying attention, you may have noticed that while this was billed as a lecture on public health economics, I've been focused on disease. Maybe I should have become a professor of disease economics instead.

Joking aside, much of health research actually deals with disease instead of health. Studying disease is facilitated by the rise of modern registry data which meticulously track diseases. However, the purpose behind the registries is not to facilitate research, but to enable reimbursement systems. As treatment

11 Angelini, V., Howdon, D. D., & Mierau, J. O. (2019). Childhood socioeconomic status and late-adulthood mental health: results from the survey on health, ageing and retirement in Europe. The Journals of Gerontology: Series B, 74(1), 95-104.

12 Pallesen, A. V. J., Mierau, J. O., Christensen, F. K., & Mortensen, L. H. (2024). Educational and income inequalities across diseases in Denmark: a register-based cohort study. The Lancet Public Health, 9(11), e916-e924.

of disease is reimbursed but maintaining health isn't, the registries end up covering a limited part of human health – the sick part.

To actually engage in health research, we need to rely on other data sources. Prospective cohort studies and biobanks – such as Lifelines but also the UK Biobank and the Tohoku Medical Megabank – play a crucial role here. Unlike registries their starting point is not disease but health.

1.5 Lifelines

Viewing health and not disease is the unique strength of Lifelines. One that the University of Groningen, the University Medical Centre Groningen, Northern Netherlands and the Ministry of Health can be proud of supporting but also have a responsibility for maintaining.

By collecting data and materials straight from the participants we are able to provide health assessments for nearly ten percent of the population every five years. Academic research hardly ever gets more tangible than this.

In Lifelines we have been following the health of the Northern Netherlands population for almost two decades. By collecting data from biosamples, functional measurements and questionnaires, and linking these with information on environmental

exposures and socio-economic conditions, we can trace health and disease, as well as their determinants, over the life-cycle.

To understand how health develops over the life-cycle consider this graph – I promise it's the only one today. The graph displays the number of biomarkers such as blood sugar levels and cholesterol, which are commonly associated with various diseases later in life, that are above a value that would make your GP worry.

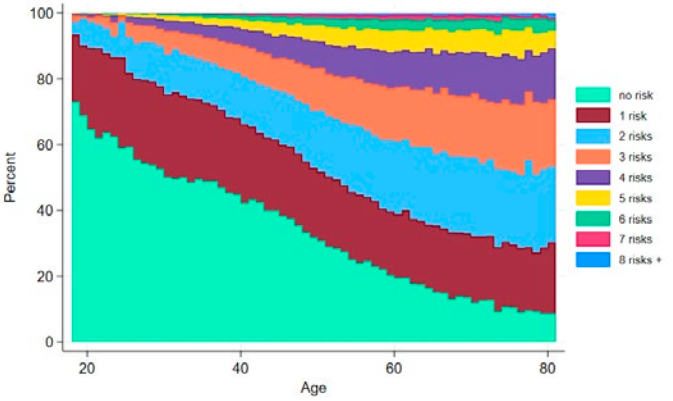


Figure 1: The Evolution of the Number of Biomarker-Related Risks Over the Life Cycle[13]

13 Note: The number of risks refers to the count of biomarkers exceeding the threshold for an individual at a given age. The figure illustrates the percentage of participants with varying numbers of risks across different ages. For details see Shui, A., van den Berg, G. J., Mierau, J., & Viluma, L. (2025). Lifetime Trajectories and Drivers of Socioeconomic Health Disparities: Evidence from Longitudinal Biomarkers in the Netherlands. IZA DP No. 17796

The green part shows the share of individuals who don't have a single biomarker that upsets GPs. While this group becomes smaller over time, even at very high ages there are quite some people who, based on their biomarkers, are healthy. If we want to understand healthy aging, this is the most interesting group. Yet if we rely on disease-based registry data we would never be able to identify them. Lifelines data are therefore a treasure trove to anyone interested in healthy ageing.

In ongoing work with Laura Viluma, Ailun Shui and Gerard van den Berg, we have already been able to use these data to establish that biomarkers show socioeconomic disparities already early in life.[14] With other words, even before diseases such as type-2 diabetes manifest themselves there is a difference in the early signs of these diseases across socioeconomic groups. This means that we should not wait for disease to set in but focus on prevention and early detection in order to combat health disparities.

1.6 Differences within groups

Just as I have done until now, we often emphasize the health differences between social classes, but we need to be careful.

14 ibid.

As Marmot already observed: poverty is not destiny – many poor people are actually quite healthy.[15] I would add to Marmot that affluence is also not destiny – many wealthy people are actually quite unhealthy and have poor health behaviour.

Collaborating with Ruud Koning, Erik Buskens and Willem de Boer and using Dutch health insurance data we have created an important nuance in looking at health disparities.[16]

While our research showed the common pattern that low-income neighborhoods tend to have higher healthcare expenditures, our research also revealed large differences in healthcare expenditures across neighborhoods with the same income level.

Quite a number of poorer neighborhoods actually have lower healthcare expenditures than richer neighborhoods and there are quite some richer neighborhoods who have much higher health expenditures than poorer neighborhoods. This means that we can potentially realize substantial health and economic benefits without adjusting the underlying economic differences.

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15 Marmot M. Closing the health gap. Scandinavian Journal of Public Health. 2017;45(7):723-731.

16 de Boer, W. I., Buskens, E., Koning, R. H., & Mierau, J. O. (2019). Neighborhood socioeconomic status and health care costs: a population-wide study in the Netherlands. American Journal of Public Health, 109(6), 927-933.

Analyses with Louise Dekker, Gerjan Navis, Yinjie Zhu and Stephan Bakker have shown that the key to realising these benefits lie in lowering smoking rates, increasing physical activity[17] and taking into account how individual and neighborhood deprivation interact with each other.[18] And ongoing research is highlighting that loneliness is a major contributor to health differences among individuals with the same socio-economic position.[19]

These insights beg to change the question from: "Why are poor people sick more often than rich people?" to the question: "Why are poor people healthy?" – let's look for the exception rather than the rule and see what the exception can teach us about the rule.

Together with Erik Buskens, Stefan Pichler, Laura Viluma and Mariana Soares we hope to provide better answers to this question through our Ecotip project.

17 de Boer, W. I., Dekker, L. H., Koning, R. H., Navis, G. J., & Mierau, J. O. (2020). How are lifestyle factors associated with socioeconomic differences in health care costs? Evidence from full population data in the Netherlands. Preventive Medicine, 130, 105929.

18 Zhu, Y., Duan, M. J., Riphagen, I. J., Minovic, I., Mierau, J. O., Carrero, J. J., ... & Dekker, L. H. (2021). Separate and combined effects of individual and neighbourhood socio-economic disadvantage on health-related lifestyle risk factors: A multilevel analysis. International Journal of Epidemiology, 50(6), 1959-1969.

19 Viluma, L. Howdon, D. D., & Mierau, J. O. (2025). My loneliness is killing me: loneliness explains within-SES-group differences in health among older European adults. Mimeo.

2.1 Sources of Health

I hope that by now I have demonstrated that health is a crucial factor of production and that its unequal distribution acts as a drag on our economic development. Now it is time to focus on where this factor of production comes from.

While we often associate health with healthcare, healthcare alone does not create health.[20] Only ten to twenty percent of health is attributable to healthcare. The rest is due to biological and genetic factors, individual behaviour, the social environment and economic conditions. If we want to understand health, we, therefore, have to look beyond healthcare and focus on factors threatening health.

Historically, the major threats to health were like natural disasters – famines, pests, vulcano outbreaks, extreme weather, earthquakes etc. In contrast, today in the Anthropocene era, health threats are not natural disasters but are by-products of our economic system – capitalism.

Major health threats such as smoking, poor diets and lack of physical activity did not descend like meteorites from the sky; they have been driven by the deliberate actions of health

20 Kaplan, R. M., & Milstein, A. (2019). Contributions of health care to longevity: a review of 4 estimation methods. The Annals of Family Medicine, 17(3), 267-272.

harming industries polluting the air, selling tobacco, providing unhealthy food and facilitating a sedentary lifestyle. Sitting, indeed, is the new smoking.

Health harming industries have grown to such an extent that the World Health Organization estimates that they now account for 19 million deaths annually worldwide.[21] These industries, driven by profit motives have become a significant force in shaping public health outcomes, with their actions posing an avoidable risk to health on a global scale. These new risk factors have been coined as the commercial determinants of health.[22]

2.2 Capitalism and Health

While the focus on commercial determinants of health is a relatively recent development in my opinion, the mechanisms behind them can best be understood by focusing on the economic logic of capitalism.

21 Commercial determinants of noncommunicable diseases in the WHO European Region. Copenhagen: WHO Regional Office for Europe; 2024.

22 Gilmore, A. B., Fabbri, A., Baum, F., Bertscher, A., Bondy, K., Chang, H. J., ... & Thow, A. M. (2023). Defining and conceptualising the commercial determinants of health. The Lancet, 401(10383), 1194-1213.

Since the beginning of the industrial revolution, volumes have been filled about the workings of capitalism.[23,24] Instead of rehashing those debates, I would like to highlight some of the main tendencies of capitalism in the hope that it will help you understand its impact on health today and its implications for modern health policy.

The central goal of capitalism is the accumulation of capital. Profit, therefore, is the key objective of entrepreneurs but the ability to make profits is limited by competition with other entrepreneurs. In order to outcompete others, entrepreneurs must constantly innovate, those who fail to innovate, fall behind and are eliminated from the market.

Innovation can manifest itself through product improvement or cost reduction. Product innovation has provided society with many goods that have improved health and wellbeing – fertilizer, sliced bread and super soft toilet paper! And, of course, the production of all these goods provides millions with their livelihood.

But the objective of innovation is not the increase of wellbeing, it is to survive in the competitive struggle. Hence, innovation

23 Marx, K., Fowkes, B., & Mandel, E. (1992). Capital: Volume 1: A Critique of Political Economy (Penguin Classics).
24 Weber, Max. The Protestant Ethic and the Spirit of Capitalism: And Other Writings. Verenigde Staten, Penguin Publishing Group, 2002.

has also brought many health-harming goods such as alcohol, tobacco, sugar sweetened beverages and social media.

Moreover, the other form of innovation, cost reduction, often leads to the exploitation of workers and nature. Think about pollution and poor compliance with labour laws leading to hazardous working conditions.

Exploitation is often viewed through a moral lens. However, Marx already observed that: "[The] capitalist is [...] is only capital personified. His soul is the soul of capital. But capital has one single life impulse, the tendency to create value[...]".

Exploitation is not, therefore, a moral failure of the individual entrepreneur. Competitive pressure drives entrepreneurs to adopt a strategy that accords with the norms of the market. While each individual entrepreneur may have a moral that forbids adopting harmful practices, that moral will melt in the competitive pressure. Therefore, what we observe as norm in the market is not the average of the morals of the entrepreneurs but the minimal norm upon which competition is played out – the law.

In the absence of laws protecting labour and nature, exploitation eventually leads to the collapse of society. With workers exploited to the point of exhaustion and nature to the point of

extinction, capitalism cannot function. As we observed fifteen minutes ago, regardless of how skilled workers are or how valuable machinery is, if workers are too ill to use them, society comes to a halt.

I already hear you thinking: the collapse of capitalism has been prophesied since its inception, but it is only gaining momentum. True, while the tendency to collapse is inherent in capitalism, so are the countervailing powers that prevent it from collapsing.

Capitalism does not just produce goods and services, it also produces the institutions that keep it in power. Exploitation of labour has, therefore, been met with reductions in the length of the labour day and an improvement of working conditions. While we tend to remember these as victories of the labour movement, these reforms importantly saved capitalism from itself.

2.3 Capitalism and Health Today

Having explored the main mechanisms of capitalist dynamics in health, let's return to today's challenges. Luc Hagenaars and I argue that we see the same forces at play.[25] Capitalism is still a great engine of innovation, but it has also not shed its

25 Hagenaars, L.L. & Mierau, J.O. (2024). Stel als overheid grenzen aan verdienmodellen die de volksgezondheid schaden. Economisch Statistische Berichten - 109(4839) 496 - 499.

exploitative feathers. However, with safer working conditions – at least in the high income economies – the exploitation of health has shifted to consumption.

Health is now exploited through the goods and services offered on the market. Food has been engineered to the point of addiction and inescapable marketing is constantly pushing health harming goods and services.

This is not limited to food. Tobacco firms have paved the way for the past century and many of their practices are being adopted by other industries. Today tobacco, ultra-processed foods, fossil fuels and alcohol account for 34 percent of all deaths worldwide.[26]

These deaths do not arise from illintent of shareholders; they are the consequence of the competitive struggle in which only those shareholders survive who are willing to invest in health-harming goods, regardless of the harm that it brings. Firms that choose not to play by the norms of the market are ruthlessly eliminated from economic existence.

26 Commercial determinants of noncommunicable diseases in the WHO European Region. Copenhagen: WHO Regional Office for Europe; 2024.

But by competing on this lower bound, capitalism is once again moving toward its collapse. Overconsumption of health-harming goods and services is making the workforce ill with stark consequences for the labor market and the economy at large. And while previously labor was abundant, population aging has dried up the industrial reserve army and every sick worker is an irreplaceable loss in economic productivity.

2.4 Capitalism and Possible Realities

To engage with these capitalist dynamics of health, research needs to move toward new hypotheses. Just like early research on capitalism dealt with the tendencies inherent in it, we should look to establish how these tendencies are affecting health today.

From these tendencies we can then derive new, testable, hypotheses but for now the crucial step is to develop new questions and hypotheses.

Taking the tendencies of capitalism as a starting point, an important observation is that health research itself is not immune to the forces of capitalism. This has a profound impact on the strategies we follow to overcome public health challenges.

I am excited about the new project that Jan Willem Romeijn and I are starting in which we aim to generate a better understanding of how the profit motive inherent in capitalism affects what we know. Put complex, capitalism has epistemological implications. Let's put it more simply, but don't lose me at the first sentence.

Following Leibniz, consider the existence of many possible worlds. Out of all possible worlds, each social system reveals a particular one. Capitalism reveals the one that is profitable. Through its focus on capital accumulation, capitalism censors other possible realities. Not because it wants to suppress them, but because in capitalism only the possible realities survive that play by the norm of the market.

The products on the shelves are the ones that sell, the entertainment we see is the one that attracts paying audiences, the news we read is shaped by what advertisers want.

While capitalism may profess that we are free to choose, in fact we are only free to choose among choices that are profitable. Capitalism occasionally lets through a glimpse of other possible worlds, but the dominant one is the profitable one.

Now let's apply this tendency to public health research. Consider all potentially effective strategies to overcome public health problems such as rising obesity rates. Since there are always more ideas than resources, only a limited number of the potentially effective strategies are actually proven to be effective.

Ideally, these are a good reflection of the potentially effective strategies. However, because science requires resources, a bias emerges concerning which strategies receive validation – interventions that are potentially profitable for the provider are much more likely to be researched than the ones which do not have direct profits.

This concept might seem complex, so let me explain that a bit more. Today, the lion's share of health research is industry funded – by an industry that is driven by profits and competition. As a consequence, research is skewed toward interventions that generate profits. Strategies that do not deliver profits, or even threaten them, are much less likely to be studied.

This means that out of all potentially effective strategies, we mainly see the profitable ones. Crucially, this effect is not solved by making agreements on intellectual property rights nor does it arise from scientific misconduct – even if companies adhere to the highest standards of scientific integrity and all

contracts are fair – the knowledge produced is a limited sample of potential knowledge – the profitable one.

This tendency provides a critical role for universities – ensuring that the proven effective interventions are a good reflection of all potentially effective interventions.

This does not mean avoiding collaboration with industrial partners but rather acknowledging the bias it creates. It means supporting interdisciplinary infrastructures such as the Aletta Jacobs School of Public Health. It means not attaching co-financing requirements to research grants but assuring that research is funded that has societal benefits without necessarily having a return for an individual commercial party.

It also means assuring public funding for Lifelines, for if we deliver biobanks and cohort studies to industry, every health problem will eventually have a pharmaceutical solution.

Given this tendency and its impact on research, it is no surprise that the market's answer to the obesity pandemic is treatment and not prevention. The effectiveness of the new class of obesity drugs is not in question – though concerns about side-effects and long-term consequences remain.

The point is that history has shown that public health problems are solved through prevention, not by treatment. But prevention does not have a private business model, while obesity drugs have enormous returns for shareholders. Hence, when faced with the choice between investing in prevention or treatment, investors will prefer treatment. Not because of malice, but because that's how the market works.

2.5 Arms Race

The market, however, cannot solve the public health crises it helped create. While obesity drugs may improve the health and wellbeing of those who take them, firms that produce ultra-processed foods, sugar-sweetened beverages or fast food are not standing still – they are innovating to survive. First signs are arising of manufacturers developing food that is attractive even to those individuals who are using obesity drugs.[27]

In the coming years, we are likely to see an escalating arms race; ever more effective obesity drugs versus food that is engineered so that it remains attractive nonetheless.

The constant adaptation is not limited to market competition; it also applies to regulation. Just as firms innovate to outcompete each other, they also innovate in response to regulation.

27 Weber, T. (2024, November 19). Will Ozempic Crush the Junk-Food Business? The New York Times.

This can be beneficial, as when soft drink manufacturers in the UK lowered the sugar content of soft drinks in response to sugar taxes.[28] But it can also be harmful such as the addition of a homeopathic quantity of dairy to juices by Dutch producers to circumvent the same sugar taxes.

Static regulation, therefore, cannot regulate dynamic markets. Over time firms will find a way to undermine the regulation – with the consequence that they corrode the very foundations that are necessary to sustain the market and society as a whole.

In sum, neither the market nor static regulation can address the public health challenges that we face. We need to look further.

2.7 Health Goals

Many of the greatest advances in health did not come from treatment; they came from the protection of health. But the protection of health threatens two business models – the health harming industries that create the problem and the industries that benefit from treating avoidable diseases. A powerful public health strategy therefore counters two strong private business

28 Dickson, A., Gehrsitz, M., & Kemp, J. (2023). Does a spoonful of sugar levy help the calories go down? An analysis of the UK soft drinks industry levy. Review of Economics and Statistics, 1-29.

models yet creates a public benefit.[29] But industry funded research is unlikely to generate the evidence necessary for developing such a strategy. Making sure that these strategies are researched and developed is the alpha and omega of academia.

The question is, therefore, how to effectively protect health in capitalist societies? Together with Brigit Toebes, I have been working toward a new idea on health protection – one which begins with holding political actors accountable for health outcomes.[30]

Looking at major challenges over the past half century, we see that turning points came when accountability was clearly set. European public finances improved with the introduction of the fiscal targets in the Stability and Growth Pact, inflation was tamed through inflation targets and the climate goals set out in the Paris Accords led to an increase in the policies aimed at mitigating climate change.

For health, however, there is no public accountability if targets set out in various agreements are not met. A breach of targets is often met with silence. Just think about last week's report in

29 Mierau, J. O., van der Pol, S., Sandhu, A., & Jansen, D. E. (2024). Performance assessment to improve public health systems. Bulletin of the World Health Organization, 102(7), 541.

30 Mierau, J. O., & Toebes, B. C. (2022). Towards legally mandated public health benchmarks. International Journal of Health Policy and Management, 12, 7123.

the media that despite all policies, obesity rates in the Netherlands are still increasing.[31] There was no emergency debate in parliament, no cabinet crisis. Nothing, just silence.

Essentially, public accountability for health outcomes acts as a counterweight to the market objective of capital accumulation. In practice it means that we need to give the same status to the goals set out in the Sustainable Development Goals – think about a 30 percent reduction in mortality from non-communicable diseases – as we do to budget and climate targets. By holding the government accountable for health outcomes and markets for capital accumulation, we can work toward a society in which public health and economic development strengthen each other. Exactly what we set out to do half an hour ago.

Legally mandated health goals are not a magic bullet, just setting them does not change anything. What it does do is break the silence when the goals are not met. It means that parliament can legitimately ask why the WHO Quick Buys are not fully implemented despite the dire state of public health.[32] The Quick Buys are an extensive list of cost-effective public health interventions that provide quick results. Think about a

31 We roken en drinken steeds minder, maar blijven te zwaar. (2025, March 21). @NOS; NOS Nieuws.

32 Galea, G., Ekberg, A., Ciobanu, A., Corbex, M., Farrington, J., Ferreira-Bores, C., ... & Stuckler, D. (2025). Quick buys for prevention and control of noncommunicable diseases. The Lancet Regional Health–Europe.

sugar tax that depends on the amount of sugar in beverages. It would also mean that we would provide local councils with legal tools to avoid cities from becoming fat swamps – just count the number of fast-food outlets on your way out today – and it would encourage shareholder action to stop super-markets from being merchants of disease.

I am encouraged to see that the idea of political accountability for public health has quickly caught on in the policy debate. A parliamentary majority has already called on the government to study the imposition of public health goals more closely, various political parties have taken up public health goals in their election programs and some of the highest advisory bodies of the government have advised it to take the goals seriously. And to my joy last week Minister Karremans emphasized the need for public health targets in an interview with the Volkskrant. Change is coming!

3. Closing

Now that we have come to the end of the lecture, I hope to have extended your perspective on health and health policy.

We started by recognizing that physical and mental health are crucial factors of production – ones that determine economic potential at the individual as well as national level. Yet our economic system, driven by a need to accumulate capital, is putting health under pressure. Health disparities persist and exclude those in disadvantaged positions from economic opportunities.

Market forces prioritize treatment, despite clear evidence that health gains come from prevention. Static regulation is insufficient in a dynamic market, and industry-funded research is skewing our knowledge base toward profitable solutions.

To truly protect health in a capitalist society, we must counterbalance the power of the market with a societal goal to protect health. This begins with government accountability for public health outcomes. Legally mandated health goals will protect our health and save capitalism from itself.

Ik heb gezegd!

Laudatio Jochen

Jochen Mierau kennen wij allemaal als hoogleraar economie van de volksgezondheid. Na zijn promotie in 2011 volgde wat je wel als bliksemcarrière zou kunnen duiden. Een tenure track mondde in 2015 uit in een benoeming tot universitair hoofddocent. In die paar jaar tijd maakt hij een switch van economische modellen naar modellen van en over gezondheid. Nog maar enkele jaren later legt Jochen de fundamenten voor Aletta Jacobs School of Public Health waarvan hij in 2018 wetenschappelijk directeur wordt. Maatschappelijke impact verzekerd en een bevestiging van zijn vele talenten. Een jaar later volgde de benoeming tot hoogleraar, en na weer een academische oogwenk nam Jochen in 2022 een volgende stap in de wereld van onderzoek en zorg voor gezondheid en epidemiologie. Hij werd wetenschappelijk directeur van Lifelines, een grootschalig drie-generatie cohortonderzoek in Noord-Nederland. Zijn onderzoek richt zich op gezondheidsverschillen tussen, maar ook binnen groepen, bijvoorbeeld gekenmerkt door regio, sociaaleconomische positie, opleidingsniveau en inkomen. Veel van zijn werk gaat over mentale gezondheid gedurende de levensloop, en de impact van economische omstandigheden op de volksgezondheid. Op die manier heeft Jochen zich gewijd aan het verbeteren van de volksgezondheid in Nederland. Maar er is meer. Tijdens de coronapandemie verwierf hij landelijke bekendheid door zijn regelmatige optredens in de media en deelname aan adviescommissies. Dat opende weer allerlei deuren, en al snel

werd hij een veelgevraagd spreker op radio, televisie en in podcasts. Met zijn heldere analyses en wetenschappelijk onderbouwde adviezen heeft hij een breed publiek weten te bereiken. Zijn boodschap is altijd verhelderend, toegankelijk en gericht op het creëren van een gezondere samenleving.

Jochen schuwt het niet daarbij stevige standpunten in te nemen. Zo stelt hij dat door gezondheidsproblemen te voorkomen de druk op de zorg zal verminderen, en op lange termijn kosten bespaard kunnen worden. Beleid om dit te bereiken dient gestoeld te zijn op evidentie, ofwel gebaseerd op data en onafhankelijk wetenschappelijk onderzoek, in plaats van dogma en electoraal goed verkopende oneliners. En tot slot steekt hij niet onder stoelen of banken dat onze wetgever zich best met een wet, en dus juridisch afdwingbaar, bepaalde gezondheidsambities op mag leggen.

Kortom, Jochen heeft een duidelijke visie, ambities en ontegenzeggelijke leiderschapskwaliteiten, die velen in de schaduw stellen. Het zal dan ook niemand verbazen dat het in het openbaar aanvaarden van het inmiddels niet meer zo heel nieuwe ambt van hoogleraar, nog maar een begin is van een glans- en invloedrijk vervolg. We gaan het meemaken.

Maar wie is nu eigenlijk Jochen, en hebben we als we hem iets beter leren kennen een verklaring voor zijn drive?

Zijn wieg stond in 1983 in Jena in de Duitse Democratische Republiek. Er volgde een verhuizing naar Berlijn, Oost-Berlijn wel te verstaan. Het gezin (inclusief grootouders) waarin Jochen opgroeit bood een academisch milieu, dat voorzag in de nodige culturele bagage. Als 6-jarige "ziet" hij de muur tussen Oost en West vallen. Een life-changing event, dat hem ervan heeft doordrongen dat het heel veel uitmaakt waar je wieg staat. De verschillen tussen Oost en West bleken namelijk heel groot, en niet altijd voordelig uit te pakken voor mensen uit voormalig Oost, ook al was iedereen op papier voortaan Duits. Deze omstandigheden maakten dat Jochen's vader in 1991 een kans om in Groningen promotieonderzoek te doen aangreep. Het gezin Mierau verhuisde naar Nederland. Dan kom je dus als voormalig Oost-Duits joch van 8 of 9 jaar in Beijum te wonen, spreek je de taal nog niet en mag je nieuwe vriendjes maken. Al knikkerend leert Jochen Nederlands, en de waarde van verschillende kleuren en formaten glazen bolletjes kennen. Hij vergaart naar verluid aanzien, vermogen en inzicht in de economie van knikkers. De econoom is geboren. Het integreren gaat goed en in die tijd maakt Jochen veel vrienden voor het leven. De middelbare school staat in Haren, en dat roept herinneringen op aan de grote verschillen in de samenleving. Rijkeluiskindjes uit Haren, met hun vele, voor hen vanzelfsprekende privileges, verschillen nogal van zijn buurtgenoten in Beijum. In die tijd worden bij wijze van spreken de socioloog en antropoloog geboren. Net als bij iedere puber zijn er wat

strubbelingen, maar een fantastisch stel hersens, aansprekende voorbeelden in de familie (dus toch die wieg!), een gezonde geldingsdrang, en een intussen verkregen maatschappelijke ambitie, maken dat een academische studie en carrière volgen. “The rest is history” zou je kunnen denken, maar er is meer.

Als student wil je de wereld leren kennen, en dat kost geld. Dat geld wordt als pizzakoerier op de brommer met een zekere doodsverachting bijeen gescheurd. Daardoor krijg je belangrijke inzichten. Groningen ken je als je broekzak, je ziet en ondervindt letterlijk per wijk sociaal-economische gezondheidsverschillen. En last but not least – je ziet in dat een motor als vervoermiddel voor een roekeloze rijder misschien niet zo’n goed idee is. Zelfinzicht en lijfsbehoud.

Tot slot Jochen als mens, collega, vriend, en family man. Ik hou het bij steekwoorden. Oprecht, geïnteresseerd, geïnformeerd, ongekende dossier en feitenkennis, boud, creatief, ervaringsdeskundige, hongerig en vrijgevig, “the boss” – “nobody wins unless everybody wins”(Bruce Springsteen), en niet onbelangrijk: geliefd.

The world is your stage, maar in Groningen hebben we je hard nodig.

Prof. dr. E. Buskens
4 april 2025

Jochen O. Mierau (Jena, 1983) is Professor of Public Health Economics at the University of Groningen and the University Medical Centre Groningen as well as Scientific Director of Lifelines. His overall objective is to use science to inform policy aimed at improving population health and reducing health disparities. He obtained his graduate and undergraduate degrees in economics from the University of Groningen. He set up the Aletta Jacobs School of Public Health in 2018, serving as its Scientific Director before switching to Lifelines in 2022. He has published numerous articles in economics, public health, epidemiology and various clinical disciplines. He is an active participant in the public discourse on health policy and has served on a variety of national committees to enhance public health policy in the Netherlands and Germany.

