Health Promotion for OlderPeople in Europe. Institutional and financial dimension

Health promotion is the core of modern public health. The part of it that is addressed to the elderly is a key element of the European healthy ageing strategy, which is focused on developing and consolidating a healthy lifestyle as well as changing it, if the current habits are not conducive to health, according to the limitations of the body caused by ageing.

Health promotion targeted to the elderly proposes an alternative to increasing the spending on costly health care for the elderly, whose numbers keep growing dynamically.

The contemporary population of the elderly is markedly different in their behaviour from earlier cohorts, born before World War II. Nowadays, the elderly are more aware of their health needs and more willing to voice their needs as well as demand their satisfaction. At the same time, more and more of them has control over their health, even in a situation of chronic diseases and reduced efficiency in everyday functioning.

The basic idea and a more detailed concept of health promotion has been defined in the 1986 WHO conference in Ottawa (Canada), where the Ottawa Charter Promotion was adopted as a general statement of health. The objective of health promotion enshrined in this document is to enable individuals to increase the ability to control and improve their health, and any activities and actions that allow them to do so should be supported and propagated. This necessitates the circulating of knowledge of what promotes health and why. Motivation, guidance and support are all needed when learning to apply this knowledge as well as when taking action and influencing others (including politicians, media) to do the same. As established in Ottawa, health promotion is equally important for achieving good health (and maybe more so) as other services the health sector.

Although each individual makes their own decisions about their behaviour and lifestyle, in matters of health they accept the opinions of others, especially when they come from professionals and institutions. Who can carry out activities in the field of health promotion? Who is equipped with appropriate knowledge and who should support its development and resort to it when taking decisions and actions? The answers to these questions can be normative (who is supposed to do it)or research-based, by studying who is doing it and with what result. The answers to those questions were sought in the framework of the European research project on the promotion of healthy lifestyles among the 65+ through the prevention of specific risks, shortened to "Pro-Health 65+" carried out in the Jagiellonian University Medical College by a Institute of Public Health team, in collaboration with partners at the University of Maastricht, University of Sacro Cuore in Rome and the Centre for Social Policy in Bremen.

The studies and analysis conducted within the project included in-depth literature reviews, reports on the research results from the implementation of other research projects (global, European and from selected other countries) and our own reconnaissance in the 10 cooperating countries; apart from our main partnering countries, the study included Portugal, Greece, the Czech Republic, Hungary, Bulgaria and Lithuania.

The choice of countries for analysis, and previously as a partner in the project, was dictated by the proper representation of the European welfare state models. The classic classifications of welfare states [1], which consist in the highlighting of three models (the three worlds of the capitalist state): liberal, conservative and social democratic, have been supplemented and modified under the influence of criticism and analyses examining both the coherence within each type, and the real differentiation between countries [2–4]. As a result, in contemporary Europe, there are now five models of welfare state, including the southern European and post-communist model.

The typology of welfare states is based primarily on the political and institutional criteria in terms of social policy and labour market: the degree of de-commodification in labour relations and the different balance between the participation of the state, the family, the market and social organisations in meeting individual human needs. They also take into account the level of social stratification.

In previous research and studies on welfare states, the post-communist countries were not given as much attention as the developed capitalist countries [5]. The studied factors were the economic and institutional differences between countries (the countries with their own national institutions as opposed to the post-Soviet countries without such institutions) and the changes in the directions of social policy reforms in those states in transitions [6]. A thesis has been formulated that these countries develop a hybrid model of social policy [7, 8], which is subject to some unification as a result of adaptation to EU regulations.

The analyses conducted as part of the "Pro-Health 65+" project focus on the countries that so far were analysed to a lesser extent: the European post-communist countries and the southern European countries. Two countries with advanced capitalism: Germany and the Netherlands, were selected as reference points in terms of their influence on institutional solutions on the post-communist countries.

The traditional welfare state classifications included the differences in health systems only to a limited degree, since those were subject to numerous reforms, regardless of whether the country was classified as conservative or other. Attempts have been made to create a classification

Analysed countries	Type in classification of welfare states	Sources
The Netherlands	Social Democratic Bismarckian	Esping-Andersen 1990 [1] Ferrera 1996 [2]
Germany	Conservative Bismarckian	Esping-Andersen 1990 [1] Ferrera 1996 [2]
Italy	Southern	Ferrera 1996 [2]
Portugal	Southern	Ferrera 1996 [2]
Greece	Southern	Ferrera 1996 [2]
Poland	Post-communist: hybrid of liberal southern and conservative	Księżopolski 2008 [7], Golinowska 2009 [8]
The Czech Republic	Post-communist: mixed system social – democratic and liberal	Klimentova, Thelenová 2014 [9]
Hungary	Post-communist: mixture of liberal and conservative	Szalai 2013 [10]
Bulgaria	Post-communist: mixed system liberal, southern and social democratic	Tache, Neesham 2011 [11]
Lithuania	Post-soviet: mixture of liberal and universal social democratic on the low level	Aidukaite 2013 [12]

Table I. *The countries analysed grouped by welfare state classification.*
Source: Own compilation.

that would consider health systems [13, 14] but they mostly took into account the institutional and financial mechanisms of health care and only in OECD countries.

Additionally, for a long time, the health status of the population was not included in this typology as a distinguishing criterion for the classified countries [15, 16], although together with the development of research on health inequalities, analyses of the differences in health in countries with different welfare state systems were made. Among the indicators included in these analyses were infant mortality, low birth weight [17], self-assessment of health status [5, 18]) or the average life expectancy [e.g. 19].

There was also the question of the place of public health and health promotion in welfare state typologies. In the American empirical analysis conducted in the years 1998 to 2006 [20], scholars attempted to systemise the organization of public health in different locations in the USA. Three dominant features of the public health institutions were identified: differentiation, integration and centralisation. As a result, the study arrived at seven organisational combinations (clusters) and found that even in the span of eight years, the changes were too significant to consider the grouping permanent. The authors drew attention to the factors that caused it, such as variation in the structure of health needs, new epidemiological trends (the prevalence of chronic diseases), the significant impact of the environment, and lifestyle changes under the influence of new technologies. All of these factors make the creating a typology of long-term significance a challenging task [20]. At the same time, the authors have pointed to a solution that is difficult to achieve in practice – a combination of multiplicity and pluralism with coordination based on tools developed centrally.

The relationship between institutional arrangements and the level of expenditure in the field of public health in relation to the health status of the population in countries with different institutional regime has only become the subject of scrutiny in recent years [21]. Following this trend, the “Pro-Health 65+” project also included an analysis of institutional solutions and the level and effectiveness of spending on public health and health promotion in selected European countries. For the analysis of health promotion for older people the following countries were selected: two wealthy continental European countries: the Netherlands and Germany; three Southern European countries: Italy, Portugal and Greece, where the lifestyle and climatic conditions favour long life expectancy; and five Central and Eastern European countries: Poland, Czech Republic, Hungary, Bulgaria and Lithuania, which face the most notable problems of the quality of life the longer it lasts.

The health experts from the countries selected for analysis responded to questions posed to them in the template, provided answers to direct questions and, last but not least, they were the first to read and review the reports. The findings have been published in this issue of Scientific Issues of Health Protection.

The picture that has emerged from the expert diagnoses is diversified but similar trends can still be observed.

The ageing of the population in European countries commonly spurs action related to the activation and sustaining of health in the elderly. This is facilitated by the EU strategy of active and healthy ageing. In the less affluent post-communist countries this is borne out primarily by legal measures, by adopting laws on public health and emphasising health promotion. In the wealthier continental European countries, like the Netherlands and

Germany, such regulations (which are usually passed a few years earlier) are followed by a number of practical measures aimed at the elderly.

Health promotion is not always clearly defined and corresponding organisational solutions are not always clearly marked out. Actions in this area are taken both by public bodies – at the central, regional and local level – and by private and charity initiatives. A considerable amount of activity in the field of health promotion is initiatee and lead by non-governmental organizations. The institutional picture of health promotion is much more diverse than That of health care, which has defined boundaries and is standardised to universal standards of medical procedures.

The health sector and the circles of medical professionals are the decisive force in stimulating the development of health promotion in general and specifically for older people in each analysed country. However, it is not always used to promote health and intervening in the prevention of chronic diseases. In wealthier countries, there is a large degree of skepticism towards sufficiently proven prevention programs as conducive to health. In less affluent countries, with low spending on health care, the crucial factor is the lack of resources (funds and staff), which results in limited range of non-medicinal activities.

In most European countries there are circles of experts, often concentrated in the agencies of the ministries of health, central research institutes (national institutes of health), or at universities; they conduct research on the effectiveness of health promotion and prevention of chronic diseases in general, and also specifically directed to the elderly. Representatives of these groups participate in European projects related to health promotion and create international network of institutions and experts. They also publish their research, evaluate and describe good practices and launch new initiatives. They become the most formidable advocates of health promotion and preventive measures.

Older people increasingly more often actively participate in the development of plans, programmes and specific actions for health promotion and prevention of chronic diseases. This participation is enabled by the institutions responsible for the social participation of older people in the decision-making process. This type of participatory institutions was created in Poland as part of the policy for senior citizens in 2012–2013. The participation of older people is supported by the European projects through subsidising of network creation, dedicated conferences attended by policy makers and media programmes.

Health promotion and prevention of chronic illnesses is underfunded everywhere. This is mostly because their main sources of financing come from the health sector (including social health insurance, e.g. in Germany or Poland), thus competing with spending on health care. Health promotion programmes are therefore subsidised by social organisations (foundations, associations, special-purpose collections) and private initiatives (companies and individual payments from the participants and beneficiaries of specific programmes). This situation may increase the risk of inequalities in maintaining the health of the elderly.

In summary: there is very little of a coherent picture of trends and institutional types with respect to the promotion and prevention of chronic diseases of the elderly in the European countries analysed. There is, however, a steady qualitative and quantitative development of programmes for health promotion and prevention of diseases. However, their availability is limited, which may contribute to the growth of inequality in health. To counter this, new legislative initiatives are being taken in the countries analysed, and new public resources are being allocated for their financing. Some of these initiatives (e.g. the preventive law in Germany or health education law in Portugal) cite the national reports presented herein. The evaluation of the impact of these new regulatory actions on the health of older people will be (should be) the next step in research.

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