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Promocja zdrowia adresowana do osób starszych w wybranych krajach europejskich. Aspekty instytucjonalne i finansowe

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Promocja zdrowia adresowana do osób starszych w wybranych krajach europejskich. Aspekty instytucjonalne i finansowe

Promocja zdrowia stanowi rdzeń współczesnego zdrowia publicznego. Adresowana do osób starszych, jest kluczowym elementem europejskiej strategii starzenia się w dobrym zdrowiu (*healthy ageing strategy*), która jest ukierunkowana na rozwijanie i utrwalanie zdrowego stylu życia, a także jego zmiany, jeśli dotychczasowy szkodzi zdrowiu, odpowiednio do ograniczeń organizmu wywołanych postępującym wiekiem.

Promocja zdrowia adresowana do osób starszych stanowi po części alternatywę dla programów wzrostu wydatków na kosztowną opiekę zdrowotną osób starszych, których liczebność dynamicznie wzrasta.

Populacja osób starszych w obecnych czasach różni się zauważalnie w swych zachowaniach od wcześniejszych kohort, urodzonych przed drugą wojną światową. Jest bardziej świadoma swych potrzeb zdrowotnych i zgłasza chęć, a także domaga się ich zaspokajania. Jednocześnie coraz bardziej samodzielnie kontroluje swe zdrowie, także w sytuacji występowania chorób przewlekłych i ograniczenia sprawności w codziennym funkcjonowaniu.

Podstawowa idea, a także bardziej szczegółowa koncepcja promocji zdrowia została zdefiniowana w 1986 roku na konferencji w Ottawie (Kanada), gdzie powstała Ottawska Karta Promocji przyjęta przez WHO jako powszechna deklaracja zdrowia. Celem promocji zdrowia zapisanym w tym dokumencie jest umożliwienie jednostkom zwiększenia zdolności do kontrolowania swego zdrowia i jego poprawy. Ludziom należy więc wskazywać działania i wspierać te, które umożliwiają kontrolowanie indywidualnego zdrowia, aby je utrzymać i poprawiać. Do tego potrzebna jest informacja i wiedza o tym, co – i dlaczego – sprzyja zdrowiu. Potrzebne są motywacje, doradztwo oraz wsparcie przy nabywaniu umiejętności zastosowania tej wiedzy, a także przy podejmowaniu działań oraz oddziaływaniu na innych (w tym także na polityków, media), aby czynili podobnie. Jak założono w Ottawie, promocja zdrowia ma równie istotne znaczenie dla osiągania dobrego zdrowia (a może nawet bardziej) jak inne usługi sektora ochrony zdrowia.

Mimo że każdy indywidualnie podejmuje decyzje o swym zachowaniu i stylu życia, to w sprawach zdrowia akceptuje opinie innych, szczególnie gdy mają one profesjonalną oraz instytucjonalną legitymację. Kto i jak może prowadzić działania w zakresie promocji zdrowia? Kto jest wyposażony w odpowiednią wiedzę i kto powinien wspierać jej rozwój i po nią sięgać, gdy podejmuje decyzje i konkretne działania? Odpowiedzi na te pytania mogą być normatywne (kto to powinien robić?) albo oparte na badaniach; na rozpoznaniu – kto to robi i z jakim skutkiem. Odpowiedzi poszukiwano w ramach badań europejskiego projektu na temat promocji zdrowego stylu życia i prewencji specyficznego ryzyka zdrowia osób starszych (*Promotion of healthy lifestyles among the 65+ through the prevention of specific risks*) o akronimie „Pro-Health 65+", realizowanego w Collegium Medicum UJ przez zespół Instytutu Zdrowia Publicznego we współpracy z partnerami: Uniwersytetem Maastricht, Uniwersytetem Sacre Coure w Rzymie oraz Centrum Polityki Społecznej Uniwersytetu w Bremie.

Rozpoznania i analizy prowadzone w ramach projektu obejmowały pogłębione przeglądy literatury, raporty o wynikach badań, pochodzące z realizacji innych projektów badawczych (ogólnoświatowych, europejskich i z niektórych krajów) oraz własne rozpoznania eksperckie w dziesięciu krajach współpracujących, poza głównymi partnerami jeszcze z: Portugalią, Grecją, Czechami, Węgrami, Bułgarią i Litwą.

Wybór krajów do analizy, a wcześniej jako partnerów w projekcie, podyktowany był odpowiednią reprezentacją europejskich modeli *welfare state*. Klasyczna klasyfikacja *welfare states*, zaproponowana przez Gostę Esping-Andersena [1], polegająca na wyróżnieniu trzech modeli (trzech światów państwa kapitalistycznego): liberalnego, konserwatywnego i socjaldemokratycznego, była przedmiotem uzupełnień i modyfikacji pod wpływem krytyki oraz analiz badających zarówno koherencję w ramach każdego z typów, jak i realne zróżnicowania między państwami [2–4]. W ich wyniku wyróżnia się obecnie w Europie pięć rodzajów państwa opiekuńczego, dodając model południowoeuropejski (śródziemnomorski) oraz postkomunistyczny.

Typologia *welfare states* opiera się przede wszystkim na kryteriach polityczno-instytucjonalnych w zakresie polityki społecznej i rynku pracy: stopień dekomodyfikacji w stosunkach pracy (*the degree of decommodification in labour relations*) oraz odmienne proporcje między udziałem państwa, rodziny, rynku oraz organizacji społecznych w zaspokajaniu potrzeb ludzi. Biorą też pod uwagę poziom społecznej stratyfikacji.

W dotychczasowych badaniach i rozważaniach na temat modeli *welfare state* kraje postkomunistyczne nie były analizowane w takim samym stopniu, jak kraje rozwiniętego kapitalizmu [5][1]. Obserwowano zarówno różnice ekonomiczne i instytucjonalne między krajami (z jednej strony kraje z posiadanymi wcześniej własnymi instytucjami państwowymi, a z drugiej – kraje postsowieckie bez własnych instytucji państwowych), jak i zmienność kierunków reformowania polityk społecznych w tych krajach [7]. Sformułowano tezę, że wykształca się w nich hybrydowy model polityki społecznej [8, 9], podlegający pewnemu ujednoliceniu na skutek dostosowywania się do regulacji UE.

Analizy prowadzone w ramach projektu „Pro-Health 65+" koncentrują się na tych właśnie grupach krajów, które w mniejszym stopniu były przedmiotem dotychczasowych analiz: europejskich krajach postkomunistycznych i krajach Europy Południowej. Dwa kraje

Analizowane kraje	Model w klasyfikacji państw opiekuńczych	Źródła
Holandia	Socjaldemokratyczny Bismarkowski	według Esping-Andersena 1990 [1] według Ferrery 1996 [3]
Niemcy	Konserwatywny Bismarkowski	według Esping-Andersena 1990 [1] Ferrery 1996 [3]
Włochy	Śródziemnomorski	według Ferrery 1996 [3]
Portugalia	Śródziemnomorski	według Ferrery 1996 [3]
Grecja	Śródziemnomorski	według Ferrery 1996 [3]
Polska	Postkomunistyczny: hybryda modelu liberalnego, śródziemnomorskiego i konserwatywnego	według Księżopolskiego 2008 [8], Golinowskiej 2009 [9]
Czechy	Postkomunistyczny: mieszany system modelu socjaldemokratycznego i liberalnego	według Klimentovej i Thelenovej 2014 [10]
Węgry	Postkomunistyczny: mieszany system modelu liberalnego i konserwatywnego	według Szalai 2013 [11]
Bułgaria	Postkomunistyczny: mieszany system modelu liberalnego, śródziemnomorskiego i socjaldemokratycznego	według Tache, Neesham 2011 [12]
Litwa	Postsowiecki: mieszany system modelu liberalnego i socjaldemokratycznego na niskim poziomie świadczeń	według Aidukaite 2013 [13]

Tabela I. *Usytuowanie analizowanych krajów w klasyfikacji* welfare state.
Źródło: Zestawienie własne.

rozwiniętego kapitalizmu: Niemcy i Holandia, stanowią kraje odniesienia ze względu na wpływ ich rozwiązań instytucjonalnych na kraje postkomunistyczne.

Tradycyjne klasyfikacje modeli *welfare state* w ograniczonym stopniu uwzględniały różnice w systemach zdrowotnych, które podlegały licznym reformom, niezależnie od tego, czy kraj sytuowano w grupie konserwatywnej, czy innej. Wprawdzie podjęta została próba klasyfikacji uwzględniająca systemy zdrowotne [14, 15], ale brała pod uwagę głównie mechanizm instytucjonalno-finansowy opieki zdrowotnej i tylko kraje OECD. W innych podejściach łączono *welfare state* i zdrowie z kapitałem społecznym [16] lub z nierównościami [17, 18].

Także status zdrowotny populacji długo nie był włączany do tej typologii jako kryterium wyróżniające klasyfikowane modele [19, 20], chociaż wraz z rozwojem badań w zakresie nierówności zdrowia podjęto analizy różnic w zdrowiu w krajach o różnych systemach *welfare states.* Brano pod uwagę takie wskaźniki, jak: umieralność niemowląt, niska urodzeniowa masa ciała [21], samoocena stanu zdrowia czy przeciętne trwanie życia [17, 21].

Pojawiło się także pytanie o miejsce zdrowia publicznego oraz promocji zdrowia w typologiach dotyczących modeli *welfare state*. W amerykańskiej analizie empirycznej prowadzonej w latach 1998–2006 [22] dokonano próby usystematyzowania organizacji zdrowia publicznego w różnych miejscach USA. Wyróżniono na wstępie trzy dominujące cechy funkcjonowania instytucji zdrowia publicznego: zróżnicowanie, integrację i centralizację. W rezultacie badania uzyskano siedem kombinacji (klastrów) organizacyjnych i stwierdzono, że dynamika zmian nawet w ciągu ośmiu lat była zbyt duża, aby można było uznać pogrupowania za trwałe. Autorzy zwrócili uwagę na czynniki, które to powodowały, takie jak zmienność w strukturze potrzeb zdrowotnych, nowe tendencje epidemiologiczne (dominacja chorób przewlekłych) i znaczny wpływ środowiska naturalnego, a także zmiany stylu życia pod wpływem nowych technologii. To utrudnia tworzenie typologii o długookresowym znaczeniu [22]. Jednocześnie autorzy wskazywali drogę, która w praktyce jest trudna do osiągnięcia – połączenie wielości i pluralizmu z koordynacją opartą na przemyślanych narzędziach wypracowanych centralnie.

Jak się mają rozwiązania instytucjonalne oraz poziom wydatków w zakresie zdrowia publicznego w powiązaniu ze statusem zdrowotnym populacji w krajach o różnym reżimie instytucjonalnym, stało się pytaniem obecnym w badaniach dopiero ostatnich lat [23]. Idąc w ślad za nimi, także w ramach projektu „Pro-Health 65+" podjęto analizę rozwiązań instytucjonalnych oraz poziomu i efektywności wydatków na zdrowie publiczne i promocję zdrowia w wybranych krajach europejskich. Do analizy promocji zdrowia dla osób starszych wybrano następujące kraje: dwa kraje z grupy zamożnych krajów Europy

kontynentalnej: Holandię i Niemcy, trzy z grupy krajów Europy Południowej: Włochy, Portugalię i Grecję, w których styl życia i warunki klimatyczne sprzyjają dłuższemu jego trwaniu, oraz pięć krajów Europy Środkowej i Wschodniej: Polskę, Czechy, Węgry, Bułgarię i Litwę, kraje z największymi problemami dobrej jakości życia w jego dłuższym trwaniu.

W wytypowanych do analizy krajach eksperci z nich pochodzący odpowiadali na pytania sformułowane w przygotowanym w ramach projektu *template*, udzielali odpowiedzi na bezpośrednio zadawane pytania i – w końcu – byli pierwszymi czytelnikami raportów, a także je uzupełniali. Prezentujemy je w tym numerze „Zeszytów Naukowych Ochrony Zdrowia. Zdrowie Publiczne i Zarządzanie".

Obraz, jaki się wyłonił z eksperckich rozpoznań, jest zróżnicowany, ale zarazem widoczne są podobne tendencje.

- Starzenie się populacji w krajach europejskich powszechnie wywołuje działania związane z aktywizacją i podtrzymaniem zdrowia osób starszych. Sprzyja temu strategia aktywnego i zdrowego starzenia się Unii Europejskiej. W biedniejszych krajach postkomunistycznych są to działania przede wszystkim prawne. Uchwalane są ustawy o zdrowiu publicznym akcentujące promocję zdrowia. W zamożniejszych krajach Europy kontynentalnej: w Holandii i w Niemczech, w ślad za takimi regulacjami, *nota bene* podejmowanymi kilka lat wcześniejszej, idą już liczne działania praktyczne adresowane do osób starszych.
- Promocja zdrowia nie zawsze jest jednoznacznie zdefiniowana i nie są wskazane dla niej odpowiednie rozwiązania organizacyjne. Działania w tym zakresie podejmowane są zarówno przez liczne podmioty publiczne: na szczeblach centralnych, regionalnych i lokalnych, jak i prywatne oraz społeczne. Znaczny zakres aktywności w dziedzinie promocji zdrowia inicjują i prowadzą organizacje pozarządowe. Instytucjonalny obraz działań promocji zdrowia i prewencji jest znacznie bardziej zróżnicowany niż opieki zdrowotnej, dla której zostały zdefiniowane granice i w znacznym stopniu wystandaryzowane procedury postępowania medycznego.
- Sektor zdrowotny i środowisko profesjonalistów medycznych stanowią decydującą siłę w stymulowaniu rozwoju promocji zdrowia ogólnie i w odniesieniu do osób starszych w każdym z analizowanych krajów. Jednak nie zawsze jest ona wykorzystywana do promowania zdrowia i interwencji w zakresie prewencji chorób przewlekłych. W krajach zamożniejszych przeważa sceptycyzm dotyczący dostatecznie udowodnionych programów prewencyjnych jako sprzyjających zdrowiu. W krajach biedniejszych – o niskich wydatkach na ochronę zdrowia – to brak zasobów (funduszy i kadr) jest decydujący dla ograniczonego zakresu działań pozaleczniczych.
- W większości krajów europejskich istnieją środowiska eksperckie, często skupione w agencjach ministerstwa zdrowia, w centralnych instytutach badawczych (narodowych instytutach zdrowia) czy na uczelniach, które podejmują badania efektywności promocji zdrowia i prewencji chorób przewlekłych w populacji ogólnej oraz także kierowanej do osób starszych. Reprezentanci z tych środowisk uczestniczą w europejskich projektach dotyczących promocji zdrowia, tworzą międzynarodowe sieci instytucji lub sieci ekspertów. Publikują, oceniają i opisują dobre praktyki, podejmują nowe inicjatywy. Stają się największymi rzecznikami promocji zdrowia i działań prewencyjnych.
- Osoby starsze coraz częściej aktywnie uczestniczą w tworzeniu planów, programów oraz konkretnych akcji promocji zdrowia i prewencji chorób przewlekłych. To uczestnictwo umożliwiają instytucje partycypacji społecznej osób starszych w podejmowaniu decyzji publicznych. Taki rodzaj instytucji partycypacyjnych został stworzony w Polsce w ramach wprowadzonej w latach 2012–2013 polityki senioralnej. Partycypację osób starszych wspierają projekty europejskie, dofinansowując tworzenie sieci specjalnych konferencji z udziałem *policy makers* oraz programów medialnych.
- Na działania promocji zdrowia i prewencji chorób przewlekłych wszędzie brakuje funduszy. Głównym ich źródłem są bowiem środki sektora zdrowotnego (także społecznych ubezpieczeń zdrowotnych, jak w Niemczech czy w Polsce), te zaś konkurują ze środkami na opiekę zdrowotną. Programy promocji zdrowia są więc dofinansowywane ze źródeł organizacji społecznych (fundacji, stowarzyszeń, specjalnych zbiórek itp.) oraz prywatnych (firm oraz przez indywidualne opłaty uczestników i beneficjentów programów). Ta sytuacja może zwiększyć ryzyko nierówności w dostępie do podtrzymywania zdrowia osób starszych.

W sumie trudno o koherentny obraz tendencji oraz typów instytucjonalnych w odniesieniu do promocji i prewencji chorób przewlekłych osób starszych w analizowanych krajach europejskich. Następuje natomiast rozwój programów promocji zdrowia i prewencji zarówno co do ich rodzajów, jak i pod względem ilościowym. Jednak ich dostępność jest ograniczona, co może przyczyniać się do wzrostu nierówności w zdrowiu. Aby temu przeciwdziałać, podejmowane są w różnych krajach nowe inicjatywy legislacyjne oraz wyznaczane środki publiczne na ich finansowanie. Niektóre z tych inicjatyw (np. w Niemczech ustawa prewencyjna, a w Portugalii o edukacji zdrowotnej) ewidencjonują prezentowane raporty krajowe. Ocena wpływu tych nowych działań regulacyjnych na zdrowie osób starszych będzie (powinna być) kolejnym krokiem w badaniach.

Przypisy

[1] Ukazują się wprawdzie prace, w których podejmuje się próby klasyfikacji polityki społecznej w krajach postkomunistycznych, lecz na ogół nie mają one pogłębionego charakteru i bywa, że piszą je doktoranci z innych regionów świata i z perspektywy raczej normatywnej, np. [6].

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Stanisława Golinowska, Milena Pavlova

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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Stanisława Golinowska, Milena Pavlova

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Advocated but Sidelined: Health promotion for the elderly in the Netherlands

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Abstract

Health promotion (HP) in the Netherlands is the responsibility of both the national (the Ministry of Health, Welfare and Sport) and local governments. Two government organizations are involved in the development, implementation and monitoring of HP: the Dutch Institute of Public Health (RIVM) and The Netherlands Organization for Health Research and Development (ZonMw). Within RIVM, the Center for Healthy Living (Loketgezondleven.nl) has been established. ZonMw subsidizes the Academic Collaborative Centers (ACC) in eight areas which together cover the whole of the Netherlands. ACC centers are responsible for transferring evidence based scientific knowledge into practical activities. Also, health promotion "thematic" institutes such as the TRIMBOS institute (Institute for mental health) and NISB (Dutch Insitute for Sport and Physical Activity), the GGDs (the municipal institutes for public health), general practitioners and work and health professionals (Arbo-coördinators) are actors in HP.

There are two laws that regulate the role of HP namely: The Public Health Law ("Wet publieke gezondheid") (Wpg), and the Social Support Act (Wmo).

Funding for HP comes from the central government, local municipalities, health insurance companies and regional care offices. Health insurance companies are mostly responsible for financing indicated and disease related HP. Evidence from Loketgezondleven.nl shows that only few HP are efficient and effective. Because of this both municipalities and insurance companies are reluctant to invest in HP. HP for elderly are mostly financed by public sources and, basic health insurance premiums but also through patient payments.

Key words: **financing, health promotion, The Netherlands**

Introduction: Health promotion in the Netherlands: developments, current organization and financing

Health promotion (HP) appeared in the Netherlands in the 1970s [1]. At that time, it was primarily the enthusiastic work of small group of health care professionals and volunteers. HP was focused on low-key interventions such as spreading information about a healthy life style [2]. The national government was responsible for the design and volume of HP. In the period 1980–2000, HP has grown [1]. The number of health professionals involved in HP has increased, the type and the extent of intervention have also grown and they have become a well-planned system of activities [3]. At the same time, it was recognized that HP should tackle the health problems specific for certain population groups and certain areas [4]. Because of this, the responsibility for HP – their planning, implementation and financing was shifted from the central government to the local level (municipality) [1]. Currently, HP in the Netherlands is an important part of the broader public health care system and consequently is related both central and local governments. However, in this paper we will not focus on the organization of Dutch health care system and the position of public health care and HP within it. We rather focus on HP (particularly those related for the elderly) and their financing within this system. Therefore we describe the organizations and stakeholders relevant for financing HP. The detailed description of the Dutch health care system can be found elsewhere (please see: Schäfer W.,

Kroneman M., Boerma W., van den Berg M., Westert G., Devillé W., van Ginneken E.V., *The Netherlands: health system review*, "Health Systems in Transition" 2010; 12: V–XXVII).

Similar to other services included in public health care system, HP services are the responsibility of both national and local government [2, 5]. The national government has established institutions for the development, implementation, organization, funding and evaluation of HP. The two most important institutions are The Netherlands Institute for Public Health (RIVM) and The Netherlands Organization for Health Research and Development (ZonMw) [5]. In 2006, the Dutch Ministry of Health, Welfare and Sport (VWS) has founded the center for Healthy Living (Loketgezondleven.nl) within RIVM (https://www.loketgezondleven.nl). The goal of this center is to strengthen the effectiveness and coherence, and to monitor HP in the Netherlands. All HP, including those that are not funded by public sources and those that are not evidence-based should be registered in one database available on Loketgezondleven.nl [6]. Registration also means complying with certain criteria's such as a theoretical background, epidemiological and health relevance, implementation plan and evaluation (including effectiveness of HP towards health problems and cost-effectiveness) [2, 6]. Each HP is assessed by a group of independent experts before is officially registered [6]. The Netherlands Organization for Health Research and Development (ZonMw) is another important stakeholder related to HP. ZonMw focuses on the effectiveness, funding and collaboration of all parties related to HP. In order to provide better collaboration between policy makers, practitioners and researchers involved in HP, with money received from the Ministry of Health, between 2008 and 2016 ZonMw has also subsidized the eight regional Academic Collaborative Centers (ACC) within the National Program Elderly Care ('nationaal programma ouderenzorg'). From 2017 onwards this is continued within the program 'Better Older' ('BeterOud') which focusses on improving the quality of life for elderly people. ZonMw is also directly funds HP interventions [1].

The Dutch Ministry of Health considers health protection (Gezondheidsbescherming)and health promotion (Gezondheidsbevordering) as the main elements of public health policy [7]. The distinction between health promotion and health protection is based on the types of measures that are applied in order to implement the intervention. Health prevention includes measures that are applied routinely and that do not need active involvement of citizens (such as hygienic measures in preventing contiguous diseases). Health promotion includes measures that aim to affect both individuals and groups and that are applied in their social environment [16]. For the period 2014–2016, The Ministry of Health, Welfare and Sport has developed a national policy related to health prevention known as the Nationaal Programma Preventie (NPP) (https://www.rijksoverheid.nl/onderwerpen/gezondheid-en-preventie/inhoud/nationaal-programma-preventie).

The NPP is a strategy to secure collaboration between different partners including municipalities (gemeenten), health workers, health organizations, sport clubs and sport workers, health insurance companies, schools and NGOs. The main interest of NPP is to support HP related to prevention of obesity, alcohol consumption, and smoking and to increase participation in physical activities. NPP is also focused on prevention programs related to adequate use of antibiotics. NPP is widely known through the website "Alles is gezondheid" and focuses on several areas (sectors): work (*op het werk*), educational environments (*op school*), health environments (*in de zorg*) and neighborhoods (*in de wijk*). The evaluation of NPP is assigned to ZonMw, while the monitoring is done by the RIVM. Besides the health prevention strategy, the ministry of health also pays attention to health promotion. This includes promotion of a healthy life style, promotion interventions related to addiction, promotion interventions related to obesity, fall prevention and promotion of qualitative and accessible care [7]. Although NPP and other national policies officially overrule the local policy, municipalities are seen as main stakeholders for HP and local policies are also embedded within the national prevention policy [3]. Municipalities are responsible for social support arrangements, are involved in developing HP, their funding and involvement of all other important community members. Also, municipalities are responsible for HP through the Municipal Public Health Service -GGD (Gemeentelijke gezondheidsdienst) [5]. They are involved in different areas of HP relevant for their region and they are targeting different population and ageing groups.

The role of HP in the Netherlands and the responsibilities of national and local governments are defined by two laws: The Public Health Law ("Wet publieke gezondheid") (wpg) enacted in 2008 and the Social Support Act (wmo) that was enacted in 2007. The Public Health law regulates the responsibilities of national and local organizations in developing, implementing, evaluating and funding HP. Through this law it is also defined that the major role regarding the HP will be given to municipalities (gemeenten). The Social Support Act was extended in 2015 to include social support for people with disabilities and elderly to continue living in their homes and to enable them to participate in society. This law enables the development of HP that encourages social inclusion of older adults.

Some of the responsibility for financing and implementing HP is also given to the insurance companies in the Netherlands. This is defined by the Health Care Insurance Act (Zvw). Since 2006, the Dutch health care system is financed through the system of managed competition where the government has a regulatory role. Each citizen in the Netherlands is obliged to buy a basic insurance package from one of the nine private insurance companies. The government has the role of regulator and determines the necessary services that are covered by the basic insurance package. According to the Zvw, indicated prevention (interventions related to individuals that are not sick but have high risk to become sick in the future

according to their physician or GP) and diseases-related prevention (interventions related to individuals diagnosed with certain diseases in order to decrease the side effects of diseases such as physical activity on prescription (PARS)) can be covered in the insurance package. The minister of health decides on the content of the basic insurance package.

HP in the Netherlands, includes a broad scope of interventions that cover different areas of health such as mental health, healthy life style (prevention of smoking, alcohol consumption and obesity) and environmental health promotion, while special attention is given to youth population groups, vulnerable groups (migrants, homosexuals etc.) and older adults. HP follows an integrated approach that is also represented in curative care [3, 4]. This means that HP usually includes several different interventions proven to be effective.

Like in other European countries, within the Dutch health care system, a distinction is made between primary prevention (interventions to prevent the onset of diseases), secondary prevention (interventions to detect the diseases in early stage) and tertiary prevention (interventions to decrease negative effects of already diagnosed diseases). Based on the target groups that HP aim to address, a distinction is made between universal prevention (targeting the whole population), selective prevention (targeting the groups that are at risk to develop diseases), indicated prevention (targeting groups that are still not diagnosed with certain diseases but have high probability to be so), disease-oriented prevention (targeting population groups with already diagnosed diseases in order to decrease adverse effects). Indicated and disease -oriented prevention use individual interventions as a tool, while universal and selective prevention are mostly community based. We have also described other distinctions that are used to classify HP in **Appendix 1** [8]. These distinctions are also used by main stakeholders to describe responsibilities regarding the funding and financing of HP.

HP for the older adults is organized in a similar way as HP in general. The national strategy that regulates HP for older adults is based on several policy documents and it is best reflected through integrated prevention based programs such as Nationaal Programma Ouderenzorg [9] and BeterOud (BeterOud.nl). The main goal of this program is to provide healthy independent living of older adults including fall prevention, mental health prevention and social inclusion [8, 10]. On the local level, the main role for HP for older adults is given to municipalities and the GGD. Many municipalities have already formed centers for older adults. Their goal is to provide information on health prevention, curative care and social support for older adults. Also, many different organizations are directly involved in HP for older adults. They include not only public institutions but also foundations, NGOs and semi-governmental organizations. Particular attention is paid to HP for vulnerable population groups such as

Based on target groups	**Description**
Universal prevention	targeting whole population
Selective prevention	targeting the groups that are at risk to develop diseases
Indicated prevention	targeting groups that are not diagnosed with a disease but have high probability to be according to their GPs
Diseases-oriented prevention	targeting population groups with already diagnosed diseases in order to decrease adverse effects or to influence the progress of the disease
Based on type of health care process	
Primary prevention	interventions to prevent the onset of diseases
Secondary prevention	interventions to detect the diseases in early stage
Tertiary prevention	interventions to decrease negative effects of already diagnosed diseases
Based on type of measures	
Health protection	Measures that are taken as a routine without practical involvement of citizens (safety roads)
Diseases prevention	Measures that are specifically focused on prevention of certain diseases
Health promotion	Measures that are focused on physical and social environment and life style of individuals and groups
Based on applied methods	
Organization of social and physical environment	smoke-free schoolyards, changes in the infrastructure of disadvantaged neighborhoods and social support residents
Regulations	Laws, taxes, advertising policies
Information and education for groups	educational programs on healthy lifestyle at school and national publicity campaigns
Signaling and individual advices	Screening programs in rural areas, prevention consultations
Support	GP advices

Appendix 1. *Divisions of HP based on different criteria.*
Source: Own work.

older migrants and older homosexuals [11]. The Social Support Act (Wmo) aims to promote self-reliance. For older people this means that they should be able to live independently in their homes as long as possible. The aim of the Social Support Act is to help them to stay independent. Most municipalities use social neighborhood teams to decide whether support is needed. These social neighborhood teams can allocate household help (for cleaning the house) or other forms of social support such as transportation (mobility) and access to social activities. Based on personal circumstances, the social neighborhood team can decide to provide a professional if informal support is not available and elderly people are not able to participate in society without help. Persons eligible for professional help can opt for in kind support or can use the monentary equivalent – a personal budget - to organize help by themselves. Since the aim of social support act is to secure that older people can live independently, they also have a role in HP [16].

For both HP in general and HP for older adults, the main challenges include providing stable funding, maintain health benefits and decrease health inequalities [4]. Institutionalization of the existing interventions is also one of the challenges. Those challenges are considered as the main obstacles to the sustainability of HP. The Ministry of Health provides most of the funding for HP, but HP are also funded through private and other types of sources (international funding such as EU projects) However, there is still reluctance from the side of main stakeholders to finance HP [16]. Their major concern is related to lack of data on the effectiveness of HP.

In the **Box 1** we present relevant indicators on public funding of HP. Since one of the main goals of HP is to decrease health inequalities reflected in epidemiological outcomes such as life expectancy at different age and among different income and education groups, we also present those data in **Box 2**.

	2013	2014	2015*	2016*
Total health care expenditure as a percentage of GDP	11.0%	10.9%	–	–
Public health care expenditure as a percentage of total health care expenditure	87.6%	87.9%	–	–
Health prevention expenditure as a percentage of public health expenditure	17,1%	21,4%	15.7%	15,4%
Health promotion expenditure as a percentage of public health expenditure	8,9%	11,1%	8,4%	7,9%
Data are obtained from: Het Centraal Bureau voor de Statistiek (CBS) through web-platform StatLine (statline.cbs.n)				

* Data for 2015 and 2016 are estimated not real values.

Box 1. *Indicators related to health care system funding and HP.*
Source: Dutch Statistical Office, http://statline.cbs.nl/Statweb/?LA=en; assessed: May 2016.

Remaining life expectancy at	Age 55		Age 60		Age 65		Age 70		Age 75		Age 80	
	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female
Lowest income	23.3*	26.3	19.5	22.2	15.8	18.1	12.4	14.4	9.4	10.8	6.6	7.4
Low income	26.3	31.0	22.2	26.7	18.3	22.6	14.7	18.8	11.5	15.1	8.6	11.8
Middle income	28.1	31.8	23.8	27.4	19.7	23.2	15.9	19.1	12.4	15.1	9.3	11.6
Higher income	28.4	32.4	24.3	27.8	20.1	23.4	16.0	19.2	12.4	15.1	9.2	11.4
Highest income	29.8	31.9	25.2	27.2	20.8	22.7	16.7	18.3	12.8	14.2	9.4	10.4
Remaining life expectancy at	Age 55		Age 60		Age 65		Age 70		Age 75		Age 80	
	Male	Female	Male	female	Male	Female	Male	Female	Male	Female	Male	Female
Basic education	25.0	28.1	20.9	23.9	17.1	19.8	13.6	15.9	10.5	12.1	7.7	8.6
Vmbo	26.1	30.1	21.8	25.7	17.8	21.5	14.1	17.4	10.8	13.6	8.0	10.2
Havo vmo mbo	27.0	31.7	22.7	27.2	18.6	22.9	14.9	18.8	11.3	14.8	8.3	11.3
Hbo university	29.1	33.0	24.6	28.4	20.3	23.9	16.2	19.6	12.6	15.8	9.5	12.2

Box 2. *Population ageing indicators.*
Source: Dutch Statistical Office, http://statline.cbs.nl/Statweb/?LA=en; assessed: May 2016.

Source of funding	Beneficiary	Additional Comments
Taxes *Including:* – general taxes – local taxes – earmarked taxes	**General taxes** are used by Ministry of Health for funding health promotion activities. In 2015, it was estimated that around 53.554.000 euros was spent on HP. Money is particularly allocated to HP related to prevention of unhealthy behavior (smoking, obesity, alcohol consumption) and to promotion of physical activities such as: Sport en Bewegen in de buurt by Sportimpuls [7]. **Local taxes** are used by municipalities to fund HP relevant to the particular areas [7]. **Earmarked taxes** are not used to fund HP [7].	Ministry of Health, Welfare and Sport use general taxes to fund HP through different patterns. In some cases like in cases the money is send to ZonMw and from ZonMw to thematic institutes who then fund particular HP. In some cases resources coming from general taxation are also sent to municipalities who then fund particular HP [2]. The ministry of health uses different instruments to fund HP. One is subsidies. Major subsidies for mental prevention are given to TRIMOBOS (Dutch institute for mental health). For decreasing obesity Ministry of Health subsidize Het Convenant Gezond Gewicht which is a cooperation that involves 26 different parties: governments, businesses and different civil society organizations that work together to achieve a decrease in overweight and obesity. The subsidies for fall prevention for older adults are given to non-profit foundation de Stichting Veiligheidnl and they approximately 4 million of euros [7]. Besides subsidies, Dutch Ministry of Health also gives contributions to RIVM and ZonMw particularly for HP and contributions to municipalities.
Health insurance premiums *Including*: – voluntary and/or private insurance	All citizens in the Netherlands pay for the basic health insurance. The package includes many services and among them access to GPs. All HP that are prescribed by GPs are available through this basic packages [12].	Some HP although prescribed by GPs include small amounts of out-of-pocket patient payments [13].
Other public institutions	RIVM and ZonMw as well as thematic institutes (TRIMBOS, NISB) can also act as funding agents for HP. They use public money that is received from Dutch Ministry of Health. GGD receive subsidies from municipalities and governments. They can also use those sources to fund HP.	
Other sources:		
Funds from the employers		
Households	"Eigen bijdrage" is Dutch term for out-of-pocket patient payments. Those payments related to HP are present but include small nominal amounts up to 50 euros per person per year. Some of these payments can be also refunded [14].	
Foundations	There are many foundations that are involved in funding HP. They use donations that they receive from business organization but also subsidies that they receive from government and/or municipalities. Some of those foundations are consider as semi-governmental organizations.	**Vilans** is a specialized organization that provides knowledge related to long-term care. It is also, involved in prevention of loneliness and dementia among elderly. The Groninger Active Life Model **(GALM)** exists 17 years. GALM has been able to develop thanks to start-up grants and cooperation with various parties: the Ministry of Health; the Dutch Heart Foundation; ZonMw; NOC * NSF; Elderly Assistance Fund; Dutch Institute for Sport and Exercise; Royal Dutch Gymnastics Union; GALM is also part of four national campaigns of the Ministry of Health namely "Netherlands on the Move", the "FLASH campaign", the "Sports For Plus50"and the "Dutch Action Plan for Sport and Exercise". Additionally GALM is funded through municipalities and by the contribution of the participants. The GALM Foundation also collaborates with the University of Groningen – Interfaculty Center for Human Movement Sciences.
Foreign	Resources coming from European projects.	The problem with HP that founded by European funds is that they cease to exist after the projects are over. The lack of sustainable funding is the main obstacle although some of these HP are considered as valuable for older adults.
Others		

Box 3. *Potential sources of funding HP – who is funding HP.*

Source: Own work.

- **Financing of health promotion interventions for older adults**

The central government and the municipalities are the main stakeholders responsible for providing funding for HP (**Box 3**). Municipalities are also involved in the implementation and financing of HP. They are the main stakeholders in financing universal and selective HP and they also play a role in financing disease-related HP. Besides municipalities responsibilities to finance HP are also given to health insurance companies (zorgverzekeraars). Health insurance companies are mostly responsible for financing indicated and disease related HP. Besides their responsibilities given by law, health insurances companies and municipalities may also have a financial interest to finance HP. Evidence shows that older adults who have a healthier life style live longer (on average 7 years more), than those with unhealthy life style. However, their average health expenditures are similar. Since older adults with healthier life style live longer, they also pay premiums to the insurance longer [16]. Taking in account that HP have higher social than individual effects, municipalities may also benefit from financing HP. From the point of view of municipalities, investing in HP will not only lead to a longer and more happy life of older adults, but will also decrease the need for formal social support provided by the municipalities.

The evidence from Loketgezondleven.nl shows that only few HP are efficient and effective [16]. This means that both municipalities and insurance companies are reluctant to invest in HP. Many municipalities find it important to allocate sources to more proven cost-effective interventions within their social support arrangements such as youth care, than to invest in HP with unclear benefits. Also, within the Dutch health care system there are several negative incentives for both municipalities and insurance companies that make them more reluctant to invest in HP [16]. Those incentives are related to the organization and/or financing of the health care system. For example, municipalities can invest in HP, but benefits may be higher for insurance companies than for municipalities itself. This is for example the case within HP that aims to monitor homeless people. In this case in Den Haag, the municipality has invested 26.696 euros while the financial benefit is 30.420 euros. On the other side, health insurance companies did not invest in this HP, but they also have benefits estimated at 15.000 euros [16].

The Dutch health care system is carried out by 9 insurance companies of which the 4 largest have a market share of more than 90%. An insurance company that decide to invest in HP has to take in account that people may change insurance company and that other companies also benefit. This is related to the nature of HP-most of them yield benefits only after a longer period of time. According to the Dutch law, once per year during a period of 6 weeks each individual can change insurance company. Another negative incentive is related to the Risk Equalization Fund. In the Netherlands, health insurance is compulsory and health insurance companies are obliged to provide basic insurance to everyone irrespectively of health status. To avoid risk selection and to create a level playing field among insurance companies, the government has established the Risk Equalization Fund. The fund is financed by income - related premiums. The funding insurance companies receive from the risk equalization fund are to a large extent based on costs for health care made in the past. This provides a disincentive to engage in prevention to avoid making costs for health care.

In order to provide more structural and stable financing for HP, several new models have been proposed. These include:

Regional funds for prevention – it aims at shared responsibility between health insurance companies and municipalities. Also, this fund guarantees that the costs related to HP are also equally shared.

Health impact bond is a contract between the government (central or local) and the organization that implement HP. The sources for HP are obtained from external investors. The government pays to the organization only if the HP has some social impact. The example is the contract between Buzinezzclub, ABN Amro, Start Foundation and local municipality Rotterdam. ABN Amro and Start Foundation invest in Buzinezzclub that provides jobs for young unemployed and unqualified people. The municipality pays back to investors using the savings in social benefits.

Shared savings refer to the situation when the insurance company and/or provider receive a portion of the saved costs because of HP. This portion is usually predetermined.

Although attention for these social innovations is high, none of these alternative financial arrangements have been truly implemented.

Besides the financial models mentioned above, there are many other pilot models that try to aim to provide sustainable financing of HP. They include prevention costs groups in risk equalization, long term policies for prevention and health transfer systems. The evidence from RIVM shows that the majority of HP is financed by municipalities and/or insurance companies, while some of them also include financing from regional funds.

- **Health Promotion for Older Adults**

HP for Older Adults include fall prevention, HP related to physical activities, HP related to social inclusion and mental health of older adults and HP related to healthy life style of older adults [7]. In the **Table I** we present HP that are registered by the RIVM Center for Healthy Living and that are targeting adults older than 55. Also in the text below we present two HP that are targeting older adults and we describe their mechanisms of financing.

We present two examples of HP related to older adults: GALM which is a HP intervention related to physical activity of older adults and Pink Buddies, which is a HP intervention related to support and assistance of older homosexuals.

The Groningen Active Life Model (GALM) is a HP intervention that aims to increase the participation of older adults in physical activity. The target group is defined as individuals between 55 and 85 years. Interventions

include several different programs related to physical activities but also to diet advice and training advice. Activities are done in cooperation with sport leisure centers, local communities and within the houses of older adults. To finance the HP, GALM group use subsidies from national government, municipalities and ZonMw. The group also uses donations from different foundations such as NSF and the Elderly Assistance Fund. The group is also an active participant in the Dutch national program 'Netherlands on the move' ("Nederland in beweging") and has managed to obtain additional resources through this campaign. GALM is also cooperating with University of Groningen in order to obtain better quality of HP. Participants of the different programs might be asked to contribute financially – for example to be registered within the groups. Amounts vary and go from 1–3 euros. GALM exists now for 17 years and present a successful case of private-public financing of HP.

Roze Buddyzorg Amsterdam is HP for homosexual older adults. The HP intervention was launched by the Schorerstichting – a foundation established in 1968. The goal of HP was to provide a buddy-a regular visitor to older homosexual people in their homes. The buddy can provide care but also do activities together with older adult. The foundation received funding from the municipality of Amsterdam approximately 350 000 per year and subsidies from Dutch government approximately 650 000 euros per year (http://rozebuddyzorg.nl/?page_id=177). The foundation also received donations from members and business organizations to finance HP. However, the foundation did not cooperate with public institutes and other organization responsible for monitoring and evaluating HP. This resulted in suspension of public funding from both local municipality and from the state. Without this funding, it was not possible to finance HP since 2012. Nowadays, Roze Buddyzorg Amsterdam HP exists within the organization that has the same name: Roze Buddy Stichting, and is also funded by the government and private donations (http://rozebuddyzorg.nl/?page_id=177).

- **Organizations involved in Health Promotion**

National level institutions:

- ✓ **RIVM** – Dutch institute for public health with specialized centers such as **Centrum Gezond Leven** (www.loketgezondleven.nl). This is the center for health promotion and prevention. The main role is to emphasize the effective local health promotion activities.
- ✓ **ZonMw** – The Netherlands Organization for Health Research and Development. It is involved in the design, implementation, monitoring, and evaluation and funding of HP for older adults.
- ✓ **Health promotion "theme" institutes:** the TRIMBOS institute (Institute for mental health), NISB (Dutch Insitute for Sport and Physical Activity), VeiligheidNL (Dutch foundation for fall prevention), Soa Aids Nederland (Dutch foundation for sexually transmitted diseases), Pharos (Dutch foundation for migrant health).

Regional level:

Academic Collaborative Centers (ACC)-assist in the cooperation between policy makers, researchers and street-level health promotors.

Local institutions:

- ✓ **GGDs** are local institutes for public health. They are involved in prevention of infectious diseases, prevention of sexually transmitted diseases, vaccination programs, environmental health, tuberculosis control, public mental health, assistance with natural disasters, forensic care, health screening and health education, general hygienic, youth health, epidemiology, and policy development They are also involved in community health prevention activities related to the elderly (wpg).The GGD is responsible for the health education and for developing, support and realization of health promotion and health prevention activities for elderly such as prevention of depression, loneliness, promotion of active movements, prevention of accidents and fall prevention, promotion of healthy nutrition and informal care (mantelzorg). GGDs also monitor the health status of the (elderly) population.
- ✓ **Professionals related to specific districts and towns** such as social workers or workers within institutes for family care. Those professionals help specific groups of older adults such as elderly migrants, homosexual older adults etc.
- ✓ **GPs and health professionals involved in home care** (thuiszorg) – their role is to inform and encourage older adults to participate in HP, when applicable. Health care professionals in home care also encourage HP related to social inclusion of older adults, healthy eating and may help them to live in their home as long as possible.
- ✓ **Medical specialists** are usually involved in HP for older adults that are already diagnosed with a chronic disease. Medical specialists may encourage HP of the patients.
- ✓ **Professionals specific for work – Arbo-coördinators** are health professionals involved in HP for working older adults.
- ✓ **Health insurance companies** also contribute in implementation and financing of HP for older adults. They contribute by providing the donations for some HPs or by financing HP included in the basic insurance package.

- **Social Assistance Sector**

The Social Assistance Sector is included in HP for older adults through municipalities. Municipalities organize HP together with GPs and social sector institutions. The social sector is mostly focused on HP related to social inclusion of older adults and independent living [10].

- **NGO Sector**

There are NGOs specifically oriented towards HP for older adults as the main contributor or as a co-partner. The majority of the NGOs work together with municipalities and they are very often subsidized by municipalities.

	Type of activity	Responsible organization	Who is funding	Organizations that are involved
In de put, uit de put 55+: zelf depressiviteit overwinnen	Healthy life style Physical activity	No data available	No data available	No data available
Vallen Verleden Tijd	Fall prevention Motor development	Sint Maartenskliniek	ZonMw (The Netherlands organization for Health Research and Development)	Nederlands Paramedisch Instituut
Blijf Staan	Physical activities Fall prevention	VeiligheidNL	No data available	Actiz
Zicht op Evenwicht	Depression Physical activity Fall prevention	Trimbos institute	Government	Trimbos institute
Op verhaal komen	Depression Stress	University Twente	Health insurance	No data available
Functionele Training Ouderen (FTO)	Fall prevention Physical activity	TNO Behavioral and Societal Sciences	Health insurances ZonMw	No data available
Halt! U valt	Fall prevention	VeiligheidNL	No data available	No data available
	Type of activity	**Responsible organization**	**Who is funding**	**Organizations that are involved**
In Balans: valpreventie programma voor ouderen	Fall prevention Healthy life style Rheumatology	VeiligheidNL	Own resources from foundation and participants fees Government National funds	Municipalities Thuiszorg (home care) Health insurance companies
Denken en Doen	Sport Social inclusion	Nederlandse Bridge Bond	Municipalities	No data available
Valanalyse 65+ voor de eerstelijnszorg	Fall prevention Sport activities	VeiligheidNL	Government Own resources from organization	V&VN NVvPO
Sociaal Vitaal	Healthy life style Physical activities	GALM foundation	Municipalities National government Regional government Tijdelijke stimuleringsregel	Local welfare funds GGD (Dutch regional institutes for public health) Health institutions Sport organizations GGZ-instelling Local GPs
Het OTAGO thuisoefenprogramma	Fall prevention Physical activity	VeiligheidNL	No data available	No data available
	Type of activity	**Responsible organization**	**Who is funding**	**Organizations that are involved**
Ouderen in Beweging	Healthy life style	Yalp	Municipalities Organizational resources	Commercial organizations
Beweegtuin voor ouderen	Outdoor physical activity	Nijha b.v	Resources provided by organization	Zorgcentrum Beringhem Huize Salland Zorgcentrum Zandhove

Verbeterde zelfzorg in de thuissituatie voor Turkse mannen met diabetes	Life style Diabetes Overweight	GGD Hart voor Brabant	No data available	No data available
GALM	Physical activity Healthy life style	GALM foundation	Regional funds Municipalities National government Regional government	GGD Local organization for older adults Local welfare foundations
SCALA	Physical activities Chronic disorders Life style	GALM foundation	Regional funds Municipalities National government Regional government	GGD Health institutions Local organization for older adults Local welfare foundations
SMALL	Healthy life style Social inclusion	GALM foundation	Municipalities National government Regional government	Local welfare foundations Local sport organization Local organization for older adults
	Type of activity	Responsible organization	Who is funding	Organizations that are involved
Beweegpret 55+ aan zet	Healthy life style	Huis voor Beweging	Government Own resources by organization	No data available
Elke stap telt	Depression Healthy life style For older women	SportZeeland	Own resources by organization Regional government Sponsored by industrial companies	Welfare foundations IVN (instituut voor natuureducatie en duurzaamheid) KNBLO Woonzorgcentra voor senioren
Body-Mind Fit met aikido	Psychological health Fall prevention Healthy life style	Aikido Nederland	No data available	No data available
Ouderenzorg in Beweging	Healthy life style Physical activity	Sportief Besteed	Own resources	No data available
Oldstars/Walking Football	port Healthy life style	Eredivisie Media en Marketing CV	No data available	No data available
Fit4Life	Healthy life style	IJslander	Own resources	Top Health Partners
Goldensports	Fall prevention	Stichting GoldenSports	Municipalities	No data available
Zeker Bewegen	No data available	No data available	No data available	No data available

Table I. *HP interventions for older adults in the Netherlands-data provided by RIVM Gezonde Leven.*
Source: Own work

- **Health**

Welfare organizations, GPs, health centers, sports service agencies, general hospitals and other healthcare providers and emergency, together with health insurers and municipalities are involved in improving the health and increasing the participation of older people in the HP. The main activities for older adults are related to the use of the help of these integrated teams in order to live independently in their homes. One example of such HP is the intervention provided by Care Innovation Center Brabant. This organization helps older adults to use new technologies and new devices in order to stay living in their homes as long as possible. Special role is given to GPs. The older adults perceived them as trustworthy persons. HPs that are advertised or implemented by GPs usually have better success among the older adults, than large national interventions [8].

- **Sport and education**

NISB is the main stakeholder involved in HP for older adults through the sport sector. Other sport institutions mostly have executive roles - this means that they are involved in HP that are already designed by other stakeholders. Some institutions (leisure centers) receive subsidies from the Ministry of Health, while some others are involved voluntary, usually through municipalities.

- **Work places**

Healthy adults can work full time at older age, but work can also contribute to better health during the aging process. This is the main paradigm of RIVM related to HP for older adults. Main stakeholders in this area involve work doctors and company management. Companies are encouraged to provide healthy restaurants and facilities for physical activities [15].

- **Neighborhoods**

There are huge differences between neighborhoods in the Netherlands when it comes to the physical and socioeconomic environment. In deprived neighborhoods for example, there is high unemployment, people eat unhealthier and children cannot always safely play outside. This causes health inequalities. Obesity, chronic illnesses and unhealthy behaviors lead to negative outcomes: in these neighborhoods, people live on average seven years less. GPs, district associations and health organizations, are jointly engaged in tackling the problems such as obesity, diabetes and loneliness in deprived neighborhoods. District organizations also help people to obtain better collective health insurance and to obtain better access for HP related particularly to older adults-for example leisure centers accessible to older migrant's women.

Conclusion

Health promotion in the Netherlands is financed through different institutions and combines public and private resources. This means that HP for elderly is financed by public sources, basic health insurance premiums but also through patient payments. This mix financing is useful to provide enough resources necessary for HP. Nevertheless, HP is financed more by public means than by private payments.

This is in accordance with organization of HP in the Netherlands. The main responsibility for HP is given to the central government and local municipalities. It is expected that local municipalities can best recognize the needs of their citizens. The role of local municipalities is particularly important for financing of HP for older adults. Following the introduction of the Social Support Act (wmo), the Dutch Ministry of Health has emphasized the importance of preventive measures for elderly that allow them to remain living independently in their homes and to actively participate in their communities. Municipalities can use the financial resources available through the wmo regulations for this.

Health insurance companies are also involved in financing of HP. Health insurance companies are mostly responsible for financing diagnosed and disease related HP that are covered by basic insurance packages,

The evidence stored at the Loketgezondleven.nl shows that only few HP are efficient and effective. This means that both municipalities and insurance companies are reluctant to invest in HP. In order to stimulate both insurance companies and local municipalities to invest more in HP, it is necessary to develop better tools for evaluating the HP and to assess their effects on target population groups.

For both HP in general and HP for older adults, the main challenges include providing stable funding, maintain health benefits and decrease health inequalities [4]. As we have mentioned above, in order to provide for sustainable funding, it is necessary to provide incentives for both health insurance companies and local municipalities. One way is to provide better information about the effectiveness of HP. Also, the use of financial incentives such as small user payments can contribute to sustainable funding of HP. Institutionalization of the existing interventions is also a challenge. This means that many HP are developed and implemented for certain period of time, but they do not become regular prevention programs within institutions. Those challenges are considered as the main obstacles to sustainability of HP. In order to make HP for older adults more sustainable and more adjusted to the needs of users, it is necessary to provide better data related to their effectiveness.

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Healthy ageing in Germany – common care and insurance funding. Institutional and financial dimension of Health Promotion for Older People

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Abstract

In Germany responsibilities for health promotion and prevention lies with a multitude of different actors and institutions. The institutional arrangement of health promotion is shaped by the German federal structure of the state on the one hand and by a health care system that is characterized by divided responsibilities between governmental organisations, self-administered bodies and non-governmental organisations on the other hand. Although federal-level programs are successfully implemented in the country, the attempt of the Federal government to consolidate and clarify responsibilities in the public health area meets resistance. The Preventive Health Care Act from 2015 is an attempt to strengthen health promotion, its effective impact will be for the future to show.

Health promotion activities are initiated and provided by a variety of institutions: governmental, self-administered and voluntary (NGOs) often based on networks form. They cover activities on federal, Länder and local level. The Federal Ministry of Health and federal health agencies (specially BZgA) play an important role in this field. They created a number of health promotion regulation and activities initiatives which added to disease and addiction prevention. In health promotion for older people (HP4OP) programs, there is also a number of regionally and locally oriented initiatives.

In this paper, we outline main features of the HP4OP activities in Germany with regard to institutions and financing mechanism. In addition, we describe health-targeting programmes/projects indicated as good practices:(a) established and developed in Germany and (b) provided by the European Commission with significant participation of German institutions. The multitude and variety of HP4OP programs differentiate positively German health system from other health systems in ageing countries.

Key words: **health promotion, older people, health insurance, Germany, funding and financing, institutions, good practices**

Introduction

Germany is one of the conservative welfare states, which offer relatively generous benefits and social services, and provide these based on a social insurance financial mechanism. The legislative authority for most policy areas in Germany is divided between the federal level (Bund) and the 16 states (Länder). The legislative authority for the health field has developed over time, which has led to the current situation, where the authority is divided between governmental organisations, self-administered bodies, and non-governmental organisations, resulting in a multi-dimensional division of responsibilities between different organisations on the Federal, Länder and communal level. Although Federal-level programs (e.g. some screening and health prevention pro-

grammes) are successfully implemented in the country, the attempt of the Federal government to consolidate and clarify responsibilities in the public health area has met resistance [1].

Health care is based on a social insurance principle and health promotion programmes are mainly financed by insurance contributions [2]. Nevertheless, there is a clear institutional separation between public health services, ambulatory care and hospital (inpatient) care.

Health promotion activities are initiated and provided by a variety of institutions, including the Federal Ministry of Health, Länder health ministries, local governments, self-administered bodies of health-care providers, especially the Statutory Health Insurance (SHI) and NGOs. Nevertheless the Federal Ministry of Health plays an important role and has recently initiated several legal reforms to strengthen prevention and health promotion and to include a focus on older people (HP4OP), e.g. by defining national health targets in this area. The German Forum for Prevention and Health Promotion was created in 2002 based on stakeholder initiatives at the federal level to define health targets and outline ways to strengthen prevention as well as to promote the development of broad preventive programmes and information, including prevention targeting older adults [1]. In the following years the ministry created a set of public health initiatives that added disease and addiction prevention. In health promotion for older people (HP4OP), there are more regionally and locally oriented initiatives.

In this paper, we first present some general data about health related demographic and epidemiological information (Section 2). We then provide an overview of the specific organisational structure of health issues in Germany (Section 3) and discuss the current legal and regulatory landscape relevant to health promotion and prevention generally and for older people particularly (Section 4). The remaining two sections contain information on the funding of organizations and activities involved in HP4OP (Section 5) and on selected programmes and activities in this area indicated as good practices (Section 6).

1. Population ageing and health status of the older population

Germany has one of the world's most rapidly ageing populations. The share of the older people in Germany is significant accounting for 15.4% of the population for people aged 65–79 and to 5.4% of the population for people being over 80 years old in 2014. These indicators are above the EU-28 average of 13.4% for people aged 65–74 and 5.1% for people aged 80 or more.

The average life expectancy at birth is 83.2 for women and 78.6 for men, which is close to the EU-28 average of 83.3 for women and 77.8 for men. The healthy life years at birth are estimated as 57.8 for men and 57.0 for women, which is below the EU-28 average of 61.4 years for men and 61.5 years for women. According to these estimates, men spend an average of 74% and women 69% of their lives in good health and without disability. The average life expectancy of men aged 65 is 18.2 and women is 21.1 for women, which is slightly above the EU-28 level for men (17.9 years) and close to the average EU-28 level for women (21.3 years). Healthy life years at the age of 65 equal 7 for both men and women, which constitutes about 39% of the average life expectancy at this age for men and 33% for women. This is below the EU-28 average of HLY (healthy life years) at the age of 65, which is equal to 8.5 for men and 8.6 for women (see **Table I**).

Life expectancy: Life expectancy at birth males/females: 78.6/83.2 years Life expectancy at 65 males/females: 18.2 /21.1 years
Healthy life years: Healthy life years at birth males: 57.8 years Healthy life years at birth females: 57.0 years Healthy life years at 65 males: 7 years Healthy life years at 65 females: 7 years
Share of older population: Proportion of population aged 65+: 20.8% of total population Proportion of population aged 80+: 5.4% of total population Old age dependency ratio 65+: 32.7%

Table I. *Population ageing indicators – Germany (data for 2014/2015).*

Source: Based on the Eurostat database, http://ec.europa.eu/eurostat/data/database; accessed: 7.04.2016.

The proportion of older people (65+) in the population is projected to increase from 20.8% in 2014 to 32.3% in 2060. The share of the oldest old (80+) is projected to more than double: from 5.4% in 2014 to 13.4% in 2060. Given these trends, the projected old age dependency ratio will increase from 32.7% in 2015 to 59.2% in 2060 (see Table I).

Mortality from all causes in the population aged 65+ amounted to 4,528/100,000 population in men and 3,134/100,000 population in women in 2013 (see **Table II**). The main cause of death in the older population are cardiovascular diseases constituting about 39% of deaths in men (17,778/100,000 population) and 43% of deaths in women (1,358/100,000 population) followed by cancers, which amount for 27% of deaths in men (1,225/100,000 population) and 23% in women (707/100,000 population). Pulmonary system diseases are the third most important cause of deaths amounting to 9% of deaths in men (404/100,000 population) and 7% in women (216/100,000 population).

Health status self-assessment worsens with age. At the age of 65–74, about 41% of older people assess their health status as fair and only 10% reports bad or very bad health (EU-SILC data of 2014). In the population aged 75–84, these shares increase to 50% and 15% respectively and above 85 years of age, they reach 56% and 29% (see Table II). The share of people with two or more chronic illnesses amounted to 76% of women and 68% of men aged 65–74, and 82% of women and 74% of men above the age of 75 in 2009 [3]. The most com-

Mortality rates (2013): Mortality from all causes age 65+ males: 4528/100 000 population Mortality from all causes age 65+ females: 3134/100 000 population
Self-assessed health status (2014): Health status self-assessment age of 65–74 fair/bad or very bad: 41%/10% Health status self-assessment age of 75–84 fair/bad or very bad: 50%/15% Health status self-assessment age of 85+ fair/bad or very bad: 56%/29%
Prevalence of two or more chronic illnesses (2009): Share of people age of 65–74 with two or more chronic illnesses males/females: 68%/76% Share of people age of 75+ with two or more chronic illnesses males/females: 74%/82%
Self-perceived long-standing limitations in usual activities due to health problems (2013): Age group 65–74 males/females: 54%/53% Age group 75–84 males/females: 64%/70% Age group 85+ males/females: 76%/88%

Table II. *Health status of the older population – Germany.*

Source: Based on the Eurostat databases; EU-SILC data of 2014, http://ec.europa.eu/eurostat/data/database; accessed: 7.04.2016 and Robert Koch Institut data [3].

mon chronic conditions in the older population include circulatory system diseases, cancers, muscles and skeleton illnesses and diabetes. The prevalence of circulatory system diseases accounts to 20.5% in women and 31% in men aged 65–74, and 35.1% in women and 40% in men aged 75+. The prevalence of cancers is reported as 17.5% in women and 13.6% in men aged 65–74, and 16.6% in women and 18.8% in men aged 75+.

A similar occurrence is observed for the diagnosis of diabetes: 16.3% in women and 18.2% in men aged 65–74, and almost 20% for men and women above 75 years of age. Illnesses of muscles and the skeleton (osteoporosis, arthritis, rheumatism) are very prevalent in the oldest population, reported by 63.7% of women and 45.8% of men aged 75+.

Long-standing limitations in everyday activities caused by health problems were reported by 54% of men and 53% of women aged 65–74; 64% of men and 70% of women aged 75–84; and 76% of men and 88% of women above the age of 85 in 2013 (see Table II).

The main risk factors for poor health in older age include smoking, excessive alcohol consumption and physical inactivity. 8.9% of women and 11.6% of men aged 65 to 74 smoke. 18% of women and 34% of men in this age group drink excessively. Studies of the Robert Koch Institute [3] show that 16.8% of women and 19.3% of men aged 60–69, and 11% of women and 16.5% of men age 70+ are regularly and intensively physically active. Obesity is a frequent risk factor with 22% of men and 24% of women aged 65–74, and 19% of men and women age 75+ reporting Body Mass Index equal or higher than 30. The incidence rate for fatal falls is reported as 74.2 per 100,000 population 65+.

2. Organisational solutions for health promotion and prevention in Germany

The institutional arrangement of health promotion in Germany is shaped by the German federal structure of the state on the one hand and by a health care system that is characterized by divided responsibilities between governmental organisations, self-administered bodies and non-governmental organisations on the other hand. There are a multitude of different stakeholders, structures and interests involved. There are no standardised or uniform structures of health promotion [4].

The "Pro-Health 65+" project experts [5] indicated that the most important institutions for providing health promotion functions are regional/local actors. Health promotion on the regional level is under the authority of the Länder legal regulations – and in consequence regional activities and services – may differ widely. Many interventions or projects specifically for older people are initiated by local health insurances and non-governmental organisations. Local sports clubs and adult education centres provide many activities for older people as part of their general range of activities.

In general, health promotion activities may be initiated, shaped or influenced by a wide range of different actors including governmental institutions (1), the self-administered institutions of the health sector (2) and non-governmental institutions (3) on different policy levels (Federal, Länder and local level). Deeper analysis stresses the importance of the national cooperation networks. Strong networks in health promotion are first of all: The National Health Targets, The Equity in Health and Healthy Cities Network. They coordinate activities and link actors across different levels and sectors.

To illustrate the complex and specific German institutional arrangement in health promotion and the multitude of institutions and organisations involved, **Figures 1–3** present the main institutional actors in these three fields: governmental institutions (Figure 1), public and self-administered bodies (Figure 2) non-governmental (voluntary) organisations (Figure 3). However some of these institutions operate in more than one field, particularly those in the form of a network, such as the State Health Conferences and the Working Platforms on Health Promotion and Prevention.

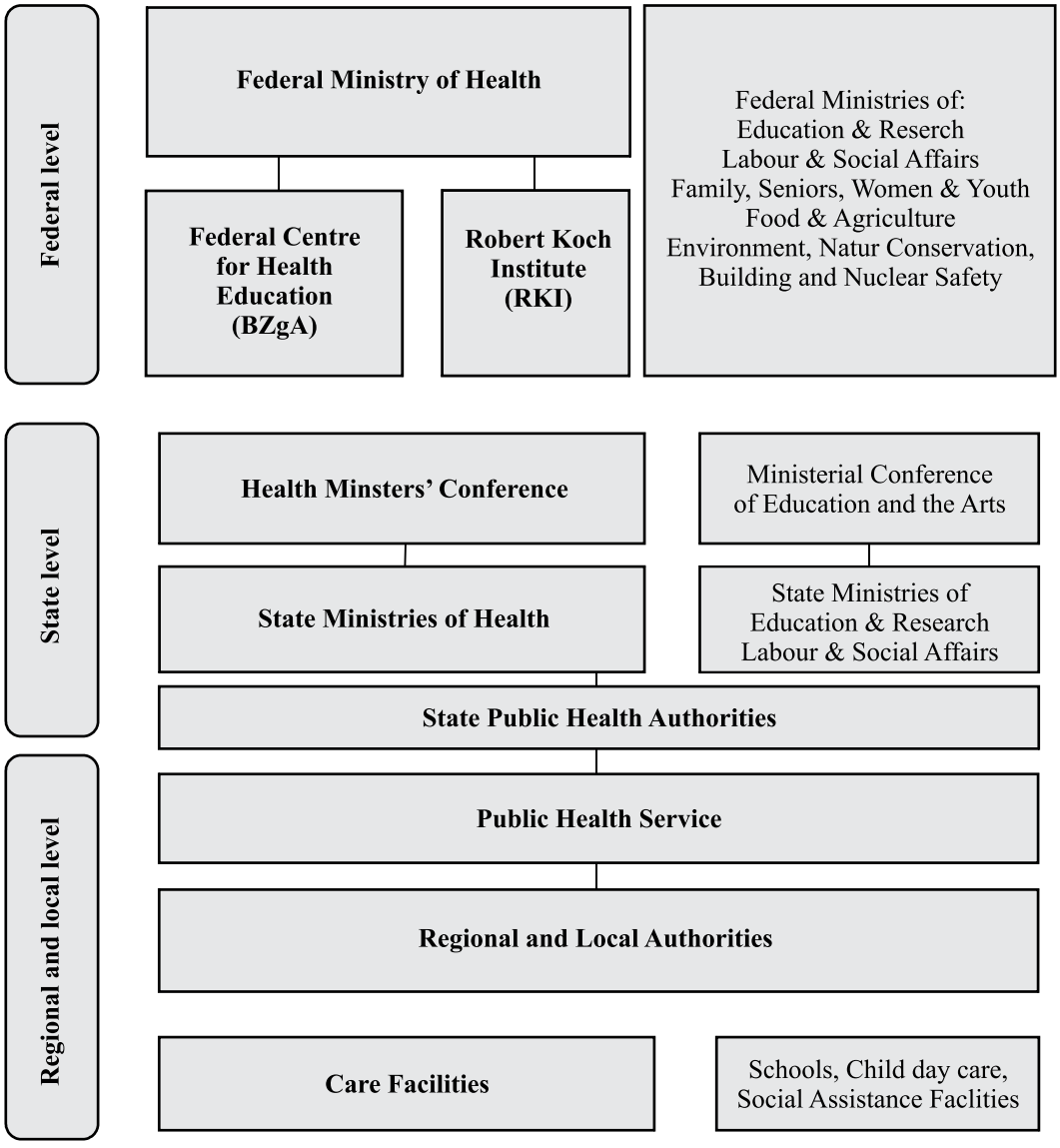

Figure 1. *Governmental institutions involved in health promotion and prevention in Germany.*

Sources: Inspired by Blümel S. [6] and Kunkel T. [7], http://www.chrodis.eu/wp-content/uploads/2015/02/Germany-country-review; accessed: 14.09.2016.

Health promotion on the federal level is a special field of the Federal Centre for Health Education (Bundeszentrale für gesundheitliche Aufklärung – BZgA). This institution was founded in 1967. Its main task is information and health education as well as the organisation and coordination of prevention campaigns, but it is also – and to an increasing extent – the responsible agency for many health promotion and prevention projects.

The Robert Koch Institute (RKI) is a traditional epidemiologic research institute responsible for tracking diseases (communicable and non-communicable) and assessing health status of both the entire population and its specific groups. The RKI systematic reports on the health situation and health care needs in Germany.

Health promotion as a part of the whole public health system is predominantly in the responsibility of the 16 Länder.

The Health Ministers' Conference plays a specific role in the governmental structure of the Länder. The Conference aims at coordinating activities of the Länder, is legal initiative and has a guiding role for health policies on the Länder-level. In 1991 the Health Minister's Conference released an influential resolution (GMK-Entschließung) titled "Opportunities for preventive health care, disease prevention and health promotion in Germany". This resolution resulted in many state laws on health promotion in the Länder as a part of their public health services.

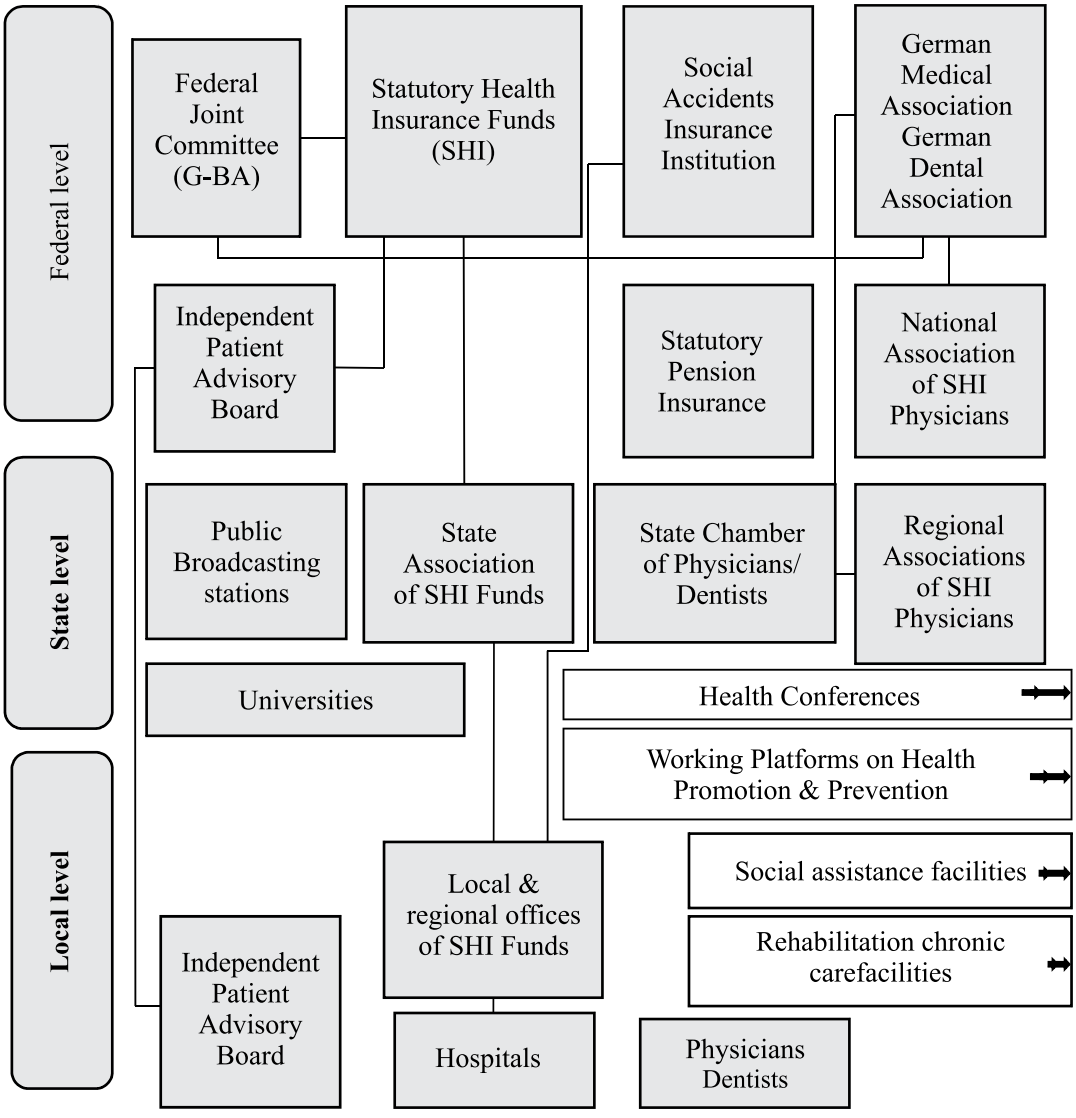

Figure 2. *Public and self-administered bodies involved in health promotion and prevention.*

Sources: Inspired by Blümel S. [6] and Kunkel T. [7], http://www.chrodis.eu/wp-content/uploads/2015/02/Germany-country-review; accessed: 14.09.2016.

Most of the Länder institutions have transferred authority for health promotion to local governments. Various health promotion programmes are locally initiated and performed with the involvement of NGOs, local health insurances, medical firms, individual doctors and nurses, local self-governments and social activists as well.

A specific feature of the administrative system of the German state is the self-administration of many public institutions. Health related institutions such as: insurance funds, medical chambers and various federal associations and boards are self-administrated. This creates a relatively complex picture of institutional order.

To overcome the fragmented responsibilities for health promotion and to strengthen the cooperation of different actors on the federal, Länder and local levels, several cooperation networks have been founded over the years. Some Länder initiated "Health Conferences" on state or regional levels to improve the coordination of health promotion initiatives [1]. The Forum on Prevention and Health Promotion (founded in 2002) merged in 2007 to form the Federal Association for Prevention and Health Promotion (Bundesvereinigung Prävention und Gesundheitsförderung e.V.). Its task is to strengthen prevention and health promotion in all political spheres, to define health targets and to establish sustainable organizational structures [1]. It comprises 130 organisations and is funded by the Ministry of Health. The Cooperation Network "Equity in Health" was founded in 2003 by the Federal Centre for Health Education (BZgA) together with the Länder to strengthen social situation based health promotion (see Section 5). Following the Ottawa-Charta of 1986, the Healthy Cities Network was founded in Germany in 1989. By now more than 150

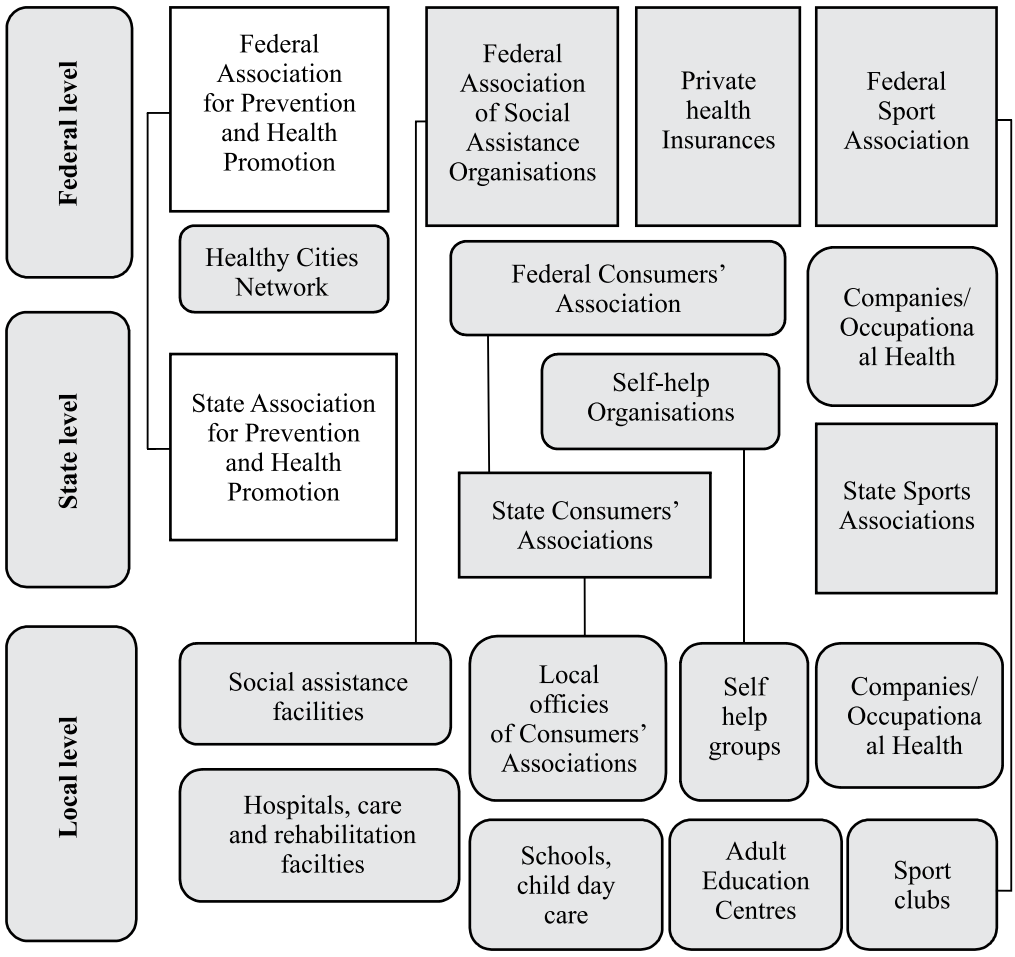

Figure 3. *Non-Governmental Organisations involved in health promotion and prevention.*

Sources: Inspired by Blümel S. [6] and Kunkel T. [7], http://www.chrodis.eu/wp-content/uploads/2015/02/Germany-country-review; accessed: 14.09.2016.

German cities are part of this network that is focussed on health promotion on the communal level encompassing different areas: health, traffic, urban planning, housing etc.

Locally operated NGOs in the field of health promotion in Germany very often have an umbrella organisation on the Länder and/or Federal levels. There well-known associations for health prevention and health promotion on both levels are presented in Figure 3. In the field of senior issues the BAGSO – Bundesarbeitsgemeinschaft der Senioren-Organisationen (German Association of Organisations for Seniors) is an important stakeholder as it is an umbrella organisation of more than 100 national associations that are concerned with the interests of older people and is involved in many projects and political initiatives on health promotion for older people.

An important NGO-actor on the federal level is the Association of Social Assistance Organisations, which plays an important advocacy role. A sign of the modern age is the network structure to unite similar health promotion activities from different settings, administrative levels and territorially places [8].

Generally, NGOs, in their modern form, are an important sector of organisations that play a double role: serving as advocacy/ lobby groups for HP4OP and providing healthy ageing activities for older people in various settings.

3. Legal basis for health promotion activities

The main sphere of influence and regulation for the national health policy is social legislation, mainly with respect to the social insurances. Legal regulations concerning prevention and health promotion are included in different parts of the Social Code (SGB). Legal regulations apply to the sphere of employment seekers/employment promotion (SGB II&III); the statutory health insurance (SGB V), the statutory retirement insurance (SGB VI), the statutory accident insurance with respect to safety and health promotion at work (SGB VII), the assistance for children and adolescents (SGB VIII) and the rehabilitation and participation of disabled people (SGB IX). SGB XI and SGB XII specifically target older people. SGB XI applies to social care and prescribes preven-

tive interventions (§5) and duties regarding information on health promotion (§7) for the social care insurances. SGB XII regulates social assistance, prescribes an overall priority of prevention and rehabilitation over social assistance (§14) and defines services promoting social inclusion, advice and support services that should be part of older people's welfare (§71).

As one of the most important laws, the Health Reform Act of 1989 included health promotion as an official mandate for the SHI (§20 SGB V). Several major revisions of this law followed. Health promotion was eliminated as a mandatory task in 1996, and reintroduced in 2000 by the SHI-Reform Act (GKV-Gesundheitsreformgesetz). Since then §20 SGB V includes the mandate for the SHI to deliver primary prevention services that intend to improve the general state of health and in particular, contribute to the reduction of socially determined health inequalities. In 2007 it was defined by the Act to Strengthen Competition in SHI (Wettbewerbsstärkungsgesetz) that a fixed sum should be spent by health insurance funds on health promotion and primary prevention per year (2,74 Euros per insured person, to be adjusted annually). Interventions funded by the health insurance funds include individual interventions (mainly health courses), setting-oriented interventions in day-care centres, schools or communal settings (e.g. for older people) and workplace health promotion. Apart from that there are several screening and primary prevention programmes that are part of the general range of services of the health insurance funds. The Industrial Safety Act (Arbeitsschutzgesetz) from 1996 is a central legal regulation for workplace health promotion.

Since 2005 there have been several attempts to adopt a law on health promotion and prevention. This was partly driven by the motive to establish prevention, health promotion and public health as the fourth pillar of the healthcare system, next to curative, rehabilitative and long-term care – or at least, to generally improve the coordination of the various actors, to consolidate and clarify responsibilities, and to enhance the effectiveness of prevention and health promotion. While earlier versions of the law tried to incorporate a broader societal perspective, to integrate other policy areas as well, the Act to Strengthen Health Promotion and Preventive Health Care (Preventive Health Care Act/PHCA; Gesetz zur Stärkung der Gesundheitsförderung und Prävention) that entered into force in July 2015 has a strong focus on the social insurance agencies. Prevention is understood as a common task of the statutory social insurance funds, with the participation of the private health and long-term care insurance funds. The main focus is on the SHI, which is funding the reform (and falls within the legislative authority of the federal government).

Primary goals are to establish new structures to strengthen the cooperation and coordination of the different actors, to develop a national prevention strategy, to improve effectiveness and to increase financial resources for health promotion and prevention. For this purpose the **statutory health insurance funds are obliged to spend € 7 per insured person per year on health promotion and primary prevention as of 2016 (instead of the hitherto € 3)**. This adds up to approximately € 500 million per year. A minimum amount of € 2 per insured person will have to be spent both on workplace health promotion and on health promotion in specific settings, like childcare facilities, schools, long-term care facilities or other communal settings (€ 1,05 per insured person will have to be spent on the support of health related self-help groups and organisations). These regulations set a very strong focus on setting-oriented health promotion, as this is expected to be more effective – or (rather) more capable of reducing health inequalities – especially compared to health courses (on nutrition, weight reduction, physical activity, stress management, relaxation techniques, addiction prevention) that only address individuals.

4. Policy, programmes and actions

A process on national health targets was initiated in 2000, based on a resolution of the conference of ministers of health (GMK) in 1999. It is carried out by a cooperation network that includes about 160 cooperation partners (gesundheitsziele.de). Eight national health targets have been developed so far:

(1) Diabetes mellitus type 2: lowering the risk of contracting the disease, early recognition and treatment of the disease;
(2) Breast cancer: decreasing the mortality rate, improving quality of life;
(3) Tobacco consumption reduction;
(4) Growing up healthy: life skills, exercise, diet;
(5) Increasing health skills and strengthening patient sovereignty;
(6) Depressive diseases: prevention, early recognition and long-term treatment;
(7) **"Healthy ageing" as a national health target was introduced in 2012**;
(8) "Reduction of alcohol consumption", added in 2015;

For the target "Healthy ageing" (7) a comprehensive report was compiled that includes detailed recommendations in three areas of activity [9]:

- Health promotion and prevention: preserve autonomy; this includes goals concerning social participation, the strengthening of resources, physical activity, a balanced diet and oral health.
- Medical, psychosocial and nursing care: this includes goals concerning supply structures, the cooperation of different health professions and the improvement of the situation of care-taking relatives.
- Special challenges: this concerns the situation of disabled older people, improvement of mental health and dementia, care for multi-morbid patients, the prevention the need for long-term care and good care for persons in need of long-term care.

On the level of the 16 federal states health targets have been defined as well, but these are specific for each federal state and approaches and strategies may differ widely. The majority of them include health targets that are specific to older people. While comprising more or less programmatic recommendations so far, the

national targets have actually gained importance as they are directly addressed by the PHCA. Consideration of the 8 national health targets and the goals predefined by the national strategy on occupational health and safety is stipulated in the PHCA.

A central structure, newly established by this law, is the Federal Prevention Conference. This is constituted by representatives of the statutory social security funds (health, pensions, accidents, long-term care) and private health insurance funds. Representatives of the federal and the Länder governments, the Federal Employment Agency, the social partners, patient representatives and the Federal Association for Prevention and Health Promotion have a consultative function. The National Prevention Conference has the task of developing a National Prevention Strategy. As one part of this strategy the National Prevention Conference adopted National Basic Recommendations on Health Promotion and Prevention in February 2016, that define common goals, main areas of activity, target groups, and participating organisations and institutions.

Three main guiding goals have been defined:
(1) growing up healthy;
(2) healthy living and working;
(3) **being healthy in old age**.

Based on these recommendations framework agreements on health promotion are subsequently developed in the 16 Länder. These framework agreements define common areas of activity for the Länder, specify the coordination of services, and clarify the responsibilities and the cooperation with the public health services and other important health promotion providers. This process is still ongoing (Sept. 2016) and will strongly influence the actual implementation of the law.

Further regulations of the PHCA relate, inter alia, to quality assurance, extended functions of the BZgA, recommendations for prevention by physicians and the obligation of the nursing care insurance funds to spend € 0,30 per insured person on health promotion and prevention in long-term care facilities.

Regarding the setting-orientation of the PHCA there is a strong focus to strengthen health promotion interventions especially for children and young persons and in workplace settings. Still "healthy in old age" is one of the defined guiding goals of the National Prevention Strategy, and definite tasks have been defined for nursing care insurance funds, but practice will tell, what the impact for health promotion or preventive interventions for older people will be.

Health promotion for older people is one of the four key fields of action of the network for health equity. This network, Equity in Health (Kooperationsverbund Gesundheitliche Chancengleichheit), was founded in 2003, initiated by the BZgA, with a special focus on supporting health promotion for the socially disadvantaged. It comprises 66 organisations. Next to its networking activities, a main goal is to identify and disseminate Good Practice projects and to strengthen quality development. Parallel to the federal platform, Länder associations for health have established coordination centres for equity in health in the federal states. They are funded by the Länder governments and the health insurance funds.

Regarding the health activity types, the first place within HP4OP in Germany is taken by physical activity. Primary prevention of chronic diseases is also permanently present. Programmes of healthy nutrition, avoiding addiction and fall prevention have been developed. Recently we have been observing many initiatives against mental disorders in older age. Programmes oriented at social inclusion and the social integration of older people in communities are supported nationally and internationally by networks of activists and experts.

5. Financial position of public health and health promotion generally and for older population specifically within the health system

Current total health expenditure in Germany accounted for 11.1% of GDP in 2014. The level of resources allocated to health has been steadily increasing (see **Table III**). During the period 2000–2014, the real current health expenditure per capita (base year 2005) have increased by one third. In the same period, the GDP per capita increased by 17.5%. Approximately 76% of the health expenditure comes from public sources (largely from social health insurance contributions). Private expenditure includes mostly out-of-pocket payments and private health insurance contributions. A vast majority of health resources (92%) is devoted to financing of individual health care services. The expenditure on prevention and public health services accounts for approximately 3% of total current health expenditure. Since 2007 the share of prevention and public health services on total current health expenditure decreased slowly by 0.5 percentage point.

The specific structure of health promotion funding in Germany is presented in **Figure 4**, and the key features of the HP4OP funding in particular are summarized in **Table IV**.

In the health promotion and prevention sectors there are many particular institutions/organisations funding and otherwise supporting health promotion functions generally and those specifically addressed at older people. However the main public payers for those activities are the social health insurance funds and public budgets.

6. Good practices of health promotion addressed at older people – selected programmes

Various good practices in the area of health and activity promotion addressed at older people have been identified in Germany. Some programmes are focused more on activation and the social integration of seniors – not directly on their health. In the last years more practices are healthy ageing oriented. The range of health promotion activities is wide: primary prevention of chronic diseases and falls, avoiding addiction, stimulating physical activity, food control and developing healthy diet, healthy

	2000	2005	2007	2010	2012	2013	2014	Change 2014 to 2000	Change 2014 to 2007
Current health expenditure per capita. constant prices OECD base year in euro	2669.2	2858.9	2982.3	3289.8	3405.5	3461.8	3548.7	+32.95%	+18.99%
GDP per capita. national currency at GDP price level 2005 in euro	27165.7	27862.7	29914.9	29869.9	31805.0	31527.8	31923.0	+17.51%	+6.71%
Current health expenditure as % of GDP	9.8	10.3	10.0	11.0	10.8	11.0	11.1	+1.3	+1.1
Share of general government in current health expenditures	78.6	75.6	75.4	75.7	75.6	76.3	76.6	–2.3	+1.2
Share of private agents in current health expenditures	21.4	24.4	24.6	24.3	24.4	23.7	23.4	+2.3	–1.2
Individual health care services and medical goods (share of current expenditure on health)	91.3	91	91.1	91.2	91.6	91.8	–	–	
Collective health care (share of current expenditure on health)	8.7	9	8.9	8.8	8.4	8.2	–	–	
Prevention and public health services (share of current expenditure on health)	3.2	3.3	3.6	3.4	3.2	3.1	–	–	

Table III. *Expenditures on health generally and on public health and prevention.*

Sources: OECD Health Statistics, http://stats.oecd.org/index.aspx?DataSetCode=HEALTH_STAT; accessed: 27.06.2016.

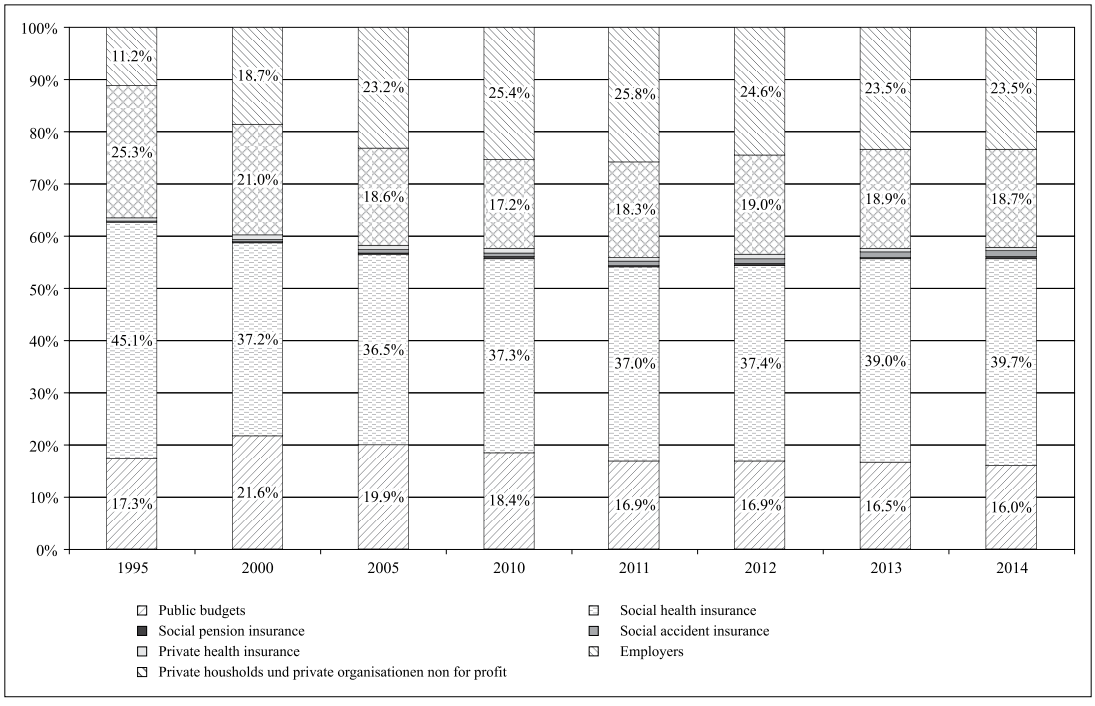

Figure 4. *The structure of funding of health promotion.*

Source: Own calculation based on Statistisches Bundesamt, Gesundheit. Ausgaben 1995–2014, Wiesbaden 2016, https://www.destatis.de/DE/Publikationen/Thematisch/Gesundheit/Gesundheitsausgaben/AusgabenGesundheitLangeReihePDF_2120712.pdf?__blob=publicationFile; accessed: 10.03.2016 [10].

Type of institution	Source of funding	Comments
Governmental institutions: Federal Ministries of Health and other ministries, Federal Centre for Health Education Federal Institute for Occupational Safety and Health State ministries of health and other ministries, state public health authorities; state institutes for teacher education and school development Local public health authorities; school, kindergarten and day care administrations	Budgetary funds – general taxation European Commission - grants based on the EU project participation Local budgets – general and local taxes	
Self-administered institutions: Statutory health insurance (SHI), statutory pension insurance and statutory accident insurance Chambers of medical professionals	Insurance funds based on insurance contributions Membership fees	**Main source of health promotion funding**
Non-governmental organisations: Federal and Länder Associations for Health Promotion and Prevention; German Nutrition Society, German Olympic Sports Confederation Foundations: e.g. Robert Bosch, Bertelsmann Foundation, Lottery Foundations, various local foundations Others NGOs: health centres; local health initiatives; sports clubs	Commitment of SHI Commitment of Federal and Länder Ministries Financial resources from foundations	
Private: Private health insurance Corporate health promotion activities [according to the legal code on health and safety at work] Private broadcasting campaigns	Private insurance premium Donations and fundraising from private individuals and corporations	According to the new law (The Preventive Health Care Act) private health insurance funds are exempt from the financing obligation of preventive activities. However, voluntary contributions are suggested and expected.

Table IV. *Funding of health promotion by institutions.*

Source: Own comparison.

life style promotion. However, physical activity plays the main role.

Good practices are here presented with short descriptions of the realised programmes; first national healthy life style campaigns, than programs addressed to specific groups of older people, regional projects and last but not least – research projects. In a separate and final section a few European Union programmes are indicated in which the contribution of the German partner is very significant.

A. German active and healthy ageing programmes realized in health and social fields

- **National Action Plan "IN FORM"**

This German national initiative to promote "healthy diets and physical activity" is aimed at bringing about lasting improvements in dietary and exercise habits in Germany by 2020. "IN FORM" is about promoting a healthy lifestyle with a well-balanced diet and sufficient physical activity. To date, almost 100 projects have been supported by the Federal Ministry of Food and Agriculture (BMEL) and the Federal Ministry of Health (BMG) under the IN FORM initiative. A specific internet portal for older people is provided as part of the programme: www.in-form.de/profiportal/service/aeltere/im-alter-in-form.html.

- **Campaign "Fit im Alter – Gesund essen, besser leben" (Fit for old age – eating healthy, living better)**

This campaign assists elderly people by offering a comprehensive healthy catering in retirement homes or at home. This campaign is supported by the German Nutrition Society. The final evaluation of the project showed that there were significant changes only for nutrition behaviour, not of physical activity and no change in health related quality of life; http://www.fitimalter-dge.de/.

- **Rezept für Bewegung (Prescription for Movement)**

Thanks to a cooperation between the German Olympic Sports Confederation (Deutscher Olympischer Sportbund', DOSB), the German Medical Association (BAK) and the German Society for Sports Medicine in several German regions and cities, physicians prescribe their patients special "green" prescriptions with adjusted sport, PA offer, classes or recommended facilities to use. Annual conferences and forums are organized to promote the green prescription idea. More information: http://www.sportprogesundheit.de/de/sport-und-gesundheit/rezept-fuer-bewegung/

- **Health promotion and primary prevention for older people with immigrant backgrounds (2007–2010)**

This project was undertaken by the Institute of Gerontology at the University of Dortmund in Germany

with the aim of evaluating the effectiveness of health promotion activities for older people with an immigrant background. The project looked at behavioural and environmental determinants of ageing and furthermore, looked into new opportunities for effective health promotion and primary prevention measures for this hard to reach target group. The research project included the evaluation of several targeted prevention measures in the areas of exercise, nutrition and cognitive function among others.

More information is available at: http://www.ffg.tu-dortmund.de/cms/de/Projekte/Lebenslagen_Lebensformen_und_soziale_Integration/Gesundheitsfoerderung_und_Primaerpraevention/index.html.

- **New Ageing in Cities (NAIS)**

NAIS is a volunteer project in partnership with the administration of the city of Bruchsal in Germany, public facilities, churches, charities, trade and industry, associations and clubs. The project has been operational since 2007 and it looks to develop effective local strategies to activate and empower older citizens. Areas of actions include: improving access to the local care system, improving care for older people in socially disadvantaged areas and actions promoting physical activity, nutrition and mental health. More information is available at: http://www.neues-altern.de/index.html.

- **SAĞLIK project**

This project promotes physical activity, nutrition and social participation in urban districts. The SAĞLIK project plans to develop, implement and evaluate community based health promotion interventions for members of the elderly Turkish migrant community in Hamburg with the aims of adapting local health promotion structures and reducing health inequalities. The interventions will focus on improving nutrition, physical activity and social participation. The project takes a multi-stakeholder approach and includes expertise from the public health, health psychology, nutrition science, social sciences and social work professions. More information is available at: http://www.haw-hamburg.de/fakultaeten-und-departments/ls/ls-forschung0/fsp-public-health/aktuelleprojekte/ saglik.html.

- **Kölner Seniorennetzwerke (Cologne networks for senior citizens)**

This project is addressed at older people in a suburb with the aim of preventing social exclusion and isolation and to integrate them. It involves local politicians, representatives of senior citizens, local employers and occupational organisations (including kiosk owners, barbers and hairdressers, associations and housing cooperatives as well as pharmacists and medical practitioners. Information is available at: http://seniorennetzwerke-koeln.de.

- **Gesund & aktiv älter werden (Healthy and active ageing)**

This is a Portal of the Bundeszentrale für gesundheitliche Aufklärung (BZgA) focused on health information available at: www.gesund-aktiv-aelter-werden.de.

- **Altern in Balance**

This programme is focused on maintaining the somatic and mental health balance of older people, their wellbeing and social integration. The programme has been developed by the BZgA and is supported by the private health insurance funds (Verband der Privaten Krankenversicherung e.V. (PKV)). The programme initiated a national competition series "Healthy ageing in the municipality – physically active and mobile," which took place for the first time from May 2015 to April 2016. Good practice models and projects in communal settings were honoured for promoting physical activity and the mobility of older people.

For more information see https://wettbewerb-aelter-werden-in-balance.de/wettbewerb.html.

- **Equity in Health**

This is a cooperation network established in 2003 on the initiative of the Federal Centre for Health Education (BZgA). The activities of the Network were focused on four key fields: health promotion in districts, for children, the unemployed and the elderly. This cooperation network already has an established structure in the Länder. Noteworthy is its advanced quality development in social status-based health promotion. This initiative is very often indicated in Germany as a good practice; http://www.gesundheitliche-chancengleichheit.de/english/.

- **Diabetes Counselling on Wheels**

This programme concerns early detection and counselling on diabetes for citizens of Turkish origin and the rural population. This pilot programme has been operational since 2003 in North Rhine Westphalia. It is not addressed to a specifically indicated age group but is rather focused on the older population with a Turkish migration background (in rural regions). Its aim is instruction concerning diabetes mellitus (information about this disease, diagnosis at an early stage, referral of newly diagnosed cases to suitable specialist contact persons locally – medical doctors, nurses and others). This project is focused on a target group that is not otherwise reached by preventive measures. The project's evaluation is still underway (2014 to 2018); http://www.chrodis.eu/wp-content/uploads/2016/03/160307DiabetesCounsellingOnWheels_DraftProgramme_5.pdf.

- **Prevention of type II diabetes**

The TULIP study (Tübingen lifestyle, Programme of Intervention, University Hospital of the Medical Faculty Tübingen) is addressed to the population over 50; people with an increased risk profile for type II diabetes mellitus whose parents suffer from diabetes, women who have developed diabetes during pregnancy, people with reduced glucose tolerance, older people who are overweight with a BMI of more than 27. Its aims are the identification of important predictive parameters (preventive strategies in terms of lifestyle change), motivation for a healthier lifestyle (more physical activity and a healthier diet), prevention of diseases of civilisation (type II diabetes, vascular calcification and myocardial infarction). The project in-

volves medical practitioners, nutrition specialists, sports scientists, sports physicians and nurses, as described by [11].

- **BMBF Förderschwerpunkt Präventionsforschung** (Funding Priority Prevention Research)

The Federal Ministry of Education and Research (BMBF) funded a priority research programme on prevention research from 2004 to 2013. This programme focussed on older people from 2007 to 2010 and funded 14 research projects on health promotion and prevention for older people. In addition a coordination project was initiated in 2009 to establish structures that ensure the application and sustainable use of research results in practice ["Kooperation für nachhaltige Präventionsforschung"] (Cooperation for sustainable research), http://www.knp-forschung.de/. The research projects on interventions for older people are presented in a brochure: *Ergebnisse der Präventionsforschung nutzen – Präventionsprojekte für ältere Menschen*, available at: http://www.bzga.de/infomaterialien/einzelpublikationen/?idx=2096.

- **AEQUIPA**

This is a research network focused on prevention in North-West Germany, coordinated by the Leibniz-Institute – BIPS. The AEQUIPA Network is funded by the Federal Ministry of Education and Research. Three aims are defined: (1) to assess the Community Readiness (CR) for older adults' physical activity in selected municipalities in the Metropolitan Region Bremen Oldenburg in the Northwest, (2) to investigate the efficacy and cost-effectiveness of capacity building strategies to increase CR to engage vulnerable older adults (e.g., low SES, obese) in physical activity interventions, (3) to examine reasons for (non-) participation in existing physical activity interventions among older adults; www.aequipa.de/.

B. Participation in European Health- and Senior target Projects

- **EuroHealthNet**

This is the network of a not for profit partnership of organisations, agencies and statutory bodies with the aim of creating successful healthcare communication programmes to contribute to a healthier Europe by promoting health and health equity between and within European countries. It has been operational since 1996. The German partner is The Federal Centre for Health Education [BZgA]; http://www.eurohealthnet.

- **AGE platform Europe**

This Platform is a European network of organisations of and for people aged 50+. AGE was set up in January 2001 to represent the needs of older people to European institutions with a single voice, as well as to strengthen the cooperation between older people's organisations across the EU. The German partners are A Soul for Europe – Berlin, Citizens of Europe – Berlin, Egality Berlin, The European Institute for Public Participation (EIPP) – Bremen and among others N-OST – the network for reporting on Eastern Europe; http://www.age-platform.eu.

- **EPIC – Elderly Network on Ageing and Health**

This is a project founded in 2004 by the European Commission – DG Health and Food Safety, which was realised in the years 2005–2007. The aim was to set up a health information and surveillance programme for reporting issues relevant to ageing and health, by establishing a central databank of standardised data including baseline information on socio-demographic, dietary, lifestyle, somatometric characteristics and self-reported morbidity, as well as follow up data on any of the above mentioned parameters and cause specific mortality of elderly Europeans. German Partners – Deutsches Krebsforschungszentrum (DKFZ) and Deutsches Institut für Ernährungsforschung Potsdam-Rehbrücke (DIEF); http://ec.europa.eu/health/ph_projects/2004/action1/docs/2004_1_06_inter_en.pdf.

- **From Isolation to Inclusion (The i2i-project)**

This project was a part of the Second Trans-national Exchange Programme (2005–2007) and was implemented in Austria, the Czech Republic, Germany, Italy, Lithuania and the UK, focused on improving the social participation of older people at risk of isolation or poverty, those with disabilities or chronic diseases, or from ethnic minorities. In each of the countries in which the project was carried out, co-operation took place between a regional or local public authority and an external consultant. The aim was to capitalise on political momentum and expert knowledge, so as to facilitate and encourage social and political changes aimed at improving the conditions of the vulnerable target groups.

More information is available at: http://www.i2i-project.net/.

- **Vintage – Good health into older age**

This project was funded by the European Commission under the Second Programme of Community Action in the Field of Health 2008–2013. The objective was to build capacity at the European, national and local levels by providing the evidence base and collecting best practices to prevent the harmful use of alcohol amongst older people, including the transition from work to retirement, and to invest in older people's health and well-being. The project was realised from the years of 2009–2011. The German collaborating partner was DHS – Deutsche Haupstelle für Suchtfragen – Hamm; http://www.epicentro.iss.it/vintage/.

- **Health Pro Elderly – Evidence Based Guidelines on Health Promotion for Elderly: social determinants, inequality and sustainability**

This project was realised within the Public Health Programme of the European Commission, (2008–2013). The overall aim was to support health promotion for older people by developing evidence-based guidelines and recommendations for action at the European, national and local levels. Determinants that influence the health situation of the elderly would be highlighted, enabling differentiation between the different target groups and their needs, taking into consideration the inequalities that the target groups are confronted with. The German

associated partner was Forschungsgesellschaft für Gerontologie e.V.; http://www.healthproelderly.com/.

- **PASEO – Successful Alliance Building for Physical Activity Promotion among older People**

This project, co-funded by the DG Health and Consumers from 2009–2011, covered 15 EU Member States – Germany included – Bavarian Ministry of Public Health and University of Erlangen Nurnberg. It was addressed to older people in general with the aim of promoting physical activity among sedentary older people by strengthening the local, regional and national capacities to facilitate two key areas: the creation of intersectoral capacities (cooperation of organisations across multiple policy sectors - i.e. health, social care, sport) and enhancing institutional efforts to promote physical activity among older people (also building intra-organisational capacities – i.e. personnel, resources, co-operation within organisations). Information is available at: http://ec.europa.eu/chafea/documents/news/Workshop_on_Transfer_of_Knowledge_.

- **JA-CHRODIS – Addressing Chronic Diseases & Healthy Ageing through Life**

This project was funded by the European Commission under the Second Programme 2008–2013 of Community Action in the field of health. The German partner – Bundeszentrale für gesundheitliche Aufklärung (BZgA) [The Federal Centre for Health Education] was responsible for facilitating the exchange, upscaling, and transfer of good practices in health promotion and primary prevention of chronic diseases, in particular, type 2 diabetes and cardiovascular diseases, between EU countries and regions – Work Package 5. The final report of the work presents, in detail, criteria used to select prevention activities indicated as good practice and then describes selected practices in 14 European countries. One of the key deliverables is the 'Platform for Knowledge Exchange,' which will include both an online help-desk for policy makers and an information portal providing an up-to-date repository of best practices and the best knowledge on chronic care. Information is available at: www.chrodis.eu.

Conclusions

Health promotion in Germany comprises a wide field of activities and involves a wide range of actors. There are many strong networking activities, a high level of exchange of experience and expertise and many model projects. It is thus a highly developed and differentiated field. And there is an especially wide field of (demand-driven) open offers people can attend, such as individual health classes concerning physical activity, nutrition or relaxation offered by e.g. adult or senior education centres or sports clubs.

Despite these definite strengths, there is little long-term and sustainable infrastructure with secured funding for setting-oriented interventions that try to reach specific target groups and especially the socially disadvantaged, who do not attend individual interventions. Services and activities differ widely from region to region. Health promotion, especially for older people, often takes place within the scope of singular projects or initiatives.

There are no comprehensive and standardised services for health promotion and primary prevention for older people [12]. The Preventive Health Care Act is a new attempt to overcome the problem of insufficient coordination among different actors on different policy levels. But there is still criticism that the law does not define health promotion and primary prevention as a task for society as a whole, as "Health in All Policies," but focuses mainly on the responsibility of the SHI. A main point of contention is that the activities defined in the law are still to be financed by the SHI and not by taxes. Private health insurance funds, which cover, for example, public officials, are exempt from this financing obligation. Furthermore, based on past experiences, there are doubts as to whether the competitive health insurance funds are appropriate agents to realise effective health promotion policies – especially the necessary setting-oriented interventions for the socially disadvantaged. In a competitive health market, health insurance funds are mainly interested in promoting individual health promotion interventions for healthy and health-conscious people, as these are the most profitable clients [13].

The law provides regulations to strengthen cooperation between insurance funds, but it remains to be seen, whether sustainable structures will be developed in the next years. In general the Preventive Health Care Act is regarded as a step in the right direction, by strengthening health and setting-oriented health promotion in particular.

Notes

[1] Eurostat data: http://ec.europa.eu/eurostat/data/database; accessed: 30.03.2016.

[2] The ratio between the number of persons aged 65 and over (age when they are generally economically inactive) and the number of persons aged between 15 and 64. The value is expressed per 100 persons of working age (15–64) (Eurostat).

[3] European health for all database (HFA-DB) WHO Regional Office for Europe, http://data.euro.who.int/hfadb/; accessed: 02.04.2016.

[4] Eurostat data: http://ec.europa.eu/eurostat/data/database; accessed: 07.04.2016.

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Healthy ageing – happy ageing: Health Promotion for Older People in Italy

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Abstract

Health Promotion for Older People (HP4OP) is a relevant issue in Italy, one of the countries where people live the longest. Strategies, programmes and projects are set and planned at the national level, mainly by the Ministry of Health within the National Health Service, but strong competencies, funds and resources derive also from the Government, the Ministry of Labour and Social Policies and the Ministry of Internal Affairs. Moreover, European funds contribute to programmes and projects in this field. After strategic implementation at the regional level, programmes and projects are carried out at the local level under the National Health Service, mainly by the Local Health Authorities in conjunction with municipalities and other relevant stakeholders such as NGOs, the voluntary sector, families and educational and religious entities, etc. Even though Italy has been engaged in HP4OP to improve active life expectancy since 1992, a lack of planning and resources for HP4OP, policy diversification at the regional level and a prevailing interest in care-assistance rather than health promotion and prevention have prevented consistent implementation of HP4OP throughout the country.

Key words: **Health Promotion, elderly, Public Health, active ageing, policy, Italy**

Introduction

The objective of the Italian Country Profile in the area of health promotion for older people is to collect and present essential information on the organisation and funding of these activities in the context of the systemic arrangement of health care and public health. The institutional and financial description includes the primary institutions responsible for carrying out tasks in this area – even if health promotion is just a fraction of their responsibility.

On the basis of expert opinions collected within Work Package 6 of the Pro-Health 65+ Project and described elsewhere [1], the most important fields engaged in HP4OP in Italy were identified as the health, social assistance and regional/local authority sectors. The complex picture of health promotion activities targeted at older people was analysed by reviewing the literature and interviewing national and local experts belonging to the three aforementioned sectors. The primary sources of information were scientific papers and grey literature as well as other materials: e.g. government websites, strategic documents, programmes and projects, guidelines and other publicly available sources that were accessible in Italian or in English. A fundamental contribution to knowledge of the role of institutions acting in HP4OP in Italy came from the experts, professionals and street level health promoters who kindly accepted the authors' interview and were mentioned in the "acknowledgment" section.

1. The Italian context for Public Health and Health Promotion for Older Adults

In 1978, the post-war social security system that included a social health insurance system administered by sickness funds was substituted by a tax-funded National Health Service (Servizio Sanitario Nazionale – SSN), based on the Beveridge model that guaranteed comprehensive health care throughout the country [2]. In the last 20 years a process of decentralization has led to a strong empowerment and autonomy of regional authorities, notably in three major reforms which reshaped the system (Legislative Decrees 502/1992, 517/1993 and 229/1999). These reforms introduced elements of an internal market and gave managerial autonomy to Local Health Authorities (Aziende Sanitarie Locali – ASLs) and hospital trusts [3–5]. Finally, with the 2001 reform of Constitutional Law, Regional Governments gained even more autonomy and responsibility, thus transforming Italy's healthcare system into a "regionally" organised National Health Service [6].

At the national level, the Ministry of Health is the leading institution in the field of health promotion but the Ministry of Labour and Social Policies and the Ministry of Internal Affairs are also partially involved directly or indirectly in HP programme management and funding. Currently, the Ministry of Labour and Social Policies, according to Law 328/2000 [7], manages the National Fund for Social Policies (addressed to regional governments) while the Ministry of Internal Affairs, through the action plan for social cohesion (Piano d'azione Coesione – Pac), promotes the national plan for the delivery of care services to children and dependent/non self-sufficient elderly (the plan is addressed to Municipalities). The Parliament also plays a direct role in this field. In June 2016, the parliamentary "Active ageing" group was founded to represent the needs of older citizens and to encourage the Government to introduce policies in favour of active and healthy ageing.

The Ministry of Health has a stewardship role that involves establishing the fundamental principles and goals of the health system through a National Health Plan (recently called the Pact for Health) or a State/Region (plus Autonomous Province) Agreement on Health [8] and determining the core benefit package of health services (called LEA, or essential levels of assistance, financed by general taxation) to be guaranteed across the country free of charge or by cost sharing, and allocating part of the national health fund to the regions. Public health and health promotion, including health promotion for the elderly, are included in the National Prevention Plan, issued by the Ministry of Health [9].

Regional governments are responsible for and have exclusive authority over execution-level planning and delivery of health care, preventive and promotion services as well as health-related fields such as work safety, food safety and scientific research [10]. It's the Regional Health Department that is in charge of the implementation of the Regional Health Plan and the Regional Plan for Prevention, which are based on guidelines set out in the National Prevention Plan. Moreover, Regional Health Departments, together with the Regional Department of Social Policies and a Standing Conference for Regional Health and Social Care Planning, are responsible for the coordination of health and social care.

At the local level, geographically based ASLs deliver public health, health promotion, community health services and primary care. The local departments of prevention are in charge of the planning and coordination of health promotion projects and activities. Integration between social and health sector actions and programmes happens at this level through a specific functional unit called District that collaborates with Municipalities, NGOs and civil society in order to plan and implement integrated projects and actions in the field of health promotion, including that for the elderly [2].

The main actors involved in Health Promotion for the elderly in Italy are shown in **Figure 1**, while the main indicators related to the Italian health system are listed in **Box 1**.

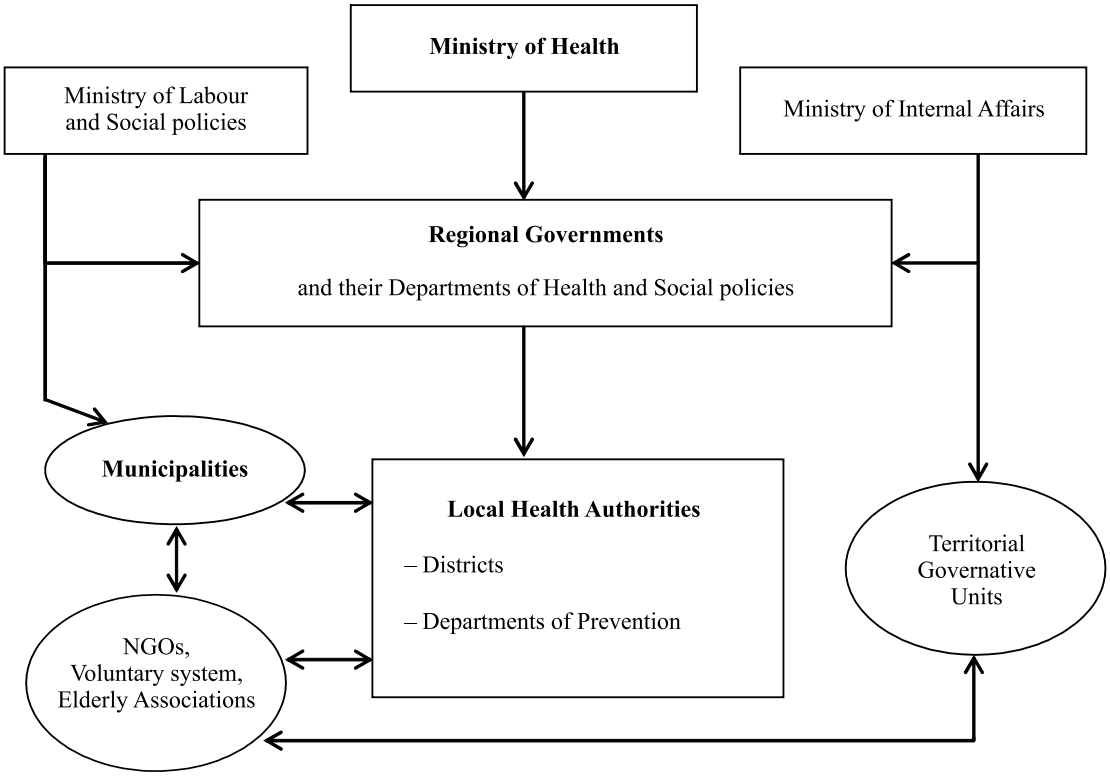

Figure 1. *Actors playing a role in Health Promotion for the elderly in Italy.*
Source: The Authors, 2016.

- **total health expenditure *per capita*** in 2013 was $3,155 [11, 12], (3,077 in current PPP per capita [13, 14]) and has dropped by 3.5% in real terms in the last 3 years due to a number of cost-containment measures that have been taken in the wake of the economic crisis to reduce public spending on health [15];
- **total health expenditure as % of GDP** rose from 7.9% in 2000 to 9.1 in 2014 but it is still below the OECD average; the same health expenditure as % of GDP excluding capital investment expenditure was 8.8% of GDP in 2013, slightly below the OECD average of 8.9%, this value can be explained by the relatively weak GDP growth for Italy over that period [15];
- **health expenditures by financing schemes** (HF NHA), in 2000 and 2013.

Public sources made up 78.2% of total health-care spending, with private spending accounting for the remaining 21.8%, mainly in the form of out of pocket payments (17.8%) for diagnostic procedures (laboratory tests and imaging), pharmaceuticals, specialist visits and for unjustified (non-urgent) interventions provided in hospital emergency departments. Only about 1% of the total health-care expenditure is funded by private health insurance [15]. For comparison, in 2000, public health expenditure accounted for about 72% and private health expenditure accounted for around 28%, with out of pocket expenditures accounting for around 24%.

Box 1. *Health system indicators.*
Source: Own work.

1.1. Health status of older people in Italy

Like many other developed countries in the world, Italy is currently facing increasingly complex and systemic social challenges due to demographic changes that have dramatically modified life expectancy and the composition of the population (see **Box 2**). In 2014, life expectancy at birth was 82.5 years (84.8 for females and 79.9 for males), while at 65 it was 21.2 years (22.8 and 19.2, respectively) [16]. The number of Italians aged over 65 could almost double between 2011 and 2065 to reach about 33% of the entire population [16]. More attention is paid to the quality of life than the quantity. It is estimated that in 2013, the healthy life years for people aged 65+ were 7.3 and 7.8 for females and males, respectively: around one third of life expectancy at that age [16].

- **old age dependency ratio (65+) trends and prognosis (2020, 2030),** the actual old age dependency ratio, i.e. the ratio between the number of persons aged 65 and over (age when they are generally economically inactive) and the number of persons aged between 15 and 64 in 2015 was estimated to be **33.3** (vs. EU 28 at 28.1). The estimates for this indicator in 2020 and 2030 are respectively **34.9** and **40.8**;
- **the shares of the population aged 65+, 65–79, and 80+ in relation to the total population** in 2015 were 21.4%, 15% and 6.4% respectively;
- **life expectancy at birth in 2014** was **85.6** in females and **80.7** for males; 83.2 as a whole;
- **life expectancy at 65 in 2014** was 21.2 total, **22.8** for females, **19.2** for males;
- **healthy life years 65+** in 2014 were equal to **7.3** and **7.8** for females and males respectively.

Box 2. *Population ageing indicators [16].*
Source: Own work.

The "PASSI d'Argento" National Surveillance System reported that in 2013 around 64% of people 65+ suffered from at least one chronic disease (33% cardiovascular diseases, 25% COPD; 20% diabetes; 13% cancer), while 13% had more than three chronic diseases [17]. More generally, 39% of the elderly (65+) were in good health with a low risk of illness, 24% were in good health but at risk of illness, 21% were infirm and at risk of disability and 16% were disabled. On the other hand, while the proportion of smokers declines with age (19%, 13% and 5%, respectively in the 60–64, 65–74, and 75+ age groups), the prevalence of alcohol consumers at risk among the elderly (65–74) remains high (21% in 2014), as does the percentage of elderly at risk due to physical inactivity (44%) (see **Box 3**).

2. Funding of Public Health and Health Promotion for Older Adults – potential sources and main institutions

The Italian national health system is based mainly on a tax-financed Beveridge model and is supplemented by co-payments for pharmaceuticals and outpatient care. Based on OECD data, in 2013 spending on health (excluding investment expenditure in the health sector) amounted to 8.8% of GDP, slightly below the OECD average of 8.9% (see Box 1).

Public sources made up 78.2% of total health-care spending, with private spending, mainly in the form of out-of-pocket payments (OOP) (17.8%), accounting for the remainder. Only about 1% of the total health-care expenditure is funded by private health insurance [2]. The share of government spending in Italy as a share of total spending on health is slightly above the OECD average, while out-of-pocket spending is relatively high compared with other western European countries such as France, Germany and the United Kingdom, although still well below some other southern European countries such as Greece and Portugal.

The public health-care system is financed primarily through IRAP, an earmarked corporate value added tax on companies and salaries paid to public sector employees. The tax is pooled nationally and allocated back to the regions, which have the flexibility to raise the level of taxation. Furthermore, Regions surcharge the national income tax (addizionale IRPEF) and receive from the central government a fixed proportion of national value-added tax (VAT) revenue [2].

The National Health Fund for 2014 amounted to about €110 billion. The Ministry of Health defines the yearly regional funding needs according to a mix of weighed capitation and historical spending. The age of residents is one of the factors that influence the weighted capitation system. The greater part of the National Health Fund is divided into three broad service areas that each region should guarantee as part of the benefit package: primary care (44%), secondary-tertiary care (51%) and prevention (5%). As mentioned above, regions have autonomy concerning the revenue side of the regional budget and complete freedom over the allocation of funds among the regional functions. Thus, the percentages fixed by the Ministry of Health can be modulated at the regional level in accordance with regional planning targets.

This regional autonomy results in the fact that, even though health promotion is considered part of public health and is entitled to receive at least 5% of the National Health Fund as part of the disease prevention core benefit package it only received 4.2% of the National Health Fund in 2013 (€4.9 billion) with wide regional variability (from 2.68% in the Autonomous Province of Trento to 5.91% in the Valle d'Aosta Region) [26]. This means that this sector is underfunded by more or less €1 billion, 0.8% below the target established in the core benefit package defined at the national level [27].

2.1. Financing major programmes/interventions in Health Promotion for Older Adults

A specific system of financing for health promotion for the elderly is not in place in Italy. Nevertheless, health promotion funds are included in the health care budget as part of the national health fund, whose definition depends on an agreement between the Ministry of Health and the Ministry of the Economy and Finance [28].

The main programmes/interventions for HP4OP in the health sector are related to the regional implementation of the National Prevention Plan and to regional projects that address priority areas and targets of national importance under the Pact for Health ("Obiettivi di Piano"). About €2 billion of the 2014 National Health Fund were allocated to the regions that comply with these priority. According to Law 662/1996, priority should be given to "projects for the protection of maternal/child health, mental health, the health of the elderly as well as activities aimed at prevention, and in particular the prevention of hereditary

The total standardised mortality rate in 2013 was equal to: 878.27 per 100,000 inhabitants, 1,112.82 per 100,000 inhabitants for males and 717.7 per 100,000 inhabitants for females [18].

Mortality by main cause for the population 65+

The standardised death rate for over 65 by all causes in 2013 was equal to 3,904.28 per 100,000 inhabitants, 4,933.7 per 100,000 in males and 3,246.73 per 100,000 in females.

The main causes of death in Italy are ischemic heart diseases, which were responsible for more than 75,000 deaths in 2012 (12.1% of total deaths); cerebrovascular diseases accounted for more than 61,000 deaths, equal to almost 10% of total deaths; other heart diseases killed around 48,000 people, (around 8% of total deaths); hypertension correlated diseases accounted for another 5% of deaths (more than 31,200). As a whole, heart related diseases represent the main cause of death in the country (more than 35% of deaths) and among the elderly as well [19].

Another important cause of death is represented by malignant tumours, in particular lung and respiratory cancers, which represent the 4th main cause of death (more than 33,500 deaths, equal to 6% of the total deaths) and the 2nd cause of death in men [20].

The number of deaths in the age class 65–84 years (157,847 in men, 124,258 in women) accounted for about 50% of overall deaths. The top leading causes were ischemic heart diseases for males and cerebrovascular diseases for females. The malignant neoplasm of the trachea, bronchus and lungs was still the second leading cause in men. At older ages (85 years and over) apart from deaths due to heart and circulatory diseases, a remarkable proportion of deaths due to dementia and Alzheimer's was observed (7% of total deaths). It must be noted that in Italy, in 2013, mortality rates related to dementias including Alzheimer's were: 34.28 and 38.23 for male and females, respectively, and 37.35 as a whole [20].

General classification of health status of older population according to "PASSI d'Argento" Surveillance System [17]:

- Elderly in good health and at low risk of illness (39%);
- Elderly in good health but at risk of illness (24%);
- Frail at risk of disability (21%);
- Disable (16%).

Prevalence of chronic diseases in the population 65+ and the main health problems of older population

Prevalence of at least one chronic disease among people 65+: 64% (33% cardiovascular diseases, 25% COPD; 20% diabetes; 13% cancer) **[17]**

Prevalence of more than three chronic diseases among people 65+: 13% **[17]**

DIABETES

In 2012, over 3 million people declared they were affected by Diabetes, corresponding to around 5% of population. The prevalence of Diabetes is growing (from 3.9% in 2000 to 5% in 2012) due to the ageing population. In fact 80% of people affected by Diabetes are over 65, affecting more than 1 out of 5 people over 75 [21].

DEPRESSION

Depression is present among older respondents to the "PASSI d'Argento" Surveillance at a rate of 21%, higher in the age group 75 and over compared to 65–74 (25% vs. 18%), with significant differences by gender (14% men vs. 26% women) [17].

The consumption of anti-depressive drugs in Italy has grown from 26.2 in 2004 to 39.3 DDD per 1,000 inhabitants per diem, showing on one hand an improved diagnostic capacity of GPs and on the other the use of such drugs as support for patients affected by oncological and chronic-degenerative diseases [22].

Behavioural health risks

SMOKE

There are 10.2 million smokers in Italy (60% males, 40% females) corresponding to around 19.5% of the population over 14 years old. The trend is in continuous decrease as well as the average number of smoked cigarettes, which decreased from 14.7 per day in 2001 to 12.1 per day in 2014. The proportion of smokers in the age class 60–64, 65–74, over 75 were 19%, 12.7 and 4.7% respectively, men being more affected [23].

ALCOHOL

The prevalence of at risk alcohol consumers among the elderly (age class 65–74) in 2014 was 21% with 38% and 8.1% for males and females respectively [24].

PHYSICAL ACTIVITY

Among older respondents to the "PASSI d'Argento" Surveillance, 44% can be considered sedentary (in accordance with the Standard identified in the National Prevention Plan) [17].

OBESITY

In Italy, in 2014, about 36.2 % of adults (over 18) were overweight (BMI $\geq$ 25 kg/m^2), with males being more affected (males 44.8% vs. females 28.2%); 10.2% of people are obese (BMI $\geq$ 30 kg/m^2) with males at 10.8% and females at 9.7%. So, a comprehensive 46.4% of the adult population is in a condition of excessive of weight.

The percentage of overweight and obese people rises with age. In fact, the percentage of overweight people grows from 14.9% in the age class 18–24 to 46.5% in the age class 65–74; likewise, the percentage of obese people rises from 2.4% to 15.7% in the same age classes [25].

Box 3. *Health status of older population.*

Source: Own work.

diseases". Since 2009, the Ministry of Health, in agreement with the State-Regions Conference, has identified, among others, at least two programmes dealing with HP4OP: chronicity management/frailty prevention and the promotion of physical activity among the elderly.

Furthermore, within this legislative framework, €240 million have been set aside for the implementation of the National Prevention Plan. In 2014, the Ministry of Health and the regions decided to allocate an additional €200 million of general national health funding for achieving the objectives of the National Prevention Plan. Careful observation of Regional Prevention Plans reveals that only a few projects can be classified solely as health promotion for the elderly, but a large number of projects aim to reduce chronic diseases and are consequently targeted at older people. Additionally, the programme

Gaining Health, even if it is not specifically for older people, should be mentioned as an essential programme in this area. It is promoted and financed by the Ministry of Health and implemented by the National Institute of Health.

Some health promotion funds for the elderly derive from the social sector as well. As a whole, the Ministry of Labour and Social Policies and the Ministry of Internal Affairs are granted funds from general taxation in accordance with the "Documento di Economia e Finanze – DEF" (Document on economy and finance of the State) issued by the Ministry of Finance and the Budget Law issued by the Parliament, which authorises the government to collect and use public resources in its administrative activities [29, 30]. The two Ministries are in charge of funding national programmes in the field of social assistance for specific categories of the population such as non-self-sufficient older people (these programmes may or may not include HP4OP).

Specifically, the Ministry of Labour and Social Policies is responsible for the coordination of social services within the national healthcare system's infrastructure. The National Fund for Social Policies, with a budget of around €300 million, is distributed to Regional Governments upon the presentation of specific programmes and projects that may also include HP4OP [31]. Recently, through its Department of Social Cohesion, the Ministry of Internal Affairs has launched the national programme, "Care Services to Children and Frail Elderly" with the purpose of providing and implementing multidisciplinary services to frail elderly citizens in regions in southern Italy [32]. These funds are distributed in a given territory based on the projects presented by its municipalities. The presence of actions in the field of HP4OP is considered a main criterion for the assignment of funds.

Finally, some Regions decided to finance some projects using the structural funds provided by the European Union to promote the competitiveness of the regional economy and increase the social, economic and territorial cohesion. Regions assign these funds to the local industries according to a specific regional plan [33].

3. Institutional analysis of health promotion interventions for older adults

3.1. Health Promotion for Older People performed by the Health Sector

As a whole, HP4OP policies have been implemented in Italy since 1992 with the first national project being "Tutela della salute degli anziani" (protection of elderly's health), whose main objective was to improve "active life expectancy" in the elderly [34]. Preventive and promotional measures to facilitate access to health and social services, transportation and housing etc. for the elderly population first appeared in the National Plan 2001–2003 [35]. From 2011 onward, National Health Plans have taken into consideration the concepts of healthy and active ageing and fostered programmes to reduce chronic diseases, reduce inequalities and inequities and improve determinants of health. Integration between social and health institutions and programmes has become a starting point in initiating HP4OP programmes.

Currently HP4OP policy is based on the assumption that it is imperative to act not only through preventive and promotional health policies, but also by tackling all the extra-health determinants of health: social situation, income, mobility and civic participation, for example, are factors which significantly affect the state of health and autonomy of older people.

As a whole, the organisational structure of Public Health (PH) and Health Promotion (HP) services follows the overall structure of the National Health Service (SSN) since Public Health and health promotion are deeply interwoven with it. For this reason at the National Level the main institution responsible for PH and HP, including HP4OP, is the Ministry of Health, which is organised into General Directorates. In particular, the General Directorate for Disease Prevention (DG per la prevenzione sanitaria), the General Directorate for Health Care Planning (DG della Programmemazione Sanitaria), and the General Directorate for Hygiene and Safety of food and nutrition (DG per l'igiene e la sicurezza degli alimenti e la nutrizione) are the administrative structures dedicated to PH and HP [36]. National health promotion for the elderly strategies, programmes and projects are set and planned at this level even though a specific department for HP4OP, specifically healthy ageing, is not present. Regardless, since 2004 the National Centre for Disease Prevention and Control (CCM) has been the institution aimed at liaising between the Ministry of Health and regional governments in regard to surveillance, prevention and health emergency response. Over the years the CCM network has expanded its role to include designing evidence-based national strategies for disease prevention, health promotion and equity, providing operational support for project implementation and for identifying and disseminating best practices. Within this framework, the CCM can establish, with several million Euros per year, projects of national relevance [37].

The most important document in the field of health promotion and prevention is the National Prevention Plan (NPP), issued as part of the National Health Plan (NHP) [38].

Public health and health promotion policies, including HP4OP, as outlined in the NPP, are implemented by the regions and their Regional Health Departments through the Regional Prevention Plan (RPP); it must be noted that Regional Health Departments coordinate both health and social care through a Standing Conference for Regional Health and Social Care Planning [36].

At the local level, health promotion and prevention of the population is ensured by the ASLs. GPs represent the main actors in terms of HP4OP due to their direct relationships with patients and since, apart from diagnosis and treatment, their main functions also include: patient education in terms of social, cultural and environmental behaviours that might influence health promotion and

prevention, health status and responsibility for information concerning district services. Apart from GPs, districts are also responsible for integrated home care delivery that includes the activity of several professionals (such as GPs, specialists, nurses, social assistants) and they enable advocacy actions towards the elderly by enhancing and sustaining programmes and behaviours in the context of health promotion and prevention [39]. Finally, another important role is played by the Departments of Prevention, which are directly or indirectly accountable for Influenza and Pneumococcal vaccinations as well as specific screening programmes for the elderly (together with GPs) and also foster patients to improve lifestyle, diet and social inclusion [40].

3.1.1. Key health promotion strategies/programmes for the elderly within the health sector

A specific national plan on HP4OP is not in place in Italy. Nevertheless, starting from 2005, the first National Prevention Plan was issued by the Ministry of Health and health promotion was included in it. Specific areas of intervention were identified in this plan and HP4OP was one of the areas considered for funding. The National Prevention Plan is implemented through the Regional Prevention Plan, taking into account the regions' needs and priorities [37]. In 2007, the National Prevention Plan, following an intersectoral approach, launched the National Programme "Gaining Health" (Guadagnare Salute), with the aim of modifying the main risk factors for the population, and, as for the elderly, to reduce the burden of chronic diseases by tackling risk factors, inadequate behaviour and the extra-health determinants of health. This programme involves a great number of stakeholders and its main objective is to develop and communicate widespread policies in order to: promote mobility and physical activity of people (transportation and urban green areas); support fruit and vegetable consumption; reduce the concentration of salt, sugar and fat in food; reduce the share of high-caloric foods in the diet; discourage smoking and alcohol abuse [41].

Additional resource for the implementation of HP4OP have been assigned by the CCM since 2007: i.e. in 2009 the CCM network funded a project aimed at testing screening and comprehensive assessment procedures for frail elderly citizens in Tuscany (Central Italy) in the model of interventions to prevent disability. Other project about frailty and its prevention have been carried out in Emilia Romagna, Liguria, Lombardia, Puglia, Veneto. This topic is very relevant and challenging and requires further investment to prevent frailty, to postpone its onset or to slow its progression as well as to measure and manage frailty in community-dwelling older adults.

In order to programme a national strategy capable of preventing the elderly from getting ill or losing their autonomy, the Ministry of Health sponsored a specific Surveillance System for the elderly called "PASSI d'Argento" which is carried out by the National Institute of Health (ISS) [17]. This monitoring system is capable of identifying the major modifiable determinants of health in elderly citizens over 65 so that the information it yields can be used to implement more appropriate and effective actions in the field of HP4OP. In fact, "PASSI d'Argento" might become the basis for good health promotion planning and the drafting of future National Prevention Plans. Consequently, Regional Plans concerning the socio-health conditions of the elderly might also use its data in order to better organise and design health promotion programmes and plans at the local level.

Other Programmes worth mentioning are: the National Operative Plan Against Sudden Excessive Heat called "Ondate di Calore" whose objective is to prepare elderly people, especially those with limited thermoregulation capacity or who are frail, to face excessive heat and high environmental temperatures [42]. This plan is issued by the Ministry of Health in collaboration with the Centre for Prevention and Control of Diseases (CCM) in order to reduce the impact of excessive heat on health; it is implemented at the local level by the ASLs with the support of General Practitioners (GPs) that identify frail elderly citizens and provide proper information and education on the issue. The program was implemented with the collaboration of the National Civil Protection (Protezione Civile) and several non-for profit organizations [43].

3.1.2. Cooperation within and between sectors

At the national level, as stated above, the Ministry of Health, following an intersectoral approach, promoted by Decree N°229/1999, launched in 2007 the National Programme "Gaining Health", which involves a great number of organisations from different sectors, including ministries, governmental agencies, the educational sector, environmental agencies and police forces etc. in order to disseminate health promotion policies among the population.

According to Decrees 229/1999 [5] and 328/2000 [7], the integration between the health and social sectors is managed by the ASLs, through a functional unit called the District (Distretto Socio Sanitario), and the Municipalities, through dedicated units. In particular, the ASLs provide the Programme of Territorial Activities (PAT), and Municipalities define social care plans called "Piani di Zona" – (Zonal Plans). These plans are combined into a wider Local Action Plan (PAL) that describes the provision of health and social services delivery at the local level, including the role and participation of the Voluntary sector and NGOs, which play a fundamental role in the effective implementation of projects, actions and policies regarding HP4OP.

In terms of HP4OP at the local level, an important role is played by the Multi-Dimensional Evaluation Unit created by the district within a given ASL territory. In addition to medical assessment, patients get in contact with this multidisciplinary team that takes care of both social and health needs, suggests to patients how to better control their illness and promotes healthy lifestyles and behaviours. The implementation of innovative and reliable instruments for multi-dimensional evaluation was developed in a specific project within the Regional Prevention

Plan of the Marche Region. Another strategy was developed in recent years in the Veneto region; with the application of the DGR 41 of 18/01/2011, a new organisation of primary care, based on Functional Territorial Aggregations (Aggregazioni Funzionali Territoriali), was launched together with the so called Integrated Group Medicine (Medicina di Gruppo Integrata). This new primary care model consists in the integration of resources, including GPs, nurses and administrative personnel from the district and social assistants and other administrative personnel from Municipalities, with the aim of creating a wider network capable of improving health promotion and prevention as well as the integration of social services and health care. Regardless, it should be highlighted that implementation of both the above-mentioned models is very different across the regions, without national standards.

In the context of specific projects, such as those realised within the framework of the CCM network, the ASL could involve local universities and regional research centres.

Finally, the most recent National Prevention Plan identified the workplace as one of the most effective settings for Health Promotion. In this framework, the ASL of Modena is carrying out a pilot project that involves the department of prevention, voluntary occupational health physicians and social partners (employer representative associations and trade unions). Italian companies, with quite a high mean age of employees, have strong internal commitment to target workplace health promotion to older people.

3.1.3. Identification of the main limitations and barriers in health sector involvement in health promotion programmes for the elderly

One of the main limitations in the dissemination of HP4OP programmes is rooted in the lack of a well-designed national strategy in this field: specific HP4OP strategies and funds are not clearly defined and only portions of them are considered under the umbrella of disease prevention.

Another barrier is the fragmentation of policies at the regional level due to the different distribution of district functions among regions: in some regions, districts are in charge of both production and commissioning of services, in others the function of commissioning is kept within district control while production of services is delegated to a third party; finally, in regions like Tuscany, the two functions are managed together by districts and Municipalities, which share responsibilities. This last model ensures that a third sector, involving the voluntary sector and NGOs, participates in decisions along with ASLs and Municipalities. These differences in terms of district organisation might be responsible for different outcomes in terms of the implementation of actions, projects and programmes of health promotion for the elderly. Furthermore, health promotion funds, plans and activities at the local level depend on the General Director's choices that, indirectly, reflect those of the regional government that appointed him; the DG is appointed by the Regional Government (Giunta regionale), a political body, without public competition to select the candidate. Finally, another barrier to the dissemination of HP4OP derives from an insufficient knowledge of district health and social services by health professionals and GPs, as well as from the fact that all the stakeholders do not share a clear interpretation of health promotion.

3.2. Social Assistance Sector

The role of the Social Assistance System is still very important in Italy despite the health system reform of 1978 that initiated the shift from a Bismark to a Beveridge model. Currently, at the national level, the Ministry of Labour and Social Policies and the Ministry of Internal Affairs contribute to the improvement of the population's health status through the definition of social assistance programmes that act directly or indirectly on health, behaviours, lifestyles, social cohesion, mobility and also health promotion for specific groups of the population, such as the elderly. The integration between social and healthcare needs is realised at the regional and, mostly, local levels through the definition and implementation of specific strategic plans. Therefore, Regional Governments and Municipalities have a fundamental role in the implementation of both social and health promotion actions.

The most important national fund granted to Regional Governments for the development of an integrated network of social services and interventions is the National Fund for Social Policies issued by the Ministry of Labour and Social Policies in accordance with Law 328/2000 [7]. Funds for Regional Governments are provided if regional social care plans are in accordance with the abovementioned national programmes and specific criteria defined by law. Regional social care plans take into consideration the social service and health care needs of the elderly population living in the area and present policies and programmes, including those regarding health promotion for the elderly, proposed by the Municipalities. The local level is indeed responsible for the organisation and implementation of actions regarding social welfare and health promotion for the elderly in the field. The performance of Municipalities is then evaluated in order to obtain the funds. Besides the Ministry of Labour and Social Affairs, the Ministry of Internal Affairs as well as the Department for Family Policies of the Presidency of the Council of Ministers might access funds from the European Social Fund (ESF) for promoting policies in the field of health promotion, social inclusion and social assistance for the elderly. These funds finance specific programmes and activities defined by European policies and carried out at national level mostly by Provinces and Municipalities but also by NGOs and other organisations that act as organisers and promoters.

It must be noted that access to social care services and interventions is allowed primarily to all citizens with low incomes as certified by the value of their Equivalent Economic Situation Indicator (ISEE), which takes into consideration: income, assets and family characteristics.

3.2.1. Key health promotion strategies/programmes for the elderly within the Social Assistance Sector

The public policy and funding framework for HP and social assistance for the elderly has not changed significantly in the last decade despite the increase in care needs. The coverage rates of public services are almost equal to those of ten years ago and are mainly based on the granting of a carer's allowance for those caring for frail elderly people. Nevertheless, in Italy there are several programmes in place aimed at health promotion towards the elderly carried out within the social assistance sector, even though they are not always structured in a well-defined strategic policy. Furthermore, the information regarding these programmes are not easily accessible, usually in Italian and without data regarding the real impact of the initiatives nor regarding indicators of the process.

The national programme "Staffetta Generazionale" (Generational Relay) is a project financed by the Minister of Labour and Social Affairs and implemented by Regions and Autonomous Provinces through the assistance of "Italia Lavoro" (Work Italy) in the framework of "Welfare to Work", the re-employment policies for 2012–2014. The project's aim is to encourage companies to hire a young worker while converting the full-time job of an older worker into a part-time job, promoting intergenerational exchange and maintaining lifetime employment of older workers, thus avoiding social isolation. The Minister of Labour and Social Affairs finances the programme to the cost of 40,285,961 euro [44].

During the European Year of Active Ageing in 2012, the Department for Family Policies was in charge of coordinating all the initiatives among its plans of activity in Italy. So, in 2012, it funded (with 1.5 million euros) 47 projects to spread greater knowledge on issues related to Active Ageing in Italy [45]. The financed projects were promoted and organised by the Provinces, Municipalities, NGOs and other organisations. For example, the project "The Pink and Grey" aims at promoting intergenerational exchange and creating a network among elderly women, who already hold top positions in enterprises, and young women early in their careers so that cases of successful women become examples for other women to learn from and be encouraged by. Another example is "Argento Vivo" (Quicksilver), a project promoted by the Municipality of Castiglione Fiorentino that aims at facilitating voluntary activity related to the transfer of knowledge between the elderly and young people on 5 social issues [46].

Several Regions are also using European resources from the European Regional Development Fund to promote research and development projects aimed at ensuring active and healthy ageing [47].

Another health promotion strategy for the elderly involves a wider implementation and strengthening of social home care, that should be integrated with the home care provided by the health sector. This requires the involvement of several professionals with the aim of improving quality of life, guaranteeing better food consumption and avoiding the isolation of elderly people. In this respect, the **Department of** Social **Cohesion of the Ministry of Internal Affairs** launched (and financed) the national programme of "Care Services to Children and the Elderly Frail" with the purpose of providing and implementing multidisciplinary services to frail elderly people in regions of southern Italy [48].

3.2.2. Cooperation within and between sectors

The cooperation of the different level of SAS is well structured and has already been described. On the contrary, the cooperation with other sectors and institutions in health promotion programmes for the elderly is not comprehensively structured and is mainly entrusted to single programmes and projects, which are often carried out at the local level.

As a whole, according to Dlgs. 229/1999 [5] and Dlgs 328/2000 [7] the integration between social services and health care is managed at the local level through the participation of the Municipalities (and their representatives) in the definition of local plans developed by the districts of the ASLs and the Municipalities. It must be noted that districts, despite being functional institutions of the ASLs, are eventually granted separate budgets within their ASLs and might also account for specific funds provided by the social sector, namely the Ministry of Labour and Social Policies.

The social, health and voluntary sectors can collaborate on specific projects, in favourable circumstances and settings. Good cooperation between different sectors depends on institutions like the family and the religious community. In fact, the lack of a structured and widespread network of services for the elderly in Italy is compensated for by families that organise, deliver and, in some cases, finance care, social assistance and health promotion activities. Because of this, the Italian national care and social assistance scheme has been labelled "familist", along with other countries of southern Europe [49].

A very interesting example of cooperation is represented by "Happy Ageing," the Italian alliance for active ageing, founded in 2014 to promote policies and programmes to protect and promote the health of the elderly in Italy. The alliance is composed of scientific societies (like the Italian Society of Hygiene and the Italian Society of Geriatrics and Gerontology), several trade unions and older representatives. The aims of the Happy Ageing alliance are advocacy for HP4OP at the national level and the collection of all the best practices in the field of elderly wellness [50]. Other interesting examples can be found in the project "Viva gli Anziani," in the "Alzheimer's Cafè" and in the initiative "Give Memory" of the Forum of Family Associations. "Viva gli anziani" (Long Live the Elderly!) is a project promoted and organised by the Sant'Egidio Community, in cooperation with the Italian Ministry of Health and the municipality of Rome, which aims at fighting the social isolation of the elderly by creating a network between older people to prevent critical events [43]. It is inter-

esting to underline that the preliminary results of this project have been recently published: Marazzi et al have shown its capacity to reduce the over-74 hospitalization rate, the use of Long Term Care and the cost of services used by the studied population [51]. The "Alzheimer's Cafè" is a place where patients with dementia and their relatives can share information, exchange their experiences and support each other. These cafès are organised by one or more municipalities in collaboration with local cooperatives and associations as well as the ASL [52]. "Give Memory" (Donare Memoria) from the Forum of Family Associations is an initiative that aims at shifting the role of elderly people from "social cost" to "social resource" by encouraging intergenerational exchange. Older people's memories are shared with young people so that the elderly have an active role and wider social inclusion [53].

3.2.3. Identification of the main limitations and barriers in Social Assistance Sector involvement in health promotion programmes for the elderly

Despite the social service and health promotion issues related to the elderly which have entered the public arena since the beginning of the new millennium, they have not been tackled adequately and there is a lack of definition of the Basic Levels of Social Assistance at the national level as well as a strong heterogeneity of regional laws that regulate the administration of integrated social services and health care.

Moreover, the missions defined in the National Budget Law and the programmes proposed by the Ministries of Labour and Social Policies and the Ministry of Internal Affairs are mostly geared to assistance, in particular care-assistance, rather than health promotion and prevention for the elderly. Although several proposals have been advanced by all political parties to implement a health promotion and prevention system for the elderly as well as a system for the needy elderly, most of the reforms adopted by the Italian government have focused mainly on the pension system and, only partially on setting health promotion policies [54].

Additionally, there are modest endowments of public services to support frail older people in Italy but public interventions are initiated mainly when people are in situations of serious dependence and, in any case, these interventions are focused on provision of a carer's allowance, the payment of which is not combined with any mechanism capable of ensuring that it is used properly. It must be noted that when the economic situation of a family is not so compromised, the carer's allowance is not guaranteed such that families have to bear the costs of care.

Another issue is that regionalisation of services has led to the jeopardisation of social care activities towards the elderly throughout the country, with huge differences in terms of allocation of welfare resources. This might imply a general inadequacy of the regional regulatory framework to produce balanced subsystems at the local level where fragmentation is actually very evident. Basically sub-regional differentiation in social assistance is not due to a different structure of needs, but rather to a dissimilar intervention capacity [55].

As a whole, the lack of a comprehensive national and regional strategy in terms of health promotion for the elderly within social care is one of the factors that have led to the consolidation of a massive private care market. In fact, the needs of elderly people have been covered mostly by low-cost private services, such as those offered by private caregivers, whose focus is on care and not on health promotion and prevention [56].

3.3. Regional/Local Self-Government

Regional and Local governments play an essential role within the Health and Social Assistance Sectors that has already been described in the previous sections. Since the 2001 Constitutional Reform, regions have shared planning and financing responsibilities with the central government in the form of the permanent State-Regions Conference. Furthermore, regional governments are in charge of the management of ASLs and Hospitals by defining their geographical boundaries, allocating resources to them, and appointing their directors. Consequentially, the 21 regional governments (19 regions and 2 autonomous provinces) are fully entitled to manage their own regional health and social system according to their specific needs and demand. That entailed the creation of different Regional Health and Social Systems with relevant implications in Social that will be discussed in this section, together with the role and peculiarity of the local governments.

3.3.1. Key health promotion strategies/programmes for the elderly attributed to different Regional and Local authorities

Key health promotion strategies for the elderly at the regional level depend on both the health and social sectors. The executive functions of the regional governments in health care, mainly carried out through the Regional Departments of Health, include the definition of a three-year Regional Health Plan. Activities and projects regarding prevention and health promotion as a whole, including health promotion for the elderly, are described in the Regional Prevention Plan. As stated before, each regional authority has the autonomy to run its own regional health system according to its specific needs and demand. Therefore some regions might decide to invest more in health promotion for the elderly programmes and projects. On the other hand, the presence of a specific programme for health promotion for the elderly within the regional prevention plan is not compulsory. Below are some examples of programmes within different regional prevention plans specifically targeting HP for the elderly:

- the promotion of physical activity (i.e. the Project "Colori in Movimento" (Colours in Movement), implemented by the Abruzzo Region; the project "Anziani in Cammino" (elderly on the way), implemented by the Umbria Region; the projects "Gente in Gamba

+65" and "Attività Fisica Adattata" (AFA), implemented by the Marche and Liguria Regions);
- the promotion of healthy eating habits (i.e. the Project "Colori in Movimento" (Colours in Movement), implemented by the Abruzzo Region; a project to improve food delivery in nursing homes, implemented by the Piemonte Region;
- the prevention of falls and trauma (i.e. a project to avoid domestic falls, implemented in several Regions (Calabria, Emilia Romagna, Liguria, etc); the project "Ossi duri si diventa" implemented by the Marche Region and aimed at training caregivers of elderly people).

For social assistance, a Social Regional Plan is approved by the Regional Council in accordance with Law 328/2000 [7]. The social plan defines an integrated system of social interventions implemented with the help of Municipalities, NGOs, the voluntary sector and the third sector as a whole. In some regions, integrated social-health plans have been proposed with the objective of removing the psychosocial hardship and marginalization of some citizens, thus transforming them into active actors in the social and health system. Furthermore, in accordance with regional autonomy and within the framework of the national prevention plan, some legislative interventions promote the elderly's involvement in social and public life as a fundamental resource: for example, in the Autonomous Province of Trento, with Regional Law n°11/2008, elderly people are invited to join the voluntary service to transfer their knowledge and experience to younger generations. Similarly, in the Umbria region, Regional Law n°14 of September the 27th 2012, has promoted active ageing as a key strategy to bring the elderly into social action and participation.

3.3.2. Cooperation within and between regional and self-governments in the sphere of health promotion programmes for the elderly

Regional Health Departments are responsible for the coordination of health and social care through a Standing Conference for Regional Health and Social Care Planning. Nevertheless, most of activities and projects for the elderly are developed and implemented at the local level by ASLs, Municipalities and Communes. When health promotion programmes for the elderly are included into the Regional Health or Prevention Plans they should be implemented at the local level by Local Action Plans. Cooperation with the social sector depends on the degree of commitment of the Regional and Local Department for Social Policies and their capacity to work together with districts of LHAs and third sector actors. Integration between NGOs, the health sector and the voluntary sector, etc. depends mostly on the Zonal programmes and plans established by Municipalities and ASLs in accordance with the other stakeholders at the local level. As an example, the Marche Region has recently signed an agreement with the UISP (Italian Union for Sport for All) to put the Department of Prevention in contact with local sports organisations to improve physical activity targeted based on age (children and teens, adults and seniors) [57].

In the context of specific projects, most of the regions involve local universities and regional research centres. For example, in the Marche Region there is the only one IRCCS (Research and Care Institute aimed at Scientific Development) specialised in geriatrics and gerontology, the National Institute for Rest and Care of Elders (IRCCS-INRCA). The IRCCS-INRCA is often involved in several European and national projects aimed at assessing the effectiveness of HP4OP strategies, such as:
- The SPRINT-T project, aimed at preventing sarcopenia and disability through a complex intervention that combines physical activity and nutrition [58];
- The Up-Tech project tested, in more than 500 families of people suffering from Alzheimer's, the effectiveness of an intervention of case-management and home automation;
- Several European projects aimed at developing new technologies for the quality of life of the elderly at home (SMART HOUSE and ROBOT-ERA Projects).

An innovative method of cooperation in the field of Social was launched in 2012 by the European Innovation Partnership on Active and Healthy Ageing through the identification of "reference sites": coalitions of regions, cities, integrated hospitals or care organisations that aim to provide a comprehensive, innovation-based approach to active and healthy ageing - and that provide concrete examples of their positive impact. Reference sites demonstrate synergy between different actions and breakthrough solutions within a short time frame, as well as the added value of a holistic approach. To date, all 5 Italian Reference Sites are regions (Liguria, Campania, Emilia Romagna, Friuli Venezia Giulia and Piemonte) and several regions submitted their application for the new call in 2016 [59].

3.3.3. Presentation and short description of examples and good practices of health promotion programmes for the elderly implemented at the regional and local levels

The first example of good practice of Social programmes can be found in the Network "Italia Longeva," created by the Ministry of Health, the Marche Region and IRCCS-INRCA. The network enhances the active role of elderly people in society, considering them a resource and not a cost: elderly people's experience and knowledge are used in order to create new social and health services (that the elderly themselves will use) through the implementation of concepts such as techno-assistance, domotics, tele-medicine and tele-monitoring. The idea is to disseminate new modalities of care, particularly home care, with the aim of guaranteeing the elderly greater autonomy, a better quality of life and, at the same time, reducing healthcare costs through the development and the implementation of new technologies. A similar project in the field of healthy ageing worth mentioning is the OPLON (OPportunities for active and healthy LONgevity) project, whose objective is to prevent the

elderly from becoming frail through the use of high technology solutions that support the creation of "smart health communities" in defined territories. This project is sponsored by the Universities of Bologna and Bari, the Polytechnic of Torino and other national enterprises [60].

The project "Orti Urbani" (urban gardens), a project promoted and organised by the NGO "Animo Onlus," in cooperation with the municipality of Cerveteri, aims at involving older people in the cultivation of land and inter-generational knowledge transfer [61]. This initiative is very popular in Italy and a great number of Italian Municipalities provide free plots of land to older people to promote activities that encourage autonomy and physical and mental well-being, socialisation, participation in community life, initiative and the self-organisation of citizens.

Interesting projects are also being developed in the Liguria region, where Law n°48 of November 2009 favoured projects of active ageing and the promotion of health and social actions towards the elderly such as: lifelong education programmes, sports and healthy lifestyle programmes, participation of the elderly into the voluntary sector and the promotion of the social inclusion of elderly people. An interesting project called "Immigration as a Social Resource Rather than a Source of Fear" (**AUSER**) aimed at overcoming older people's fear and prejudice against immigrants by setting up meetings between older people and their families and the families of immigrants as a means of overcoming stereotypes and building cultural awareness and exchange. Another initiative worth mentioning is the project "Improving Quality of Life in the Third Age through New Technology," whose objective is to train older people to become "computer literate" and familiar with technology. Thanks to this initiative, older people in the Liguria region have approached the Internet and computer technology and their quality of life has improved thanks to their ability to contact the Public Administration through online services.

The Liguria region is also one of the 5 Italian regional sites of the European Innovation Partnership on Active and Healthy Ageing, which supports projects which improve cognitive functioning "i.e., Memory Training" and physical activity. The other "Reference Sites" presented programmes to prevent and reduce functional decline and frailty among older people (Campania), to use information and communication technology in healthcare (Campania, Emilia Romagna), to improve the quality of life for the elderly population with visual disabilities (Friuli Venezia Giulia) and to train health care professionals in providing a proactive management model of care for chronic diseases (Piemonte).

Some other interesting projects include the implementation of the WHO "Age Friendly City" concept in the city of Udine (whose project turned into a model to be implemented in other cities) and the project Pro Senectute, developed in Omegna, a little town in the Piemonte region, where people over 65 were involved in music and cuisine courses, plant cultivation and healthy diet sessions, etc. and showed a better life expectancy without disabilities [62]. The "Age-Friendly City" is a WHO project that involves 35 cities in 22 Countries all around the world, with the collaboration of governmental, nongovernmental and academic groups. The project is aimed at developing or implementing policies, services such as outdoors spaces and transportation, settings and structures to support and enable people to age actively. Udine, a city in the Friuli Venezia-Giulia region with a population of almost 100,000 inhabitants, was one of the 35 "Age-friendly Cities", the first and only one in Italy. The activity of the project, undertaken by the Municipality of Udine, included the creation of new opportunities for intersectoral and inter-generational work; the involvement of the elderly community in social activities; matching the distribution of the elderly in the city to the provision of public, health and social services offered at the local level; recording the experiences and needs of older people through a consultative process with citizens, caregivers and providers of services to discover the existing "age-friendly" urban features as well as the barriers to active ageing; and promoting opportunities for older people to remain physically, mentally and socially active through activities at the local level. Additionally, the initiatives of the project led to the implementation of food and mobility policies oriented towards the elderly: involving groups of about 15-20 older people who meet at a station point for a walk of 10-15 km a day in a green park; providing elderly people with the opportunity to participate in a cycle of seminars and cooking workshops; creating occasions for socialisation and gathering people of different ages. The Municipality of Udine financed all the activities implemented in the frame of the project at the cost of about 100,000 euros [63, 64].

3.3.4. Identification of the main limitations and barriers in planning and implementing health promotion programmes for the elderly

The main barriers to planning health promotion programmes for the elderly derive from the lack of specific national and regional regulations in this field. The National Health Plan does not define mandatory funds for health promotion for the elderly and neither does the National Prevention Plan include Social as a specific issue to tackle. The same is true at the regional level with regional health and prevention plans that may or may not include Social as a main topic to address.

As for the implementation of Social projects, this mostly depends on the performance of underfinanced districts or municipal budgets. Furthermore, health, social and voluntary sector professionals are usually oriented towards care and assistance instead of promotion.

Finally, it must be underlined that in a context of limited resources, health promotion for the elderly actions and projects are not seen as priorities by decision makers who prefer results in the short term, sometimes demonstrating a lack of vision.

Summary and conclusions

Health Promotion for the elderly in Italy is carried on mainly by the Ministry of Health within the framework of the National Health System through the part

of National Health Fund dedicated to disease prevention. Nevertheless, funds and resources also derive from the Ministry of Labour and Social Policies through the National Social Fund and, for specific issues, from the Ministry of Internal Affairs. Moreover, European funds might also be used for this purpose.

In general, HP4OP is considered within the context of the National Prevention Plan, which is issued in accordance with the National Health Plan, and receives funds only if regional governments assign funds to it. This happens since each region, according to the newest reforms of the healthcare system and constitutional law, is basically free to manage its own health care system according to its specific needs. Regions have to guarantee core benefit packages established at the national level, but are independent in their choices as to financing specific priorities and programmes in the health sector as well as in terms of labour and social policies.

In the health sector, part of the funds dedicated to prevention should also cover health promotion, including that for the elderly. Resources are assigned to the operative unit of the local health authorities called Districts. As for the social sector, a compulsory fund for HP4OP is not in place nationwide. Regional governments perform territorial needs analysis and propose regional bids in order to address funds to Municipalities and other Entities acting in the territory and HP4OP receives public resources when it is considered to be of top priority or at least an issue to tackle at the regional/local level. For this reason, projects and programmes are developed heterogeneously among regions.

The integration of both social and health actions in terms of HP4OP is realised at the local level where the ASLs and the Municipalities draw the Local Territorial Plan and the Zonal Plan for health care and social care respectively. Both plans are taken into consideration in a wider Local Action Plan that determines and describes how to implement integrated social services and health care projects and actions at the local level and the actors involved in doing so, such as the district, health professionals, NGOs, the voluntary sector, educational entities etc.

As a whole, the main actors in the implementation of HP4OP actions are GPs and other health professionals together with voluntary service staff. Nevertheless an important role is also played by families and religious communities, both significant institutions throughout the country. These actors are notably historically linked and achieve impressive results and, with the help of the municipalities and the ASLs, are capable of organising structured and integrated projects of health promotion for the elderly at the local level.

In general, a strong evolution in terms of policies towards HP4OP has taken place in Italy in the last twenty years: elderly people have passed from merely being cured and assisted, viewed only as sick, unproductive and passive subjects, to being the centre of new policies according to which governments should act not only through preventive and promotional health policies, but also to tackle all the extra-health determinants of health such as social situation, income, mobility, civic participation, etc. All are factors which significantly affect the state of health and autonomy of older people. Interestingly, just on 9 June 2016, the first parliamentary intergroup "Active ageing" was founded to perform advocacy for older citizens and to stimulate the action of the government towards initiatives to develop policies in favour of active and healthy ageing in Italy. It will aim to promptly receive the recommendations from the European Commission, including the target of an increase of two years of healthy life expectancy of people by 2020 in the 28 member countries. The deputies and senators who have decided to join this group will promote bills, questions and motions to develop a concrete solidarity between generations, ensure active ageing and healthy citizens and to meet the needs of millions of families who are caring for an elderly relative.

The main barriers to the realisation of such policies are due to the lack of specific national and regional health plans, regulations and orientations in the HP4OP field. Moreover, in terms of social care, most actions and projects are also addressed to care-assistance rather than health promotion and prevention for the elderly. This general state of the actual social policies, together with the fragmentation of policies at the regional levels, constitutes a limit to the implementation of homogeneous HP4OP strategies and programmes. Another limitation is presented by the absence of data about the process and/or the impact of activities dedicated to promoting Active and Healthy Ageing. Last but not least importantly, field implementation of HP4OP projects mostly depends on the performance of underfinanced districts or municipal budgets and not all GPs, nurses or other health professionals and volunteers interpret the term "health promotion" in the same way.

In conclusion, even if Italy is one of the countries where people live the longest, the 65+ age group is burdened with chronic diseases and unhealthy lifestyle choices, and more than 40% of older people are at risk of illness or infirmity. HP4OP has generally been considered less important than care assistance and most reforms have focused on the pension system rather than HP policies. Effective HP4OP policies and programmes should be enhanced to reduce the problem of non-communicable diseases and to improve the quality of life for the ageing population. More attention should be given to multi-factorial and multi-disciplinary programmes that use a variety of strategies to target multiple domains (for example: social and work participation, physical activity, healthy eating) and encourage individuals and communities to change their lifestyles and take more responsibility for their health. Regionalisation has jeopardised health and social care activities targeted at the elderly as there are vast regional differences in terms of the allocation and use of welfare resources. A stronger stewardship role is required at the national level to develop integrated social and health promotion for the elderly sustained, by both social service and health care funds. Finally, investments in training and capacity building are essential to improve knowledge and attitudes of different public health professionals and other actors involved in HP4OP.

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Health Promotion for Older People in Portugal

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Abstract

In a country like Portugal where life expectancy is very high, Health Promotion for Older People (HP4OP) is a relevant issue and specific strategies are considered within priority health programmes defined at the national level by the Directorate-General of Health on behalf of the Ministry of Health. The National Health Plan 2016–2020 includes directives to facilitate health promotion and access to health and social services, as well as to reduce the burden of chronic diseases.

HP4OP funds and resources derive mainly from the Ministry of Health and also from the Ministry of Labour, Solidarity and Social Security. Moreover, institutions can access European and other funds to develop projects in this field and some municipalities also finance projects and initiatives. Health plans, strategies and programmes outlined at the national level are adopted by Regional Health Administrations and the Groups of Health Centres guide implementation at the local level through dedicated units that work within the primary health care context.

The integration of both social and health actions in terms of HP4OP depends on collaboration between the Ministry of Health; the Ministry of Labour, Solidarity and Social Security; municipalities; institutions in the cooperative and social sector and other stakeholders such as families, educational institutions, religious communities and health professionals.

As a whole, health promotion policies for the older people in Portugal tackle the social determinants of health too. Nevertheless, a systematic approach and an integrated strategy to tackle HP4OP might constitute an important condition for the full implementation of such policies. Additionally, fragmentation of initiatives at the regional and local levels, together with other barriers to addressing health promotion activities among health professionals, might lead to the non-homogeneous implementation of interventions of HP4OP throughout the country.

It is expected that many of these constraints will be overcome with the launch and implementation of the intersectoral National Strategy for the Promotion of Active Ageing from 2017.

Key words: **Health Promotion, elderly, Public Health, healthy ageing, policy, Portugal**

1. The Portuguese context for public health and Health Promotion for Older People

Portugal, like other European countries, has been experiencing important demographic changes due to increased longevity and the percentage of the population aged 65 or older as well as falling birth rates and the percentage of the population under 15 [1].

The Portuguese population in 2015 was 10,358,076 inhabitants. Of these, 20.5% were 65 years old or older, 65.3% were 15 to 64 years old and 14.2% were 0 to 14 years old. Life expectancy at birth in Portugal was 77.4 years and 83.2 years for males and females respectively in 2014 [1]. Despite this high life expectancy, healthy life years at age 65 in this same year were estimated to be 6.9 and 5.6 for males and females respectively, showing potential for improvements [2].

Article 64 of the Constitution of the Portuguese Republic states that everyone has the right to health protection and the duty to defend and promote health; a universal and general national health service (NHS) is the means to fulfil the right to health protection and shall generally be free of charge [3].

Currently, the Portuguese health care system is based on the universal, tax-based NHS, but health subsystems, financed mainly through employee and employer contributions, still cover about 20–25% of the population and a private voluntary health insurance provides additional coverage for 10–20% of the population [4].

Regarding the levels of care, primary health care is the gatekeeper of the NHS and is provided through a network of health centres, staffed by family doctors, nurses and different types of multidisciplinary teams. As for the second level of care, relations of complementarity and technical support among all hospitals are regulated by Hospital Referral Networks that ensure all patients access to hospital health care services and units. There are several kinds of Hospital Referral Networks, such as Mental Health and Psychiatry, Neurology, Physical Medicine and Rehabilitation and Medical Genetics, among others. Finally, at the third level of care, the National Network for Long-term Care, created by the Ministry of Health and the Ministry of Labour, Solidarity and Social Security in 2006 [5], includes inpatient units and home care teams and provides continuous and integrated health care, health promotion and social support to people who, regardless of age, are in a situation of dependency. It is worth noting that all three levels of care contribute to health promotion for older people (HP4OP) and the specificities of each level in this field will be dealt with later in the text.

The central government is responsible for the development of health policies and evaluating their implementation through the Ministry of Health. According to Decree-Law n° 86-A/2011 (Lei Orgânica do 19º Governo Constitucional) [6] and Decree-Law nº 124/2011 (Lei Orgânica do Ministério da Saúde) [7], which approve the organic law of the Ministry of Health, the main function of the Ministry of Health is the regulation, planning and management of the NHS and it is also responsible for the regulation, auditing and inspection of private health service providers, whether they have agreements with the NHS or not. Among the central services of the Ministry of Health, the Directorate-General of Health plans, regulates, coordinates and supervises all health promotion and disease prevention activities and defines technical conditions for the proper provision of health care. The Directorate-General of Health is also responsible for public health programmes, quality and epidemiological surveillance, health statistics and studies and for the design, evaluation and implementation of the National Health Plan [8].

The five Regional Health Administrations are responsible for the implementation of national health policies and the management of the NHS at the re-

- In 2015, people 0 to 14 years old accounted for 14.2% of the population, while people 15 to 64 years old accounted for 65.3% and people aged 65 years old or over accounted for 20.5% [1];
- In 2014, life expectancy at birth was 77.4 years and 83.2 years for males and females respectively [1];
- In 2014, life expectancy at 65 was 17.3 and 20.7 years for males and females respectively [10];
- In 2014, healthy life years at age 65 were 6.9 and 5.6 for males and females respectively [11];
- The population ageing index rose from 32.9 in 1970 to 143.9 in 2015 and the Longevity Index rose from 32.6 to 49 in the same years (**Table I**) [10].

Box 1. *Population ageing indicators.*

Source: Own work.

Year	Ageing Index	Longevity Index
1970	32.9	32.6
1980	43.8	33.8
1990	65.7	39.4
2001	101.6	41.9
2015	143.9	49

Table I. *Ageing, dependence and longevity indexes 1970–2015.*

Source: PORDATA, 2015b [10].

Mortality data from the Office of National Statistics [12], analysed in the report "Higher age in numbers – 2014" ("Idade maior em números – 2014") published by Directorate-General of Health [13]:

- In 2014, the total mortality rate (death for all causes) was 10 per 1,000 inhabitants. The mortality rate has declined more than 0.7 percentage points since 1975 and has showed a stable trend in the last 15 years. This trend reflects both improved access to an expanding health care network, thanks to continued political commitment and economic growth until 2000, which led to improved living standards and increasing investment in health care;
- In 2014, circulatory system diseases and malignant neoplasms remained the two main underlying causes of death in Portugal, accounting for 55.6% of deaths in the country (respectively, 30.7% and 24.9% of deaths, respectively increasing by 2.4% and 1.2% from 2013). The main cause of death were Malignant neoplasms in the age group of 65 to 75 years old and cardiovascular diseases in people over 75, both in men and women (**Table II**);
- The standardised mortality rate attributed to obesity and hyper-alimentation in the age group over 65 was equal to 7.3 per 100,000 in 2012, 9.2 per 100,000 and 4.3 per 100,000 respectively for women and men. This rate has doubled since 2007, when it was 3.4 per 100,000;
- On the contrary, the standardised mortality rate in the age group over 65 due to alcohol fell from 58.4 per 100,000 in 2007 to 56.9 per 100,000 in 2012 and the standardised rate of mental disturbance correlated to alcohol in the age group over 65 decreased from 2007 to 2012 falling from 2.9 to 1.6 per 100,000 respectively.

Box 2. *Health status of the older population.*

Source: Own work.

Age groups	1st cause of death	2nd cause of death
65–75	Malignant neoplasms 582.2 deaths per 100,000	Cardiovascular diseases 359.3 deaths per 100,000
over 75	Cardiovascular diseases 2,679 deaths per 100,000	Malignant neoplasms 1,276 deaths per 100,000

Table II. *Main causes of death at age 65 and over.*

Source: Instituto Nacional de Estatística, 2014 [12].

gional level. Specifically, according to Decree-Law nº 28/2008, of 22 February, under Regional Health Administrations' authority and administration are the Groups of Health Centres, a set of functional units that ensure the provision of primary health care to a given population and geographical area through health promotion, disease prevention, treatment and continuity of care activities [9].

Besides these institutions, a central role in HP4OP in the Portuguese healthcare system is played by the Private Institutions for Social Solidarity (Instituições Privadas de Solidariedade Social, IPSS), which obtain funding from both the Ministry of Health and the Ministry of Labour, Solidarity and Social Security to provide integrated continuous care within the National Network for Long-term Care [5].

In 2013 and 2014, total health expenditure in Portugal was estimated at 9.1% of the Gross Domestic Product, around 1,500€ per capita (**Table III**) [14]. These percentages are close to the values in other European countries, such as Italy (9.3%), the United Kingdom (9.1%) and Spain (9%) [15].

Box 3. *Health system indicators.*

Source: Own work.

Year	Governmental schemes and com-pulsory contributory health financ-ing schemes	Voluntary health care payment schemes + NPISHs[2] financing schemes + Enterprises financing schemes	Household out-of-pocket pay-ment	Total current health exp.
2013	10,306,405€	960,174€	4,216,615€	15,483,194€
	66.6%	6.2%	27.2%	100%
2014	10,374,099€	961,549€	4,346,287€	15,681,935€
	66.2%	6.1%	27.7%	100%

Table III. *Health expenditures by financing schemes (As absolute values and percentages of total expenditure on health), year 2013–2014*[1].

[1] Data calculated according to the new methodological manual System of Health Accounts – SHA 2011.

[2] Non-profit Institutions Serving Households.

Source: Adapted from Instituto Nacional de Estatística, 2016 [14].

2. Funding of health promotion interventions for older people

In Portugal, as in most of the countries in Europe, a specific fund for HP4OP is not in place. Potential sources of funding identified through the questionnaires and interviews are described in **Table IV**.

It must be noted that most of the initiatives in the field of HP4OP are funded by public resources, mainly by the national health fund managed by the Ministry of Health. The Ministry of Labour, Solidarity and Social Security is also very involved in direct or indirect financing social actions and programmes regarding HP4OP. Information on social fund distribution can be found in the Social Report of the Ministry of Labour and Social Solidarity, issued annually. Some specific initiatives and projects are also sponsored by the Ministry of Science, Technology and Higher Education and municipalities. Rare and irregular private funds are allocated for some practices and initiatives and institutions can access European and other funds to develop projects in the field of HP4OP. As will be clarified later in the text, ministries are involved in HP4OP planning and financing while implementation of HP4OP actions depend on local level institutions and stakeholders.

A fund financing non-profit organisation projects both within and outside of the scope of priority health programmes is managed by the Directorate-General of Health. Examples of interventions considered within priority health programmes are the project "Integrated Training of the Elderly with Diabetes" ("Capacitação Integrada da Pessoa Idosa com Diabetes") within the National Programme of Diabetes, the "MentHA – Mental Health Ageing" project and the project "Care for Dementia" ("Cuidados para a Demência – CuiDem") within the National Programme for Mental Health. According to the data collected through questionnaires and interviews of Pro-Health 65+, several other HP4OP projects are also developed within other national priority health programmes (**Table V**).

There are no specific or systematic financial incentives defined at the national level for HP4OP. Nevertheless, incentives based on a fee for service payment model are awarded to primary health care teams that achieve some targets, like vaccinating their patients in accordance with national recommendations for flu prevention, specifically targeted to older people.

In addition, social subsides and access to social services are guaranteed to older people living alone or to low income and disabled older people [16]. Even if these incentives are usually granted to older people to ensure better care rather than to promote health or to prevent chronic diseases, they might have an indirect effect and help older people participate more in social life and events.

In some districts, older people have the right to discounted or free fares on public transportation to avoid isolation and improve physical activity.

3. Institutional analysis of health promotion interventions for older adults

Despite the economic crisis experienced in Portugal in recent years and the consequent shortage of both human and financial resources, HP4OP in Portugal is considered an important issue to address. Nevertheless, several players are involved in this field, notably institutions belonging to the health and cooperative and social sectors, and a systematic approach with an integrated strategy to tackle HP4OP is needed.

It must be noted that primary health care units, including their health care professionals, and non-profit organisations, such as the IPSS, play a fundamental role in the HP4OP field but universities and research centres also coordinate HP4OP intervention projects funded by National and European funds and municipalities carry out initiatives and projects in this area (**Figure 1**).

Source of funding	Beneficiary	Kind of HP4OP activities
Taxes, *including:* • general taxes • local taxes • earmarked taxes	State Budget → Ministry of Health State Budget → Ministry of Labour, Solidarity and Social Security State Budget → Ministry of Science, Technology and Higher Education Municipal Budget → Juntas de freguesia and municipalities	National Health Service; National Network for Long--term Care; Health promotion projects and initiatives
National lottery	National priority health programmes (Directorate-General of Health) → Non-profit organisations	Health promotion projects and initiatives
Voluntary and/or private insurance and private health care providers	Rare and irregular funds allocated for practices and initiatives	Health promotion practices, projects and initiatives
Funds from employers	Rare and irregular funds for health promotion at workplace	Health promotion projects and initiatives
Foreign	Funds from EU and others	Health promotion projects and initiatives
Others	Religious institutions	Health promotion projects and initiatives

Table IV. *Health Promotion sources of funding identified through the questionnaires and interviews of Pro-Health 65+.*
Source: Questionnaires and interviews of Pro-Health 65+.

National priority health programmes	Project	Institution	Exp. €	Source of financing
Diabetes	Integrated Training of the Elderly with Diabetes (Capacitação Integrada da Pessoa Idosa com Diabetes)	Association for the Protection of Diabetics of Portugal (Associação Protetora dos Diabéticos de Portugal)	22,951	National lottery
Mental health	Training for primary health care professionals in the provision of care for people with Alzheimer's disease and other dementias. (Formação para profissionais de saúde dos cuidados de saúde primários no âmbito da prestação de cuidados a pessoas com Doença de Alzheimer e outras demências)	Alzheimer Portugal Association (Associação Alzheimer Portugal)	30,000	National lottery
	Identification of problems and psychosocial needs of the elderly in day centres and nursing homes (Identificação de problemas e necessidades psicossociais de pessoas idosas em centros de dia e lares residenciais)	Antroposcience. Research, Education and Consulting, Lda. (Antroposcience. Pesquisa, Ensino e Consultoria, Lda)	52,000	National lottery
	Characterization of functional and biological factors with impact on cognitive decline in the Portuguese population (Caracterização fatores funcionais e biológicos com impacto no declínio cognitivo na População Portuguesa)	Centre for Neuroscience and Cell Biology of the Coimbra's University (Centro de Neurociência e Biologia Celular da Universidade de Coimbra)	50,000	National lottery
	Study of incidence of cognitive deficit and dementia in a representative sample of the Portuguese population (Estudo de incidência de défice cognitivo e demência numa amostra representativa da população portuguesa)	Centre for Research of the Centre for Studies and Cognitive and Behavioral Intervention of the Coimbra's University (Centro de Investigação do Núcleo de Estudos e Intervenção Cognitiva e Comportamental da Universidade de Coimbra	15,000	National lottery
	Training of formal caregivers of elderly in nursing homes (Formação de cuidadores formais de idosos em lares de terceira idade)	Dr. Lopes Dias School of the Castelo Branco Polytechnic Institute (Escola Superior Dr. Lopes Dias do Instituto Politécnico de Castelo Branco)	2,650	National lottery
	Care for Dementia (Cuidados para a Demência – CuiDem)	Call center 50+ (Centro de Atendimento 50+ – CA50+)	129,273	National lottery
	Survey on the care situation of the elderly in psychiatry and mental health. Dementia opinion questionnaire. (Inquérito sobre a situação assistencial das pessoas idosas no âmbito da psiquiatria e saúde mental. Questionário de opinião sobre as demências)	Researcher Pedro Machado Santos (Investigador Pedro Machado Santos)	5,000	National lottery
	MentHA – Mental Health Ageing	Centre for Research and Development of Beira, Association (Centro de Investigação e Desenvolvimento da Beira, Associação)	148,961	National lottery
Promotion of healthy nutrition	Nutrition and Alzheimer's Disease Manual (Manual Nutrição e Doença de Alzheimer)	National Programme for the Promotion of Healthy Eating (Programa Nacional para a Promoção da Alimentação Saudável)	2,200	National lottery

Table V. *Expenditures on HP4OP activities carried out by non-profit institutions within projects funded by Directorate-General of Health in 2015.*

Source: Questionnaires and interviews of Pro-Health 65+.

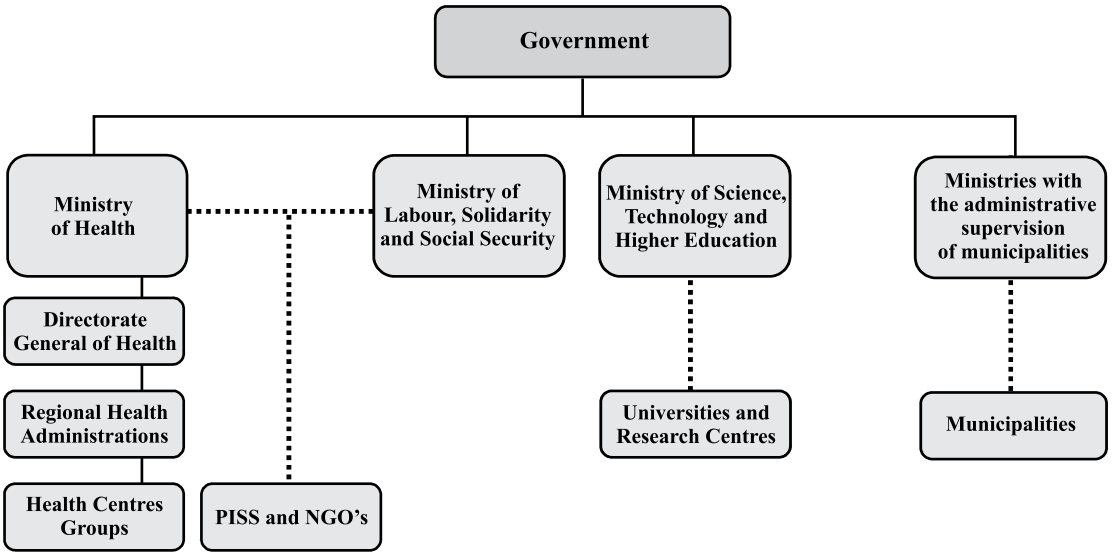

Figure 1. *Overview of some actors involved in HP4OP activities.*
Source: Questionnaires and interviews of Pro-Health 65+.

3.1. HP4OP performed by the health sector

The health sector was described by the interviewed experts as the most important sector in terms of HP4OP development and strategic planning and the Directorate-General of Health was identified as the fundamental actor for HP4OP in the health sector.

The Directorate-General of Health is involved in the definition of national health promotion policy through the Directorate of Disease Prevention and Health Promotion. This Directorate directly or indirectly addresses HP4OP by:

- promoting health gains through policies and objectives defined by the Ministry of Health;
- guiding, coordinating and evaluating the activities of health promotion and education, throughout both the individual and the family lifecycle, as well as in specific environments, including environmental and occupational factors;
- guiding, coordinating and monitoring activities for the prevention and control of communicable diseases, including the National Vaccination Programme, and non-communicable diseases;
- assuring collaboration with governmental and non-governmental organisations in the areas of health promotion and protection;
- collaborating in emergency health planning with the National Institute of Medical Emergency [17].

Directorate-General of Health orientations and directives are adopted at the regional level by the five Regional Health Administrations whose mission is to ensure the provision of health care to the population of the respective geographical scope of access, adapting the available resources to the region's needs, and to comply with and enforce health policies and programmes in their area of intervention, developing and monitoring Regional Health Plans.

Regional Health Plans are developed by the Departments of Public Health, which are also in charge of monitoring their implementation. Regional Health Plans identify and rank the health needs of the population, propose intervention strategies to address the identified needs, define health objectives for the population and present recommendations for their implementation by the various actors involved [18].

Health promotion interventions for older people within the health sector mostly depend on primary health care, namely family doctors, public health doctors, nurses, physiotherapists, nutritionists, psychologists and other health professionals that work in the units of Groups of Health Centres. In accordance with questionnaire respondents, the primary health care setting plays an important role in the dissemination and implementation of health promotion projects and practices.

Groups of Health Centres are responsible for the provision of primary care in each population of a certain geographical territory [9] through specific units, namely:

- Family Health Units and Personalised Health Care Units

Mainly composed by general practitioners (family health doctors) and nurses, their main activity is to provide personalised health care for the population of a given geographical area [9].

- Community Care Units

Composed of physicians, nurses, social workers, psychologists, physiotherapists, oral hygienists, speech therapists and nutritionists, continuously or in partial collaboration, Community Care Units provide care to groups with special needs (such as older people living

alone or people with disabilities), deliver community interventions, provide health protection, health promotion and prevention of diseases in the community. Within the National Network for Long-term Care, home care interventions, including HP4OP interventions, are conducted by these teams. They often work in partnership with other community institutions and are responsible for health promotion activities, namely for older people. Sessions of health education in IPSS and health centres and education and training of family caregivers (including older people) are examples of activities regularly performed by the Community Care Unit's teams [9].

- Public Health Units

Composed of public health doctors, public health nurses or community health nurses and health environmental technicians, they work as a local health observatory, developing and monitoring local health programmes, projects and activities (community interventions) in the fields of disease prevention, health protection and health promotion [9].

Public health doctors (medical doctors with a four-year specialist internship) are responsible for the epidemiological surveillance of the health status of the population and for activities such as health promotion. Public health doctors' responsibilities include: surveillance and control of communicable disease; surveillance of water quality parameters; environmental health surveillance (with municipalities); ensuring compliance of local services (including health facilities) with health and safety standards; environmental inspections of workplaces and work conditions; building safety and housing inspection (with municipalities). Due to their specific background and knowledge, public health doctors are fundamental for intersectoral collaboration and cooperation in terms of HP4OP.

- Shared Healthcare Resources Units

Composed of various health professionals, as doctors of many specialties other than family medicine and public health, as well as social workers, psychologists, nutritionists, physiotherapists and health technicians, they provide consulting and assistance services to the other functional units and organise functional links to hospital services [9].

3.1.1. Key health promotion interventions for older people performed within the health sector

As mentioned before, some HP4OP initiatives and projects are considered within wider national programmes such as the project "Integrated Training of the Elderly with Diabetes" ("Capacitação Integrada da Pessoa Idosa com Diabetes") within the National Programme of Diabetes or the "MentHA - Mental Health Ageing" project and the project "Care for Dementia" (Cuidados para a Demência – CuiDem) within the National Programme for Mental Health. The National Health Plan 2012–2016 [19] has been extended to 2020 and in the new plan, HP4OP is seen a relevant contribution to the country's economic development and social cohesion. In particular, the new goals of the plan for 2020 are: a 30% reduction in premature mortality (before the age of 70), improving healthy life expectancy (at 65 years), and also the reduction of risk factors related to non-communicable diseases [8]. In this context, in 2016, the nine existing priority health programmes were also renewed for the period 2016–2020 and two more programmes – the promotion of physical activity and the prevention of viral hepatitis – have been added (Dispatch No. 6401/2016, of 16 May). Particularly, the new National Programme for the Promotion of Physical Activity aims to promote healthy lifestyles and tackle a sedentary lifestyle at all stages of life [20].

At the national level, interviewed experts suggested the following HP4OP actions and projects (valid nationwide) that have been carried on to disseminate the concept of health promotion and active and healthy ageing among older people:

a) "Health 24" ("Saúde 24"): a permanent telephone helpline which incorporates strategies to promote empowerment by providing counselling and guidance to citizens. In 2014, the average number of calls per day was 1,832 [21].
b) "Local Plans of Action on Housing and Health" ("Planos Locais de Ação em Habitação e Saúde"): this manual of the World Health Organisation was published in Portuguese by the Directorate-General of Health in 2008 and represents a guide to housing and health projects at the local level. It provides information for project preparation, collection and analysis of data and policy options to put into practice. Attention is dedicated to housing accessibility, safety of older people (elimination of barriers and obstacles, better interior design, etc.) and physical, social and mental well-being [22].

3.1.2. Possible cooperation of health providers with other sectors in health promotion interventions for older people

The successful realisation of health promotion is closely related to the engagement of different sectors and activities and interinstitutional and cross-sectoral cooperation [23], which is effective in Portugal. A clear example of interinstitutional cooperation in the field of HP4OP is the creation of the National Network for Long-term Care in 2006, as a response to the lack of resources in long-term and palliative care, social support and social security services. The network obtains financing from both the Ministry of Health and the Ministry of Labour, Solidarity and Social Security and involves cooperation between health, cooperative and social sector institutions and professionals [5].

3.2. HP4OP performed by the cooperative and social sectors

In general, the social enterprise concept is not yet fully stabilised in Portugal and there is an on-going discussion about the meaning and the contents of this concept [24]. Nevertheless, according to the law on social economy, the third sector organisations that integrate the

Portuguese social economy are: cooperatives, mutual societies, Misericórdias (Mercies), foundations, other private institutions of social solidarity, associations with altruistic aims that act in the cultural or sports sphere or in local development, entities in the communitarian and self-managing subsectors, integrated in the terms of the Constitution and active in the cooperative and social sector and other entities with statutes that respect the principles of social economy [25].

Some of these organisations act as providers of public services through contracts with the public sector, public grants, subsidies and other source of funds. In this aspect, the public sector is becoming increasingly dependent on the cooperative and social sectors in the field of HP4OP.

The IPSS play a central role in the Portuguese health system and their efforts and values are strongly recognised by the Portuguese population, mostly for historical reasons. The IPSS are non-profit institutions, created by private initiative, with the purpose of giving organised expression to the moral duty of solidarity and justice between individuals. They are not administered by the State or local government bodies in pursuing their goals of, among other things, the provision of goods and services [26].

As a whole, the IPSS are a very important actor within the National Network for Long-term Care (**Table VI**).

According to the Health System Central Administration report on the implementation and monitoring of the National Network for Long-term Care [27], the IPSS account for more than 5,000 beds, contracted for the third level of care, covering 72.5% of bed availability. The IPSS's main objectives are to support children and young people; to support families; to protect older people and people with disabilities and to help people without means of subsistence or the capacity to work. Moreover, education and training of older people, health promotion and protection as well as solving housing problems are also main IPSS objectives [27].

3.2.1. Focus on Mercies (Santas Casas da Misericórdia)

Mercies represent the oldest private non-profit organisations in Portugal and their creation dates from the sixteenth century. Their intervention in the health sector began through actions by individuals of the Christian community, later evolving into the structuring of various facilities and services, including hospitals, to serve the communities in which they operate [28]. Nowadays, these organisations work as a private body in terms of resources and financial management, but they maintain features typical of public institutions regarding their structural, organic and administrative plans.

The Mercies gathered to create the Union of Mercies and work in close cooperation with the State (and the NHS) in a complementary fashion, providing a wide range of services, from primary health care to hospital care and continuous care, offering specialised care such as mental health care as well.

These institutions dedicate about 3,596 beds (out of 7,160) to the management of all 4 types of in-patient care of the National Network for Long-term Care (Convalescence; Medium and long term recovery; Very long term-stay and maintenance; Palliative care) providing more than 50% of the beds dedicated to the third level of care [27].

According to the Portuguese National Health Plan 2012–2016 and the subsequent extension 2016–2020, health policies should be brought forward in all settings and at all stages of life [8, 19]; in this aspect, Mercies are involved in the construction and administration of nursing homes targeted at older people. In these facilities, several activities are carried out such as social support activities, collective housing, food supply, health promotion and hygiene and guests are encouraged to socialise and take part in leisure activities [29]. Particularly, a new kind of nursing home for older people with mental health issues or dementia was created and launched in Lisbon and other cities around Portugal, where professionals are trained on how to manage these specific conditions: a specific project called "Lifes Project" ("Projeto Vidas") was initiated to provide education and training for health professionals on these themes but also to improve the competence of families affected directly or indirectly by such conditions.

Finally, Mercies are involved in the home care of older people and several projects are carried out to prevent isolation, loneliness and inactivity. The "Inter Generations Programme" ("Programa Inter-Gerações") must also be mentioned, in which young citizens went around Lisbon's neighbourhoods, street by street, building by building, to ask the older people about the problems and difficulties they face every day and to promote healthy lifestyles, physical activity, social involvement and healthy behaviours.

Provider	n° of beds contracted for RNCCI	% of beds contracted per provider
NHS public	443	6.2%
IPSS – Mercies	3,596	50.2%
IPSS others	1,598	22.3%
Private	1,523	21.3%
Total	**7,160**	

Table VI. *National Network for Long-term Care.*

Source: Administração Central do Sistema de Saúde, 2016b.

3.2.2. HP4OP actions and projects in the Cooperative and Social Sector

a) "Third Age Online Project" ("ProjetoTerceira Idade Online"). Carried out by the Life Association (Associação Vida), it essentially seeks to encourage Internet use by older people, thus contributing to their integration in the new information society, promoting their health and quality of life and fostering relationships and understanding between generations (www.projectotio.net).
b) "Active Ageing: a challenge for public Health" ("Envelhecimento ativo: um desafio para a saúde pública"). A conference organised by an association (Associação Portuguesa para a Promoção da Saúde Pública) that is a health and social solidarity oriented institution and the cofounder of the European Public Health Association.
c) "Living with Quality" ("Viver com Qualidade"). In development since 2005, by the Association for Community Intervention and Social and Health Development (Associação de Intervenção Comunitária, Desenvolvimento Social e de Saúde), this project is addressed to people with home care needs in extended hours. It is a 24 hour/day service and provides several support activities in health care, welfare, hygiene and comfort for dependents or semi-dependent people (https://www.facebook.com/AJPASglobal/).
d) "Wills: a volunteering initiative" ("Vontades: uma Iniciativa de voluntariado"). The integration of volunteers in the history of the Association for Community Intervention and Social and Health Development (Associação de Intervenção Comunitária, Desenvolvimento Social e de Saúde) dates to 1993 when, through youth health promoters, the association began to intervene in the slums of the municipality of Amadora. Its area of intervention is essentially health promotion and disease prevention, with special emphasis on dependent people and situations of social isolation. The project "Wills" plans to extend and focus its voluntary implementation and operations to target groups such as older people (https://www.facebook.com/AJPASglobal/).
e) "Solidarity Network" ("Rede solidária"). This is a digital platform created to allow Internet access to non-governmental organisations working with older people and people with deficiencies at risk of social exclusion (https://www.facebook.com/redesolidariafct).
f) "PT Special Solutions" ("Soluções Especiais PT"). An initiative of the PT Foundation (Fundação PT) that constitutes a range of equipment and services dedicated to fighting info-exclusion, namely for older people at risk, people with visual or hearing impairments, speech, communication and neuromotor dysfunctions (http://www.fundacao.telecom.pt/Home/Acesso%C3%A0scomunica%C3%A7%C3%B5es/Solu%C3%A7%C3%B5esEspeciaisPT.aspx).

3.3. HP4OP performed by municipalities

At the local level, the Healthy Cities Network (29 municipalities, representing 25% of the Portuguese population) and the Social Network project (implemented in all 308 municipalities) are currently established and very well placed to assume Health in All Policies [29]; these are very good fields for public health action and health promotion, including HP4OP.

Many municipalities are involved, together with Public Health Units, in the development of Local Health Plans that address local health problems and establish common inter-sectoral objectives in health programme design.

In addition, municipalities run Local Health and Home Action Plans [22], defined at the local level in accordance with the manual issued by the Directorate-General of Health. The implementation of these plans is made in cooperation with the health sector, particularly family doctors, public health doctors and nurses, as well as other primary care health professionals. At the same time, municipalities are involved in drafting Social Development Plans that are implemented in collaboration with the third sector [30].

Examples of good practices of HP4OP implemented at the regional and local levels are presented in **Table VII**.

4. National health promotion policies generally and those addressed at the older people

The Ministry of Health, through the Directorate-General of Health, showed direct involvement in HP4OP, launching the National Programme for the Health of Elderly People [31] as part of the National Health Plan 2004–2010. Most of its directives have been proposed again in the successive National Health Plan 2012–2016 and its extension 2016–2020, taking into consideration European policies towards older people, such as healthy ageing and active ageing [8, 19, 32, 33].

The National Programme for the Health of Elderly People aims to maintain autonomy, independence, quality of life and overall recovery of older people primarily in their homes and everyday life contexts. The programme calls for the multidisciplinary work of health care services, including the Network of Continuous Health Care created by Law n° 281/2003 [34].

The National Programme for the Health of Elderly People was addressed to regional health authorities and all health care providers to produce health gains and an improvement in terms of years of life in good health and free of impairment; moreover, the achievement of a better quality of life for older people would help use and better allocate the available resources.

The main strategies proposed in the National Programme for the Health of Elderly People were:

- promotion of healthy ageing;
- tailoring care to the needs of the older people;
- promoting the development of enabling environments.

City of implementation	Name of the HP4OP Project	Content, agreements, partnerships
LISBON	Age Friendly Cities (Cidades amigas das pessoas idosas)	Cooperation agreement between the Directorate-General of Health and the Municipal Chamber of Lisbon. In 2008, the Directorate-General of Health signed a cooperation agreement with the Municipal Chamber of Lisbon to develop the concept of "Age Friendly Cities" in the context of promotion of healthy ageing and health and autonomy for older people.
OPORTO	Integration and Help in an Age Friendly City (Integra & Ajuda na Cidade Amiga)	This project has implemented in the city of Oporto the methodology developed and proposed by the World Health Organisation for the Age Friendly Cities. This methodology involves listening to older people about their everyday reality and as citizens of their town through the implementation of the Friendly City Control List, adapted from the checklist presented in the Global Age Friendly Cities Guide, and subsequent dissemination and discussion of results of both older people and decision makers
AMADORA	Several HP4OP projects and activities	The Municipality Chamber of Amadora in collaboration with several local institutions carried out a series of HP4OP projects for both dependent and independent older people such as: physical activities, intellectual activities, housing projects to reduce falls, healthy lifestyles and nutrition.
SEIXAL	Healthy Seixal (Seixal Saudável)	A project developed by the Municipality of Seixal, which launched in its newsletter of December 2010, spreading information about „Friendly Cities for Active Ageing".
COIMBRA	Aging@Coimbra	Carried out by the University of Coimbra.
GONDOMAR (Global WHO Database of Age Friendly Practices [34]).	Senior University of Gondomar (promoted by the Union of Parishes of Gondomar, Valbom and Jovim)	A programme addressed to citizens aged 50 or older, oriented to enhancing participation and engagement in cultural activities & citizenship, maintaining mental activity and increasing intellectual efforts. The programme aims at fostering research on gerontology issues.
ALFÂNDEGA DA FÉ, ANGRA DO HEROÍSMO, MAIA, PORTIMÃO, VILA NOVA DE FOZ CÔA, VILA REAL DE SANTO ANTÓNIO E PÓVOA DE LANHOSO	Beating Time in the Seven Cities (Vencer o Tempo nas Sete Cidades)	The „Beating Time in 7 Cities" project is intended to help 7 Portuguese municipalities to implement in their own territories, equipment and actions to support older people in order to be recognised as Age-Friendly Cities.

Table VII. *Examples of HP4OP projects active locally.*
Source: Questionnaires and interviews of Pro-Health 65+.

From these three strategies of the National Programme for the Health of Elderly People, recommendations for action were set, considering age, gender specificities, culture and the participation of older people in the health system [31].

After 2010, at the central level, HP4OP was not considered specifically in one programme but projects and initiatives concerning HP4OP were developed within priority health programmes [20].

Local and regional plans are developed and implemented in accordance with the strategies defined in the National Health Plan and health programmes and follow Directorate-General of Health directives. One objective of the National Health Plan 2012–2016 was to strengthen public health at both regional and local levels through the provision of epidemiological expertise and leadership functions in health promotion. Responsibilities such as the epidemiological surveillance of the population's health status, disease surveillance and health promotion had to be borne by public health doctors [19].

In the newest National Plan, the extension 2016–2020, HP4OP is considered an important activity to contribute to the country's economic development and social cohesion. The new goals of the plan for 2020 are: a 30% reduction in premature mortality (before the age of 70), improving healthy life expectancy at 65 years old and the reduction of the prevalence of two risk factors related to non-communicable diseases, namely childhood obesity and smoking tobacco products [8].

It is also worth mentioning the recently launched National Health Education, Literacy and Self-care Programme and its integrated approach on all health policies implementation. One of the projects currently developed under the scope of this Programme is the project "Aging, self-care and informal caregivers".

5. Identification of the main limitations and barriers in planning and implementation of HP4OP

One of the main requirements for the full implementation of HP4OP policies and the dissemination of HP4OP initiatives is a well-designed intersectoral strategy in this field, as specific HP4OP strategies and funds are not clearly defined and the fragmentation of initiatives at regional and local levels is an issue.

The implementation of health promotion activities for older people is also limited by the shortage of public health doctors, nutritionists, psychologists, physiothera-

pists social workers and other professionals directly or indirectly involved in HP4OP and the difficulty of family doctors and nurses dedicating more of their time to this issue. Moreover, a clear definition and meaning of health promotion is not shared by all stakeholders.

Summary and conclusions

Health promotion in Portugal is considered an important issue to address, particularly for disadvantaged groups like older people. Information collected through the Pro-Health 65+ questionnaires and interviews and literature consultation showed that, despite the lack of a specific and continuous programme on HP4OP in place nationwide, several projects and activities are being carried out in this field.

On the whole, it is the Ministry of Health and the Ministry of Labour, Solidarity and Social Security that are involved in directly or indirectly financing and promoting projects regarding HP4OP; some specific actions are also sponsored by the Ministry of Science, Technology and Higher Education and municipalities.

In the health sector, the Directorate-General of Health regulates, guides and coordinates all health promotion and disease prevention activities and defines the technical conditions for proper provision of health care. It is Regional Health Administrations responsibility to develop, implement and monitor regional health plans for the population that take into consideration the strategies defined in the National Health Plan and others directives of the Directorate-General of Health. The local level implementation of such plans depends on Groups of Health Centres and their primary care units, which act in accordance with local health plans.

In the cooperative and social sector, an important role in terms of HP4OP is played at the local level by non-profit institutions, such as the IPSS, which is one of the most important actors within the Network of Integrated Continuous Care financed by both the Ministry of Health and the Ministry of Labour, Solidarity and Social Security.

In addition, at the local level, municipalities and "juntas de freguesias" (small administrative districts with their members elected directly by the population) might coordinate specific HP4OP projects if these issues are considered priorities in that given area.

Some rare and irregular private funds are allocated for practices and initiatives and institutions can also access European and other funds to develop projects in the field of HP4OP.

Health promotion policies for older people in Portugal tackle the social-health determinants of health too. Nevertheless, a systematic approach with an intersectoral strategy to tackle HP4OP might constitute an important condition for the full implementation of such policies. Additionally, fragmentation of initiatives at the regional and local levels, together with other barriers to addressing health promotion activities among health professionals might lead to the non-homogeneous implementation of interventions of HP4OP throughout the country

Last but not least important is the fact that Portugal faced a deep economic crisis between 2009 and 2014/15 and this had an influence on the health system as a whole and inequalities and inequities among regions and between social groups still exist: the Gini coefficient of equivalised disposable income in 2014 in Portugal was equal to 34.5 [35], income distribution is unequal (the income quintile share ratio S80/S20 is equal to 6) [36], the risk of poverty among older people could rise [37] and private health expenditure, including out-of-pocket payments and cost sharing has increased disproportionately, placing an additional burden on disadvantaged households and potentially limiting access to care, especially for the older people.

The response of the government to the crises led to the implementation of a comprehensive set of structural reforms to work towards fiscal sustainability, improved efficiency and better quality in the health care system, including health promotion. Particularly, the extension of the National Health Plan until 2020 provides an important platform and an opportunity to address some of the challenges raised, including, for example, strategies to promote healthy lifestyles, citizenship, active ageing and quality in health care. The new goals of the plan for 2020 are: a 20% reduction in premature mortality (before the age of 70), improving healthy life expectancy at 65 years by 30%, and also the reduction of risk factors related to non-communicable diseases, in particular, reducing the prevalence of smoking in the population aged $\geq$ 15 years and eliminating exposure to environmental tobacco smoke, controlling the incidence and prevalence of overweight and obesity in children and schoolchildren, limiting growth by 2020 [8].

As for health inequalities, even though the economic crises had a strong impact on the country and austerity posed challenges to municipalities in terms of provision of financial and technical resources, a network of Age Friendly Cities has been created in accordance with World Health Organisation concepts of healthy ageing and active ageing. Furthermore, the Portuguese Healthy Cities Network has been developing a National Roadmap for Health which aims to engage all municipalities in considering inequalities and engage local politicians in interventions and advocacy [30].

Finally, it is expected that many of the constraints to the full implementation of HP4OP policies will be overcome with the launch and implementation of the intersectoral National Strategy for the Promotion of Active Ageing of 2017.

These results, among others, demonstrate the Portuguese government's commitment to improving health and promoting good health policies, including HP4OP.

What to do next

A critical element in improving health system performance with limited resources is the ability to make policy choices to allocate resources in areas where they can be most effective in improving health and equity. It is es-

sential to recognise that, although "health" is the goal of the health system, other systems and policies have a significant impact on the level of health and on health inequalities. Within this context, the following core policy recommendations can be formulated:

- Continue to promote health policies targeting health gains and reduce health inequalities in all sectors: health promotion should be sustained as a policy of equity;
- Invest in upstream and gender-responsive health promotion activities to tackle risk factors and integrate the determinants of health into public health, health promotion and disease prevention programmes;
- Increase the value of investments in health by prioritising spending on prevention, health promotion and public health, and by enhancing the efficiency of service delivery;
- Improve access to healthcare in rural areas and easier transportation to health facilities;
- Strengthen governance of primary health care, hospital and long term care so that decision making is adequate, effective and monitored and so that citizens can more quickly access the care they need;
- Improve intersectoral governance actions: decisions and investments in health promotion should be planned and undertaken together by all the ministries involved, thus exerting influence on overall government effectiveness;
- Improve the health information and promotion capacity on both old and new information channels: internet and WEB 2.0 channels, including social media, are already being used by part of the older population so it is essential to promote "new" concepts such as e-health, health literacy and empowerment;
- Ensure a broader engagement of older patients and the public in the health system and health promotion decision-making by strengthening public health departments and supporting the partnerships between public health specialists and other health professionals, including family doctors, nurses and pharmacists (given the degree of confidence and credibility they have among the population);
- Clarify the role of the private sector, the IPSS and the NGOs in the management of older people through a coherent policy framework: regulate and ensure compliance with requirements for public reporting, standards of quality and safety, rules for dual employment, and pricing and payment mechanisms.

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A Greek tragedy of our time? Institutional and financial dimension of Health Promotion for Older People in Greece

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Authors contribution

MP and SG designed the concept, MP carried out the data collection and analysis, and drafted the paper, AS commented on the paper and provided additional data, YS, WG and SG reviewed the draft and provided comments for the final version. All authors read and approved the final version submitted.

Abstract

Despite the numerous legislative documents and public health institutions in Greece, the country lacks a comprehensive and robust long-term policy perspective in the public health area. The traditionally higher priority attached to curative care than to public health actions, is the major reason of the shortcomings. This country report draws upon several national reports focused on the Greek health system, and other country-specific sources in order to outline the major institutional and financing challenges for health promotion in Greece, and specifically health promotion for older adults. The paper is based on the method of narrative literature review. The findings show that health promotion actions for elderly persons do take place in Greece but mainly in urban areas and/or within the framework of EU-funded projects. Government efforts are required to stimulate coordinated public health interventions at the local level focusing on the positive effects of health promotion. The health promotion programs that are successfully implemented, should receive the necessary government support to assure their long-term sustainability.

Key words: **public health, health promotion, older adults, health policy, Greece**

Introduction

The public health concept has been interwoven in many laws and government regulations in Greece [1]. Numerous public health institutions have been also established (e.g. the Central Health Council, the National Council of Public Health, the Health Region Authorities). Yet, a long-term policy perspective in the public health area is still lacking, and coordinated health promotion actions are practically absent. The traditionally higher priority attached to curative care than to public health actions, is the major reason of the shortcomings. This

paper reviews key national reports focused on the Greek health system, and other country-specific sources in order to outline the major institutional and financing challenges for health promotion in Greece, and specifically for health promotion for older adults. The method of narrative literature review is used. The paper has the form of a country report and targets the decision-makers in Greece, as well as those elsewhere in Europe, who would like to get insights in the public health developments in Greece.

1. Legislation on public health and health promotion generally and for older population

Greece introduced legal provisions in the area of public health already in the nineteenth and early twentieth centuries but only with regard to communicable diseases and without an effective implementation of the legislation in practice [1]. In this period, the Ministry of Hygiene and Social Welfare was established (Law 748/1917). However, the public health measures introduced by the ministry were limited to vaccination and sanitation interventions. Furthermore, measures for health and safety at work (Law 3934/1911 and Law 551/1915), establishment of mutual societies (Law 281/1914) and obligatory insurance of employees (Law 2868/1922) were introduced with a limited success [2].

In the mid-twentieth century, the legal and regulatory actions focused on medical care. There were only sporadic public health actions mostly as a response to tuberculosis and sexually transmitted diseases. During the dictatorship period (1967–1974), the first attempt to organize a comprehensive health care system was observed, although this objective was not successfully achieved. Following the democratic changes in 1974, the need for health care reforms became evident and was acknowledged as a major government priority. However, due to the political and medical societies' opposition, the numerous reform proposals were never implemented [2].

Only in 1983, an effective legislation for the establishment of the Greek National Health System (Law 1397/83) was passed. The ambition was to create a universal coverage and equal access to health services. The state was expected to be fully responsible for the provision of health services to the population [2]. Nevertheless, the public health actions did not receive much attention in the twentieth century. For the first time in 2003, in the anticipation of the 2004 Athens Olympic Games, the Greek government seriously attempted to control infectious diseases effectively. It should be mentioned however that this effort did not include a well-conceptualized vision and had many shortcomings, including the lack of clarity about jurisdictional boundaries, lines of command, and procedural requirements [1].

In 2005, a new law was passed (Law 3370), which is still active and regulates the public health actions for preventing diseases, protecting and promoting health, lengthening life expectancy and improving quality of life. The law declares that disease prevention and health promotion are the main functions of public health [3]. Together with this law, the General Secretariat for Public Health and the General Directorate for Public Health were established at the Ministry of Health and Social Solidarity. Their direct responsibility is to implement measures within the framework of the National Action Plan for Public Health, to inspect public health agencies and to monitor and supervise the implementation of EU policies [2].

Despite this new legislation, public health services in Greece remain of low priority compared to curative care. Also, public health professionals have a rather low status within the National Health System, which results in understaffed public health facilities.

Nevertheless, some positive changes are observed, namely health promotion and health education are increasingly perceived as essential for the population health. The perceived importance of a healthy lifestyle is also growing among the Greek population [2]. More policy efforts are however needed to assure a modern and comprehensive system of public health services focused on health determinants and needs of vulnerable groups (for example the elderly and disabled). Such system is still absent in the country [1].

2. Health system indicators

The performance of the Greek National Health System has been often criticized [4]. The following areas are mentioned as most problematic: poor administration, low productivity and inadequate primary care. Guided by the objective to deal with these drawbacks, the government introduced major health reforms in 2000–2004. The reforms focused on decentralization, creation of a unified social insurance system, establishment of new management structures, organization of a primary care system, and strengthening public health and health promotion [2, 4]. These reforms were however abolished after the elections of 2004.

The most recent health care reforms, since 2005, have aimed to assure the financial viability of the health system in the short term and its sustainability in the long term. Nevertheless, the reforms have been criticized for their controversy, clientelism and political influence on the health administration [2]. Overall, a comprehensive and universal health system has not yet been established in Greece. The achievement of this objective has become even more difficult with the start of the latest economic crisis. There is an overall lack of sufficient buildings, basic technological equipment and computerization, as well as a lack of a fair distribution of the limited public health resources and understaffing. This contributes to poor quality and inequalities in access, especially for the elderly persons. Also, the system organizational culture is dominated by clinical medicine and hospital services, without an adequate attention and support for public health activities. It is therefore not surprising that the percentage of Gross Domestic Product (GDP) that Greece allocates to public health is rather low (see **Table I**).

Overall indicators: Total health expenditure per capita: 1438.78 Euro Total health expenditure as % of GDP: 8.75%
Selected functions as % of total health expenditure: Curative care: 58.75% Pharmaceuticals and other medical non-durable goods: 29.28% Preventive care: 1.08% Epidemiological surveillance and risk, and disease control programs: 0.50% Information, education and counseling programs: 0.47% Immunization programs: 0.08% Healthy condition monitoring programs: 0.02%

Table I. *Health system indicators – Greece (data for 2013).*

Source: Based on the Eurostat database.

3. Population aging indicators

The life expectancy in Greece rose from 74.6 years for males and 79.4 for females in 1990 to 75.4 and 80.5 respectively in 2000 [5], and further on to 78.9 and 84.1 respectively in 2014/2015 (see **Table II**). Besides, in 2000, the population aged over 65 was only 16.6%, while in 2014/2015 it was already 20.9%. The estimations suggest that the share of older persons (65+) will reach 31.5% of the general population in 2050 [5]. The increased life expectancy, combined with the increased population ageing, has important implications. In particular, fewer people of productive age will support the increasing demands on the Greek health and pension systems. It is therefore essential to further develop health promotion and prevention in order to help older adults to live longer and in good health. It is also essential to secure more resources for health promotion for example by reducing unnecessary medical expenditure.

Life expectancy: Life expectancy at birth: 81.5 years Life expectancy at birth males/females: 78.9/84.1 Life expectancy at 65: 20.3 years Life expectancy at 65 males/females: 18.8/21.6
Healthy life years: Healthy life years at 65 males: 7.7 years Healthy life years at 65 females: 7.1 years
Share of older population: Proportion of population aged 65+: 20.9% of total population Proportion of population aged 80+: 6.3% of total population Old age dependency ratio 65+: 32.4%

Table II. *Population ageing indicators – Greece (data for 2014/2015).*

Source: Based on the Eurostat database.

4. Health status of older population

In Greece, premature mortality was substantially reduced during the period 1980–2007 (by 43.2%). It is recognized that the establishment of the National Health System had a positive effect on the health indicators in the country. Although Greece ranks relatively high based on the population health status, there are many health-related challenges to be addressed, including problematic driving behavior as well as drinking, smoking and poor eating habits of the population [2]. In fact, the group of elderly in Greece appears to be among the most health illiterate European population groups [6]. The prevalence of mental health problems (e.g. depression) among elderly [7, 8] as well as the problem of a high rate of drug use and polypharmacy (large pharmaceutical consumption) in elderly is also acknowledged [9]. Moreover, the consequences of the global financial recession and the subsequent austerity measures had not only an economic impact but also negative consequences for the national health sector and social services, including public health services [10]. The government was unable to provide the necessary support for these services [11], which may have further contributed to the declining health status of the population, including that of older persons (see **Table III**).

Prevalence of long-standing illness: Age group 65–74 males/females: 45.5%/45.9% Age group 75–84 males/females: 59.5%/69.4% Age group 85+ males/females: 69.3%/79.1%
Self-perceived long-standing limitations in usual activities due to health problems: Age group 65–74 males/females: 48.8%/51.4% Age group 75–84 males/females: 64.0%/74.5% Age group 85+ males/females: 77.4%/87.2%

Table III. *Health status of older population – Greece (data for 2014).*

Source: Based on the Eurostat and EU-SILC databases.

5. Potential sources of funding public health and health promotion activities

The public health system in Greece is highly centralized and primarily funded through government resources (see **Table IV**). The state public health facilities mainly provide epidemiological monitoring and infectious disease control as well as environmental health control, health promotion and disease prevention at community level [2]. They are funded through annual budgets. However, the total budget for public health is not dedicated and specific. The general government budget for health care refers to both curative services and public health actions. Given the predominantly medical culture in the health sector and the lack of a health promotion vision in the country, most of the health resources are allocated to curative care leaving the public health activities with irregular funding. The current investments in long-term plans to improve the population health are insufficient [3].

Theoretically, the Social Insurance Institute (IKA), which is the largest social health insurance fund in Greece, provides its members with a wide range of preventive, diagnostic, curative and rehabilitation services, such as general medical care for the adult population and

elderly persons, health promotion, occupational medicine, first aid, vaccinations, epidemiological research, social care and pharmacy services. Thus, basic public health services are formally included in the IKA health insurance package [12]. But in practice, this is limited to prescriptions, referrals to secondary health care services and high-cost examinations (mainly for elderly people). In some cases, IKA organizes holiday trips and spa accommodation for elderly persons [2]. No health promotion services are explicitly mentioned for IKA or other social health insurance funds.

All visits to physicians and diagnostic centers that provide public health services under a social insurance fund, are free of charge for the patient. However, due to access- and quality-related problems in the public system, patients often seek primary care (including basic public health services) at the private sector. In this case, the patients pay the full user fee. There is coinsurance for diagnostic and laboratory tests (from 0 to 30%) depending on the insurance fund and the status of the diagnostic center [2].

Private health insurance in Greece plays a relatively minor role in the overall health system, since it offers coverage to no more than 12% of the population [2]. Private insurance packages include minor health promotion and prevention services, such as health checks and diagnostics.

Some public health initiatives are funded through EU resources, including the EU Structural Funds [13]. However, the use of these funds is uncoordinated, inefficient and characterized with overlaps. The objectives of the EU-Funded public health programs are also focused on the EU priorities and not necessarily on the real population needs in Greece [3].

6. Institutional analysis (sectors, organizations and their functions)

The Ministry of Health is the main decision-makers in the public health area in Greece and is directly accountable for the public health policy in the country [2]. Several directorates and departments of the Ministry of Health are engaged in the development of public health programs, including health promotion and prevention programs. This includes the General Secretary for Public Health at the Ministry of Health, the General Directorate for Public Health and Quality of Life, the Directorate for Public Hygiene, the Directorate for Nutrition, and the Directorate for Dependence. Apart from that, the governance and regulation of public health activities involve the Central Health Council, the National Council of Public Health, the National Organization for Healthcare Provision, and the National Primary Healthcare Network. All these institutions assume different tasks and responsibilities related to public health and health promotion policies in particular [3].

Seven Health Region Authorities are responsible for implementing national public health priorities at the regional level as well as for coordinating regional activities. They also advise the Ministry of Health on public health measures. The Central Council of Health Regions coordinates the work of the Health Region Administrations, as well as their cooperation with the ministry [2, 3].

At the prefectural level, the public health departments of the Prefectural Authorities have the responsibility to implement immunization and preventive medicine programs, while at the local level, municipalities are responsible for managing public health programs related to the

Source of funding	Beneficiary	Additional Comments
Taxes: *Including* – general taxes	The general public or specific target group who uses the public health services	There is no general tax revenue specifically allocated to public health and therefore, public health competes with curative care, which receives a higher priority in the distribution of resources.
Health insurance premiums *Including* – social insurance – private insurance	Socially insured patients who use public health services provided by GPs or diagnostic centers Adults who have extra private insurance	Patients do not need to pay for physician services provided under a health insurance scheme during the regular work hours. But there is 0–30% coinsurance for diagnostics. The role of private insurance is minor.
Other public institutions:	Beneficiaries of services related to public health provided by other ministries	Other ministries include for example the Ministry of Labor, Social Security and Welfare.
Other sources:		
Households	Private sector patients	Full fees in the private sector.
Foreign	International research projects and EU funds beneficiaries	Focused on EU priorities and not necessarily on the real needs of the Greek populations.
Others	Beneficiaries of NGOs initiatives	NGOs include community organizations and associations of patients with chronic disease.

Table IV. *Sources of public health funding in Greece.*

Source: Based on own review of literature.

provision of primary care, health prevention and promotion services. Many of these programs are delivered in rural health centers and the IKA health centers in urban areas. This is because the municipal public health services are underdeveloped in Greece [2].

Several NGOs implement primary and preventive health programs for refugees and socially disadvantaged population groups. The Ministry of Health supervises the work of NGOs active in the field of public health. In addition, the Ministry of Health cooperates with the Ministry of Labor, Social Security and Welfare, and the Ministry of Employment and Social Protection with regard to programs on occupational safety and health that are implemented by the latter ministry [3].

The coordination between the different bodies involved in the implementation of primary prevention and health promotion policies and programs is weak [2, 3]. Health promotion and primary prevention programs are only evaluated if they fall within the framework of a funded research project. There are insufficient resources and capacity to undertake more routine analyses of health promotion and primary prevention activities. There are no multidisciplinary teams in place to address health promotion and primary prevention. Also, there are no structures and mechanisms in place to respond to the needs and priorities of disadvantaged or vulnerable groups. For the case of elderly persons, the coordination between the health sector, social care sector and care services for elderly persons is still not adequate [3].

7. HP4OP – Health Promotion for Older People (examples of good practices)

An important aspect of the health promotion initiatives for elderly persons in Greece, is that they often take place within the Open Care Centers for Older People (KAPIs). The members of these centers are older persons (60+ years) who mostly choose to join the centers due entertainment and/or possibility for a companionship [14]. Health and social care professionals, such as nurses, social workers, physiotherapists, occupational therapists, home care assistants are usually working at these centers. They have the task to promote a healthy lifestyle among the members. Such centers are established throughout the entire country (more than 450 centers) and are very well accepted by the elderly persons [5]. The centers are managed and funded by the local authorities. Sometimes, elderly members are invited to participate in the administration.

Although there is no national mechanism to identify good practices in Greece [3], several of the health promotion initiatives implemented in the KAPIs are recognized to be well designed and effectively implemented [3, 5]:

- "Action Programme for Older People" is focused on the maintenance and improvement of mobility, autonomy and self-care among older persons, and it aims to achieve this through physical exercises. The program emerged in 1997 in one municipality in the city of Athens based on previous projects coordinated by the General Secretariat for Sports that were implemented in the KAPIs in different municipalities. The main funding of the program comes from private contributions, while the management is in the hands of the local Primary Health Care Services. The target group comprises people above the age of 60 years old. The program is implemented in two phases: (a) provision of information through lectures and discussions about health related problems, and the role of exercises in the improvement of health; (b) a set of physical exercises in a special sport room and outdoor athletic areas. Two program sessions per week are offered and the duration of each session is 45 minutes. The participants' physical state and mobility is evaluated annually, including the joint functional ability and mobility, the improvement of neuromuscular control on the movements, body balance, health-related habits and the need of physiotherapy. The evaluation of the entire project takes place every 5 years and so far, it has shown positive effects.
- "The Involvement, and the Role of Older Volunteers in Promoting Healthy Diet for the Prevention of Cardiovascular Diseases" is a program based on the Senior Health Mentoring concept. The program was implemented in KAPIs in two municipalities in Athens and received funding from the European Commission and Greek national funds. The program was designed as a pilot study to test the involvement of older people in health promotion activities through the reinforcement of existing experience and knowledge. The first phase of the program included the training of older adults in teaching and communication principles, as well as in contemporary nutritional principles based on the Mediterranean diet. The second phase of the program involved the spread of knowledge gained by the trained adults among other KAPI members. The evaluation of the program demonstrated its success in terms of participants' satisfaction, changes in their own lifestyle, useful feedback and knowledge sharing. As a results of the program, an information package was produced for all KAPIs in the country. This information package is still in use.
- "The Role of Health Education in Improving Compliance for the Prevention of Cardiovascular Diseases" is a program focused on the access to preventive services and adoption of a healthier lifestyle. The program took place in two KAPIs in Athens and was co-financed by the European Commission and Greek national funds. The key objective of the program was to provide health education sessions to increase the awareness of the importance of preventive services and healthier lifestyle for the reduction of cardiovascular risks among older people. The results of the evaluation of this program showed a successful reduction of the participants' body weight, healthier habits, more regular measurement of blood pressure and glucose, and more regular visits to the physician.

It should be mentioned however that the participation in lifelong learning and other work-related education activities in Greece is rather low, particularly for those aged 55–64, compared to other countries in the EU

[13]. Overall, such activities are rare and dependent on external funding (e.g. through EU projects) as well as on the good will of the actors involved (employers and employees). These activities also lack a systemic support (incl. financial support) by the central government, which indicates that they are not a priority for the policy-makers in Greece [13]. Direct financial-incentives programs related to health promotion that target the group of elderly persons are also absent in Greece.

8. National health promotion policy generally and addressed at the older people

In Greece, the health policies, including health promotion policies for elderly persons, are the responsibility of the Ministry of Health, which is the main health policy-making authority [2]. The ministry decides on health policy issues and national health strategies, sets priorities, determines the funding for activities, allocates resources, proposes legislative changes and undertakes the implementation of laws and/or reforms [3]. Despite this responsibility, so far, the ministry has not succeeded to develop a national health target program for setting priorities. The same holds for a national plan for the implementation of 'Health in All Policies'.

On the positive side, a public consultation process took place during 2007–2008, resulting in the development of the National Action Plan for Public Health for the period 2008–2013. This plan emphasized the importance to deal with health hazards such as infectious and rare diseases, drugs, dietary disorders, smoking, environmental hazards, alcohol, dental health, etc. However, only a few measures have been implemented. For example, the ban of smoking in public places [2] has been legislated but not really/fully implemented in practice. The economic challenge that faced the country in this period, was one reason for this policy failure.

In 2012, the Health in Action Initiative (2012) was adopted. It aims to create the conditions for a more effective health system that meets the international standards and public health targets [3]. Nevertheless, the lasting economic crisis remains a hurdle for its implementation.

Overall, the health challenges in Greece mainly remain the subject of academic discussions and EU-funded projects. Academic advisers to the Ministry of Health, as well as representatives of major NGOs have had hitherto a negligible impact on policy. Moreover, policies and programs implemented in sectors other than health, do not acknowledge their potential health impacts. In fact, there are no mechanisms in place to ensure the coordination and effective implementation of cross-sectoral interventions addressed to the prevention of chronic disease and their risk factors [3].

The failure of the Greek government to implement a successful strategy for public health despite its intentions declared in the laws, is explained by several major barriers [3]:

- the strong focus on curative care as well as the chronic lack of disease prevention and health promotion vision since the establishment of the National Health Care system in the 1980s;
- the fragmented and uncoordinated institutions in the public health area, which makes it difficult to implement national-level policy and impose them at the local level;
- the lack of knowledge and experience within the public health institutions on health determinants and underlying causes of mortality and morbidity;
- the significant shortage of financial resources for public health due to the economic crisis but also due to the low priority attached to public health and health promotion.

The factors listed above, also explain the lack of strategic documents on the development and implementation of health promotion programs for elderly persons in the country.

Conclusions and recommendations

The findings of this narrative literature review confirm that despite the numerous legislative documents and public health institutions in Greece, the country lacks a long-term policy perspective in the public health area. The traditionally higher priority attached to curative care over public health actions, is the major reason for this drawback. As a result, the public health resources, and in particular resources for health promotion and primary prevention, are insufficient and their level is unstable [3]. The processes of allocating funding to primary prevention and health promotion are not transparent, and are influenced by political interests [2]. The separation of the public health budget from the budget for curative care is the first essential step in strengthening the public health services in the country, including health promotion actions for elderly persons. However, the potential effects of such separation need to be first investigated in order to identify an effective reform implementation strategy.

The review also demonstrates that overall, health promotion actions for elderly persons do take place in Greece but mainly within the KAPIs, in urban areas and/or within the framework of EU-funded projects. Government efforts are required to stimulate coordinated information campaigns focusing on the positive effects of health promotion and disease prevention for elderly persons, but also for younger persons. Such campaigns should be designed based on empirical studies carried out among the targeted age groups. The participation in the KAPIs needs also to be further investigated to identify groups whose participation needs to be stimulated given the expected positive effects mentioned in the publications reviewed [14]. Given the specific geographic features of Greece (many islands and continental main land), the difference in life style between older islanders and their main-land counterparts should also be taken into account [15]. A national health promotion strategy should be developed and enforced at local levels. The health promotion programs that are successfully implemented, should receive the necessary government support to assure their long-term sustainability [5].

As shown by the review findings, there is also a need of to investigate and outline mechanisms for a cooperation between the public health institutions and the legal sector to minimize confusions in the current public health legislation [1]. New structural reforms implemented in practice, not just stipulated in the legislation, can help to place priority on the public health actions. Rural health centers, as well as the KAPIs in the urban areas, could be integrated as mechanisms for the enhancement of public health and prevention policies [2]. Public health actions in Greece also need to become cross-sectoral to assure that the health determinants are adequately addressed. These general policy recommendations are equally relevant when health promotion policies for elderly persons are the specific subject of policy discussions in Greece.

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The activities of older people when healthy ageing policy and funding is limited. The institutional and financial dimensions of Health Promotion for Older People in Poland

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Abstract

The presented country profile, based on several national reports, legal acts, international databases, scientific articles and pilot research performed with the use of health care sector templates, outlines the major institutional, organisational and financing challenges for health promotion in Poland, and specifically, health promotion for older adults.

Despite the numerous legislative and organisational changes in the health care sector since 1989 and the strengthening of the public health institutions in Poland, the country lacks a long-term, sustainable policy perspective in the public health area. The traditionally higher priority attached to curative care than to public health actions is one of the major reasons for the shortcomings of public health policy and the insufficient resources for health promotion and primary prevention in general, and health promotion for older adults specifically. However, there are also many weaknesses at the organisational level. One of the most important is the weak cooperation between the different levels of territorial self-government, the central government and other institutions when undertaking health promotion actions, which results in the development of both under- and overprovision of health promotion interventions for different population groups and at different geographical locations. Few self-government associations try to improve the cooperation and experience exchange in this field. However there is a need for a greater coordination and information exchange concerning plans and financial possibilities as well as for more competent health educators with better communication skills, less bureaucratic burdens, and better financial conditions.

Key words: **Health Promotion for Older People, public health, health expenditures, Poland**

Introduction

The objective of this Polish country profile in the area of health promotion for older people is collecting and presenting, in the standard report form, essential information on the organisation and funding of these activities in the context of the systemic arrangement of health care and public health. The institutional and financial description includes the primary institutions responsible for carrying out tasks in this area – even if health promotion is just a fraction of their responsibility.

To give an overview of how health promotion is funded and organised both generally and specifically for older people we used desk research to identify relevant sources of information such as official national documents, legal acts, international databases and scientific articles. Additionally the pilot research performed in Poland with the use of health care sector templates helps to identify

both: the main limitations and good practices concerning activities in health promotion for older people performed in the involved sectors. In our report we concentrate on three sectors: health, voluntary and territorial governance.

1. Position of public health and health promotion in the health sector in Poland

With the transformation of the political and economic system initiated in 1989, significant changes took place in the health care sector. Most notably, the budget financing of health care (Semashko model) was abandoned in favour of a quasi-insurance system (since 2004, a single payer system with National Health Fund/NFZ as the monopolistic insurer). The decision-making process has been decentralized and privatisation of the provision for as well as the financing of health care has begun [1].

The current total health expenditure in Poland accounted for 6.4% of GDP in 2015. The level of resources allocated to health has been steadily increasing (see **Table I**). During the period of 2000–2015 the real current health expenditure per capita (base year 2005) has nearly doubled. Approximately 70% of the expenditure comes from public sources (largely from health insurance contributions). Private expenditure includes mostly out-of-pocket payments. Households' out-of-pocket expenditure as a share of the total health expenditure is approximately 23%. A vast majority of health resources (95%) is devoted to finance individual health care services. The expenditure on collective health care accounts for about 5% of the total current health expenditure, and approximately half of these resources are spent on prevention and public health services.

The turning away from the Semashko model affected the sphere of health promotion and disease prevention which, as in other countries, are grouped primarily, but not exclusively, within the health care system. Therefore, most legislative regulations concerning health promotion are acts adopted in different areas of health care (see **Box 1**). There are also different so-called local government acts which define the organisational and financial responsibilities of territorial government bodies in the area of health promotion. Bearing in mind the implementation of the many and varied tasks related to health promotion, the Law on public benefit and volunteer activities as well the Law on the National Sanitary Inspectorate can also be considered crucial legal acts.

New state agencies, including the Departments of Health Promotion in the structures of Provincial Public Health Centres, were established. The existing institutions, such as the State Sanitary Inspection, and various research and educational institutes (e.g. the National Institute of Public Health – the National Institute of Hygiene in Warsaw, the Nofer Institute of Occupational Medicine in Łódź, the Central Institute for Labour Protection – the National Research Institute) intensified their activities and broadened the scope of their health-related initiatives. From the other side, new social organisations came into play, with statutory missions of managing prevention, health promotion and health education activities (e.g. the Polish Society for Health Education in 1993).

A new impulse for fostering health promotion ideas in Poland is expected to come from the Law on public health of 11 September 2015. Among other tasks it lists health education, health promotion and disease prevention tailored to different groups of the population, including the growing group of older people (see **Box 2**) with their specific health status and health needs (see **Box 3**). It also organises, to some extent, provisions concerning the responsibility of public and private institutions at various levels for the implementation and financing of the tasks in the field of public health, including health promotion and health education.

	2000	2005	2007	2010	2015 (or the latest)	Change 2000 to 2015	Change 2007 to 2015
Current health expenditure per capita, constant prices OECD base year 2010 in zloty	1364.0	1755.6	2013.6	2438.7	2779.2	+103.75%	+38.0%
Current health expenditure as % of GDP	5.3	5.8	5.9	6.5	6.4	+1.1	+0.5
Share of general government in current health expenditures	68.9	68.7	70.1	71.7	71.6	+2.7	+1.5
Share of individual health care services and medical goods in expenditure on health	–	96.0	95.5	96.5	95.2		
Share of prevention and public health services in current expenditure on health	–	2.4	2.4	2.1	2.6 (2014)		

Table I. *Health system indicators.*

Source: Based on OECD Health Statistics, http://stats.oecd.org/index.aspx?DataSetCode=HEALTH_STAT#; accessed: 2.10.2016.

Law on Therapeutic Activity dated 15 April 2011, dated 15 April 2011 (Journal of Laws 2011, No. 112, Item 654, as amended)
- Law on Health Care Services Financed from Public Sources, dated 27 August 2004 (Journal of Laws 2004, No. 210, Item 2135, as amended)
- Law on local self-government, dated 8 March 1990 (Journal of Laws 1990, No. 16, Item 95, as amended)
- Law on powiat* self-government, dated 5 June 1998 (Journal of Laws 1998, No. 91, Item 578, as amended)
- Law on voivodeship* self-government, dated 5 June 1998 (Journal of Laws 1998, No. 91, Item 576, as amended)
- Law on the National Sanitary Inspectorate, dated 14 March 1985 (Journal of Laws 1985, No. 12, Item 49, as amended)
- Law on public benefit and volunteer activities, dated 24 April 2003 (Journal of Laws 2003, No. 96, Item 873, as amended)
- Law on public health, dated 11 September 2015 (Journal of Laws 2015, Item 1916 as amended)
- Law on Education in Sobriety and Prevention of Alcoholism, dated 26 October 1982 (Journal of Laws 2015, Item 230 as amended)
- Ministry of health regulation on guaranteed primary care health services, dated 24 September 2013 (Journal of Laws 2013, Item 1248)
- Decree No 85/2011/DSOZ of the National Health Fund President (dated 17 November 2011) on the conditions for arrangements and realisation of contracts for health service delivery: primary care type
- Decree No 98/2012/DSOZ of the National Health Fund President (dated 21 January 2012) on the conditions for arrangements and realisation of contracts for health service delivery: Prophylaxis health programmes

* The Polish territorial self-government has been divided into three levels: regions (voivodship), counties (powiat) and municipalities (gmina).

Box 1. *Main legal acts concerning public health and health promotion issues.*

Source: Authors' own presentation.

Poland is still a relatively young European country, with 11.4% of the population aged 65 to 79 and 4.0% of the population above 80 years of age, which is below the average of the EU-28 (13.6% and 5.3% of the population respectively) in 2015. The average life expectancy (LE) at birth has been increasing over the past two decades, amounting to 81.7 years for females and 73.7 years for males in 2014 (the EU-28 average is 83.6 for females and 78.1 for males). The healthy life years are estimated as 62.7 for females and for male as 59.8 (in 2014) which means that, on average, women might expect to spend about 77% of their lives in good health and without disability and men about 81%. The life expectancy at the age of 65 amounts to 20.4 years for females, and about 39% of life in older age is expected to be spent in good health and without disability. For males the life expectancy at the age of 65 amounts to 15.9 years and about 45% is estimated to be spent healthily. Due to the increase in life expectancy and the low fertility rate, the share of people 65+ in Poland is foreseen to raise from 14.9% in 2014 to 32.9% in 2060. At the same time, the proportion of the oldest old (80+) will triple, amounting to 12% of the total population in 2060. This demographic trend will result in an increase in the old age dependency[1] ratio from 21.8 in 2015 to 60.9 in 2060.

Box 2. *Population ageing indicators.*

Source: Based on Eurostat data, http://ec.europa.eu/eurostat/data/database; accessed: 14.10.2016.

The health status of the older population is characterized by living with different illnesses, often coexisting and in many cases chronic. It is assessed based on objective indicators such as mortality as well as subjective indicators of perceived health, reported morbidity, chronic conditions and functional capacities.

Male mortality from all causes at the age of 65+ (5,476/100,000 population in 2014) in Poland is much higher than female (3,341/100,000 in 2014). The main causes of mortality are cardiovascular diseases, constituting 47% of all deaths for men (2,574/100,000) and 53% of all deaths for women (1,780/100,000). The second cause of mortality are cancers, accounting for 27% of all deaths for men (1,486/100,000) and 22% of all deaths for women (747/100,000). Respiratory system diseases constitute 8% of male deaths (400/100,000) and 5% for women (169/100,000). The self assessed health status of older people is poor, although it has slightly improved over recent years. 65% of people aged 60–69, 79% of people aged 70–79 and 88% of people above 80 years of age assessed their health status as worse than good in 2014 [2]. More than 85% of people aged 60+ reported suffering from long-term illness and at the age of 80+ this share rose to 90%. The main chronic conditions of older people are cardiovascular system diseases, pulmonary diseases, diabetes, osteoporosis and arthritis, vision and hearing impairments and cognitive disorders. According to the POLSENIOR hypertension is observed in 77% of men/79% of females aged 65–79 and 66% of men/76% of females age 80+ [3]. Over 50% of people aged 65+ have moderate vision problems and over 30% have hearing problems. 40% of the population 65+ suffers from diabetes and in half of the cases this condition has not been recognized and adequately treated. Dementia is reported in about 1.3% of the total population, but some sort of cognitive impairments are observed in as much as 60% of older people (65+). About one third of older people suffer from moderate depression [3].

Older age is characterized by a loss of functional capabilities. Long standing limitations in everyday activities are reported by 44.6% of men/46.3% of women aged 65–74 and increases to 69.3% of men/79.1% of women above 85 years of age in 2014.

The main behavioural risk factors for poor health and occurrence of functional limitations include inadequate nutrition, smoking and falls. According to the European Health Interview Survey of 2009, 28% of people aged 60–69 suffered from obesity (BMI $\geq$ 30) and this share decreased to 18% above the age of 80; 25% of people aged 60–69 smoked cigarettes and this share decreased to less the 5% at the age of 80 [4] The reported incidence rate (falls) per 100000 population accounts to 62.4/100,000 for the population 65+.

Box 3. *Health status of older population.*

Source: Based on European health for all database (HFA-DB) WHO Regional Office for Europe, http://data.euro.who.int/hfadb/; accessed: 02.04.2016; Alzheimer Europe, http://www.alzheimer-europe.org/Policy-in-Practice2/Country-comparisons/The-prevalence-of-dementia-in-Europe/Poland; accessed: 02.04.2016; Eurostat, EU-SILC data http://ec.europa.eu/eurostat/data/database; accessed: 30.06.2015; Eupha, https://eupha.org/repository/sections/ipsp/Factsheet_falls_in_older_adults_in_EU.pdf; accessed: 14.10.2016.

The Law on public health establishes the National Health Programme as the most important document and tool for implementing public health policy. The first such programme was scheduled for the years 1996–2005 and the second for 2007–2015. The new one for 2016–2020 has been passed by the Polish government on 16th September 2016. Last but not least, the law mandates the NHF to allocate at least 1.5% of their total expenditure to health care costs for health promotion and disease prevention, including the funding of health policy programmes.

2. Funding of Public Health and Health Promotion – potential sources and main institutions

The diversity of organisations performing health promotion tasks combined with the lack of an institutional separation of health promotion and the significant degree of fragmentation of health promotion activities makes it challenging to identify the real sources of funding, both public and private. At the central government (macro) level, the Polish statistics show only aggregated numbers – expenditures for public health and prevention. Three fundamental sources of data on health expenditures, i.e. state and local governments' budget reports, the National Health Fund reports, and prepared on their basis, the Central Statistical Office (GUS) reports, use different methodologies for calculating costs and different classifications of institutions. The most general methodology of the GUS, based on a system of National Health Accounts (NHA, see **Table II**), does not list health promotion as a separate position. It shows the expenditure on preventive health care and public health, which does not cover the total spending on health promotion because some spending is included in the expenditure on health services, e.g. the part of the capitation rates of the primary health care providers that covers the costs of health promotion activities carried out by them. As a result, the figures presented at the end of this chapter should be treated with caution as they are more an estimation of the order of magnitude rather than a precise calculation of expenses.

The GUS also publishes data, based on budgetary reporting, on the state and the local government's expenditure on activities related to health promotion, e.g. health inspection, health policy programmes, combating alcoholism and drug addiction. The NFZ reports an item listed as 'Costs of preventive health programmes and health policy programmes financed from NFZ funds' that includes expenditures for: General programme for early breast cancer detection, Cervical cancer prevention programme, Tuberculosis prevention programme, Prenatal screening programme, Prevention of cardiovascular diseases, and Prevention programme for tobacco-related diseases (including COPD) [5]. Although these programmes contain elements that could be included in the area of health promotion and health education, they focus on prevention programmes for early detection of diseases through relatively extensive screening. The institutions involved in activities promoting health and health education include, not only public authorities at various levels and health care providers, but also a num-

HC.6.1	Maternal and child health, family planning and family counselling	Ministry of Health: – health policy programmes (comprehensive intrauterine diagnosis and therapy programme in the prevention of complications resulting from diseases and fetal malformations) – health insurance premiums for those not obliged to be covered under health insurance (e.g. pregnancy and childbirth-related benefits)
HC.6.2	School-based medical care	National Health Fund: primary health care in schools
HC.6.3	Prevention of infectious diseases	Ministry of Health: – health policy programmes (Immunization Programme) – prevention and fighting AIDS (prevention programmes, National Centre for AIDS) Local government units: – prevention and fighting AIDS (prevention programmes)
HC.6.4	Prevention of non-communicable diseases	Ministry of Health: health policy programmes National Health Fund: the costs of prevention programmes Local government units: combating drug addiction, counteracting alcoholism, detoxification detention centres
HC.6.5	Occupational medicine	Ministry of Health and local government units: occupational medicine Ministry of Justice: expenditure on research for prisoners Private: estimated expenses of the employers on occupational medicine
HC.6.9	Other services in the field of public health (e.g. operations and management of blood and organ banks)	Ministry of Health: health policy programmes (ensuring Poland's self-sufficiency in blood and its components, a programme for the elimination of iodine deficiency in Poland, national programme for the development of transplantation medicine) Local government units: health policy programmes, public blood service Private: NGO activity in the field of public health

Table II. *Classification of expenditure on prevention and public health according to the NHA classification and corresponding expenses in Poland.*

Source: Based on OECD Health Statistics 2015 Description of Sources and Methods – Poland.

ber of other entities such as public benefit organisations and foundations (NGOs), semi-formal social initiatives, businesses, religious associations and churches, schools and universities, research institutes, individuals and foreign entities. This abundance of entities is accompanied by a variety of potential sources of funding, both public and private, with financial flows that are equally diverse (see **Table III**). Public funds go not only to public institutions but also, through grants and subsidies, to private entities performing tasks related to health promotion, education, and preventive health care. Public institutions in turn benefit on a large scale from the financial aid of private benefactors.

The estimates of the GUS drawn up as part of the NHA show that the expenditure on prevention and public health in Poland in 2013 represented 2.57% of the total expenditure on health (approx. PLN 2.7 bn, Table I [6]). Compared to 2012, there was a significant increase in the total expenditure on prevention and public health by over 30% (from PLN 2 bn) and in the share of the total current expenditure by half of a percentage point (from 2%). However, as already noted, due to the variety of activities that fall within the scope of public health, the expenditure on tasks related to public health including health promotion can also be listed as part of administrative expenditure, expenditure on medical services, or under functions related to health care, which include, among others: education and training of medical staff, research and development in health care or food, hygiene and drinking water control.

The NHA estimates indicate that public spending (including the state budget, local government budgets and the National Health Fund) in 2013 accounted for almost 73% of total expenditure on prevention and public health

Source of funding	Beneficiary	Comments
General taxation	Central government institutions: • Central offices • The State Sanitary Inspection • Local government bodies – for the implementation of assigned tasks • National research institutes (e.g. the National Public Health Institute and the National Hygiene Institute, the Nofer Institute of Occupational Medicine in Łódź, the Central Institute of Labour Protection, the Institute of Rural Medicine in Lublin, the Institute of Occupational Medicine and Environmental Health in Sosnowiec) • Health care providers implementing the central/national health programmes* • NGOs**	* Contracting of health care services through the National Health Fund ** NGOs through grants and subsidies
Local taxes and fees	• Local government bodies – for the implementation of their own mandatory tasks • Local initiatives • Schools and other educational and care facilities • NGOs* • Health care providers**	* NGOs through grants and subsidies ** for the implementation of tasks assigned by the local government - usually for the entities in which the local government is the founding body
Health insurance premiums	• Primary health care providers within capitation rates • Health care providers implementing their own NHF health programmes	
Funds from the employers	• Bodies carrying out tasks in the area of occupational medicine • Private initiatives/NGOs* • Local communities' initiatives* • Churches and religious associations*	* funding/sponsoring
Business operations*	• Institutes • Private initiatives/NGOs • Local communities' initiatives	* research institutes, NGOs/local initiatives: organising meetings, conferences/ festivals, publishing, providing services
Households	• Health care providers* • NGOs/Associations**	* charges ** membership fees, donations, legacies
Foundations*	• Health care providers • NGOs/Associations • Local initiatives • Third age universities	* e.g. the Polish-American Freedom Foundation, university foundations
Foreign*	Grant beneficiaries – research institutes, health care providers, schools and colleges, NGOs, local initiatives	* European funds, Norwegian and Swiss funds, the World Health Organization, European associations (e.g. the European Healthy Cities Network), foreign households

Table III. *Potential sources for Health Promotion.*

Source: Authors' own presentation.

(less than PLN 2 bn), which corresponds to the structure of total expenditure on health in Poland, in which public funds also constitute a 70 percent share. However, as opposed to health care (curative medicine), most public health funding does not come from health insurance contributions but from taxation revenues that remain at the disposal of the state budget and territorial self-government units. The spending on health care from the state budget (approx. PLN 7.4 bn in total in 2014) includes significant expenditure on sanitary inspections (which also includes the salaries of the Sanitary Inspectorate staff) and health policy programmes, financed mainly with the Ministry of Health's own funds (**Table IV**). An important position in the expenditure of territorial self-governments for health (total approx. PLN 3.7 bn in 2014) is the spending on alcoholism prevention (approx. PLN 700 million), managed primarily by the local governments. Territorial self-government expenditures on health policy programmes in 2014 amounted to approx. PLN 67 million, which represents 1.8% of their total expenditure on health (Table IV).

The Law on public health from 2015 puts an obligation on the NFZ to allocate in the future no less than 1.5% of total expenditure on health care services to the funding of prevention and health promotion programmes. Achieving this threshold may present quite a challenge given the fact that in recent years, the spending averaged below 0.3%. The NFZ finances mostly prevention programmes (mentioned above), which amounts to approx. PLN 169.0 million, nearly 0.3% of the total NFZ expenditure in 2015 [5]. Most of these expenses are incurred on the basis of separately concluded contracts with health service providers (hospitals, practices, doctors and nurses). However, it should be emphasised once more that the presented numbers do not show the engagement of the NFZ in health promotion funding implemented within the framework of the regular contracts concluded with primary health care units.

			2013		2014	
			Amount (million PLN)	% of total expenditure on health care in a given entity	Amount (million PLN)	% of total expenditure on health care in a given entity
State budget		Sanitary inspection	915.4	12.2%	946.9	12.9%
		Health policy programmes	891.2	11.8%	929.9	12.6%
		Public Blood Service	97.4	1.3%	95.7	1.3%
		Combating drug addiction	9.7	0.1%	9.3	0.1%
		Methodical teams for health care (Public Health Centres)	7.4	0.1%	4.7	0.1%
		Combating alcoholism	6.6	0.1%	6.6	0.1%
		Fighting and preventing AIDS	6.0	0.1%	5.9	0.1%
		Occupational medicine	1.3	0.02%	1.2	0.02%
Territorial self- government budgets	Commune local governments	Preventing alcoholism	391.1	72.2%	407.2	72.5%
		Combating drug addiction	21.2	3.9%	22.3	4.0%
		Health policy programmes	8.8	1.6%	12.7	2.3%
		Detoxification detention centres	2.6	0.5%	3.0	0.5%
	Cities with powiat rights	Preventing alcoholism	246.6	23.3%	258.6	24.3%
		Combating drug addiction	15.5	1.5%	16.3	1.5%
		Health policy programmes	43.9	4.1%	42.5	4.0%
		Detoxification detention centres	39.8	3.8%	42.3	4.0%
	Powiat	Preventing alcoholism	0.6	0.1%	0.6	0.05%
		Combating drug addiction	0.1	0.01%	0.1	0.01%
		Health policy programmes	2.9	0.2%	3.7	2.9%
		Detoxification detention centres	0.1	0.01%	0.2	0.01%
	Voivodeships	Preventing alcoholism	26.5	2.9%	29.9	3.9%
		Combating drug addiction	5.1	0.6%	6.2	0.8%
		Health policy programmes	5.2	0.6%	8.2	1.1%
		Occupational medicine	86.4	9.3%	80.6	10.4%

Expenditure of local governments including funds received from the state budget (i.e. expenses without eliminating transfers between entities).

Table IV. *State budget and local government units' expenditure on public health tasks for 2013–2014.*

Source: Based on GUS [6].

According to the GUS reporting, private spending on prevention and public health in 2013 amounted to PLN 741.1 million, which was about 115 million (18%) more than in 2012. More than 80% (PLN 613.5 million) of this amount was provided by businesses. Given the fact that these funds have been fully used by health care facilities, it can be concluded that the expenses were related to occupational medicine. The rest of the private resources came from non-profit institutions. These funds were fully used by preventive health service providers.

3. Organisation and financing of health promotion interventions for older adults

As mentioned above the diversity of tasks in health promotion and in organisations performing these tasks, makes it challenging to identify the real sources of funding. There are no separate aggregated data on expenditures for health promotion activities, not to mention data on funding of health promotion for older people. What we can try to do is to identify concrete programmes provided in different sectors by different institutions and organisations to show their funding sources and used mechanism. In Poland three sectors seem to play a major role in providing health promotion interventions for older people: the sector of local governments and municipalities, the voluntary sector and the health sector.

3.1. Health promotion for older people performed by local governments

Role of regional and local self-government in Health Promotion for Older People

Since 1999, Polish territorial self-government has been divided into three levels: 16 regions (*voivodships*), 380 counties (*powiat*)[2] and 2,412 municipalities (*gmina*) which perform public tasks not exclusively reserved for public authorities at higher levels. In the area of health care, territorial self-governments are mainly responsible for health promotion and prevention, and for tasks related to their function as the proprietors of public health care units. According to the Law on health care services financed from public sources, local governments are obliged to plan, implement and evaluate health programmes addressing diagnosed local health needs.

Several forms of local governmental activity apply to the issue of health promotion for older people. This applies to the development of local health care systems, including the development and implementation of community health promotion and prevention programmes (impact raising public awareness in the field of "healthy ageing," the promotion of a healthy lifestyle, etc.). Local government units work to create opportunities to facilitate increased access to diagnosis and treatment, support the implementation of screening programmes, and promote early diagnosis. At the regional and local levels it is becoming important to create favourable conditions for dignified ageing. Regional and local authorities are often involved in the modernisation and construction of infrastructure facilities for older people. Local governments also prioritise the development and support (also financial) of various initiatives dedicated to the elderly undertaken by NGOs (e.g. continuing education, stimulating physical activities, a healthy lifestyle, etc). At the lowest local municipality level Senior representatives – *Senior councils* – are actively involved in planning local programmes for the elderly. The local governments also play an important role in establishing wider social policy and are very often the creator of the education activities for the elderly.

Cooperation of the different levels of territorial self-government and the central government institution

Each level of territorial self-government is independent – it has its own organisational units and responsibilities. Territorial self-governments are run by political parties and lobby for their own territorial issues. This makes the coordination of activities and an effective use of financial resources (coming from different budgets) difficult [7]. The cooperation of the different levels of territorial self-government in the sphere of health promotion programmes is difficult as well. On one side, there is a lack of knowledge concerning central governmental programmes on the activation of the older population and on the other side, there are many difficulties in relation to the central government and territorial self-governments, such as direct conflict, a lack of partnership and cooperation, which make the coordination of their activities challenging. Weak cooperation among different levels of territorial self-governmental units, the central government, and national agencies (e.g. the National Health Fund, the Chief National Sanitary Inspectorate) is one of the key problems in the implementation of community health promotion programmes. Objectives and target groups of programmes realised by different institutions in the same geographical area are sometimes duplicated even if there are a few very active and supportive self-government associations oriented towards improving cooperation and sharing experience: The Federation of Polish Municipalities (*Związek Miast Polskich*), The Association of Polish Counties (*Związek Powiatów Polskich*) and The Association of Polish Healthy Cities (*Stowarzyszenie Zdrowych Miast Polskich*). Thus there is a need to provide a reliable source of information concerning realised and planned health programmes as well as their outcomes at the regional and local levels.

Cooperation with other sectors and institutions

The local government's main goals are developing and supporting various initiatives, including those undertaken by non-governmental organisations, such as continuing education, promoting physical culture, tourist associations and others. These organisations, often supported by local and regional authorities, activate older people and promote cooperation in a very professional way, at the same time taking care of their health and intellectual prowess. Territorial self-governments usually organise competitions and deliver organisational and financial support for the best proposals of the programmes.

Financing community health promotion programmes

The realisation of health programmes is a statutorily obligatory task of all local government levels in Poland. The practical aspects of this task are however highly dependent on several factors including: organisational and financial restrictions, the availability of supporting tools and the adequate competencies of local governments representatives. Community health promotion and prevention programmes are mainly funded by their own-sources. Regional and local self-governments can also apply for financial support from national and international financial sources:

- financial sources from the educational sector and the sport sector;
- Operational Programme – Infrastructure and Environment;
- Swiss Contribution Programme[3];
- EOG Funds and Norway Grants;
- National operational projects funded by European Union funds.

Polish regional and local self-governments have no legal possibility to apply for funding of their health programmes by the National Health Fund.

Examples of public programmes and good practices

A few Polish self-governments (especially big cities) are very active in the field of health promotion for older people and provide their own programmes. One interesting programme – "The Development Strategy for the Opolskie Voivodship until 2020" – was developed by the Marshal Office[4] in Opole. Its most important portion – "Golden Autumn" – is aimed at improving the quality and availability of services for older people, increasing the activity of the elderly and improving the digital competency of citizens 50+.[5]

The Municipality of Sopot is a member of the international programme, "SENIOR CAPITAL" (Develop the human capital of seniors to increase their economic and social value in a knowledge based and competitive economy), which is a follow-up of the former project, "Quality Ageing in an Urban Environment" ("Q-AGEING").[6] Within this project the Municipality of Sopot has developed a strategic approach to documenting urban barriers and to taking them into consideration when infrastructural developments are made in future (*The Urban Barrier Map*). On one hand, this Map is a digital database, containing information about the architectural barriers of the city. Secondly, it is a real map, with a photo-documentation about the barriers. It is editable, so the municipality can add new records in case new barriers are identified in future or to delete barriers that have been removed. For the municipality this Urban Barrier Map can be used as the basis for development of future infrastructural projects.

The Municipality of Krakow implemented the PASIOS (*Programme for social activity and integration of older people*) programme for social activity and the integration of older people in the city. Another programme, "The Golden Age,"[7] is focused on educational activities and preventing an unhealthy lifestyle in order to reduce the number of people who will require residential care in the future. The target groups of this project are: physicians and nurses (as participants of special trainings), the elderly and their family. The project's activities are oriented towards prevention of diseases associated with lifestyle and promotion of "healthy ageing."[8] Moreover the Municipality of Krakow is a member of the "Innovation for the Creation of Conditions Friendly to All Age Groups" programme, developed by the European Platform of Senior Organisations – AGE (AGE Platform Europe) 2013–2016 and the "Demographic Change Pact" – an initiative linking European local, regional and national governments, as well as other interested parties that declare cooperation in the implementation of innovative solutions supporting active and healthy ageing.

The regional and local governments in Poland can provide their own programmes, but in many cases are also obliged to implement national programmes. The main governmental initiatives in the field of health promotion for older adults which are implemented by the regional and local self-government units are:

a) **Programme for Social Participation of Senior Citizens (ASOS)**, addressed directly at supporting actions – projects (based on priorities: education, integration promoting solidarity between generations, social participation and services for older citizens as a key element of active ageing) by the organisations that operate in the area of public benefit for senior citizens;
b) **The Long Term Senior Policy in Poland 2014-2020 (LTSP)** (as a follow up of the ASOS Programme adopted by the Polish Government in December 2013[9]);
c) A programme called "**Senior – Wigor"**[10]**, started by the Ministry of Labour and Social Policy**. This programme will be carried out from the years 2015–2020 and will include all voivodships. Once the local government unit receives funds for the programme, it is obliged to carry out the programme for at least 5 years. Under the programme, local governments are obliged to organize day care/activation centres as a place for the meetings of the elderly 60+ (offering various forms of activities like: educational courses, sports exercises, rehabilitation, dance and others).

Main limitations and barriers in planning and implementing public health promotion programmes for older people

Beyond the financial and coordination problems, the lack of professionals poses a particular challenge for the planning and implementing of community health promotion programmes. All programmes must be submitted to The Agency for Health Technology Assessment and Tariff System (AOTMiT), which conducts an appraisal process. The Agency issues an opinion (positive or negative) which includes suggestions for corrections to the programmes' projects. Many programmes submitted to the Agency are not well prepared. The analysis of the opinions' texts reveals the most common problems: an

unclear description of programme objectives, a lack of a precise description of the programme's expected outcomes (which consequently hinders the monitoring and evaluation process), inadequate information on the programme's financing sources, the lack of a programme budget (which makes it impossible to assess the programme's cost-effectiveness) and the lack of relation to local epidemiological data.

In the area of the social participation of senior citizens, the main focus must be put on education as well as volunteering, civic engagement and participation in culture. A significant barrier is the willingness to participate in the programmes offered by self-governments. Therefore, it is important to establish wider promotion of all possible channels to reach potential customers for both active seniors and younger generations. Intergenerational relations are also an important goal of senior policy. However the most urgent challenge within ageing societies is putting conditions for healthy ageing in place. To achieve this target, various stakeholders must be involved (including social partners and NGOs, as well as citizens themselves).

3.2. Health promotion for older people performed and provided by the voluntary sector

Role of voluntary sector in health promotion for older people

After only a quarter century of democratic government, civil society in Poland is still in development. According to the most recent data, 19% of Poles declare that they have spent their free time in voluntary non-payed work for some form of organisation [9]. Nevertheless in 2015, there were circa 103,000 NGOs registered in Poland – 17,000 foundations and 86,000 associations.[11] However, only 70,000 of them remain active. NGOs that fulfil certain requirements, primarily performing their enumerated goals, as well as entities that are not legally classified as NGOs, can apply for the status of Public Benefit Organisations (PBO). Out of the entirety of NGOs, 8,033 enjoy this status.[12]

In 2015, 2,484 NGOs declared themselves as being active "for the benefit of retirement-age persons". About 200 NGOs with the status of Public Benefit Organisation operate for the benefit of older people as their primary or supplementary activity.[13] The main institution responsible for the cooperation of the government with the NGO sector is the Ministry of Family, Labour and Social Policy (MRPiPS[14]) – the same one that is responsible for policy programmes oriented towards health promotion for the older population.

The main activities in the field of health promotion for older people within the voluntary sector fall into several categories: social engagement and self-support or providing healthy activities (sport, recreation, tourism, travel) as well as health information, education and marketing. Often NGOs also organise health screenings and diseases prevention with assistance from other sectors.

Based on the level of financial support, the most significant role is played by those PBOs that perform public tasks delegated and financed by governmental institutions (both central and local). This includes the central initiatives mentioned above, such as the ASOS Programme and the Senior-WIGOR Programme. There are also local programmes such as the PASIOS programme in Kraków which delegates to NGOs the organisation and management of Senior Activity Centres. Another noteworthy field are Universities of the Third Age that serve from 100,000 to 160,000 learners per year with 320 learners per institution [10, 11]. In this area Poland is considered among the leaders in the world, providing experience for even western-European countries, even though these institutions are not legally regulated in any special manner. According to the data of March 2015, there are over 500 such institutions in Poland and this number is systematically growing from about 300 in 2011 and 400 in 2012.

Another relevant category of NGO institutions which traditionally plays a significant role in providing fresh-air physical activity and recreation for older people living in cities – especially those of retirement age are Family Allotment Gardens. It should also be noted that among the voluntary activities in Poland, religious institutions (most notably the Catholic Church) play an important role in the social activation of older people. These take varying forms, from the "rosary circles"– informal prayer groups – to organised pilgrimages to places of worship (also abroad). They are largely based on voluntary work of their participants and provide social activation and interaction and self-help as well as recreation and physical activity [12]. Church-based institutions can also acquire PBO status and apply for recognition in the performance of public tasks.

Cooperation of NGOs with other sectors

Public resources – especially those received from territorial self-governments – remain the main source of income for NGOs in Poland. Overall, the declared level of cooperation with organisations from other sectors (local self-governments: 92%, local communities: 89%, local media: 89%, companies: 75%) as well as within the sector (92%) is very high and it is growing. The problem is, however, the sustainability of such cooperation [13–15]. Increased cooperation between NGOs and business enterprises is being observed. However, it is mostly of a non-financial character; thus, it does not translate into increased donations.

Financing of NGOs

It is an increasingly common practice that NGOs with PBO status perform delegated public tasks. The subsidies for those duties as well as other grants from the central and local governments are a significant and growing source of income for NGOs. 60% of NGOs receive them. On the other hand, donations by individuals and companies are decreasing. The income from membership fees is insufficient and the fees for services (such as in case of Universities of the Third Age) discourage participation [13–15]. The external financing for Universities of the Third Age comes – through the Ministry of [Family], Labour and Social Affairs – from the Fund for Citizens'

Initiatives (FIO, *Fundusz Inicjatyw Obywatelskich*) and from the Polish-American Freedom Foundation as well as from the Grundtvig European Commission Programme and the European Social Fund.

Examples of programmes in the voluntary sector

The expertise in the activities of NGOs comes from various sources as shown in the healthProElderly study, which indicated several older Polish health promotion programmes from the 1990s addressed towards the older population [16]. But there are also several more current initiatives that potentially could be indicated as good practices in the sector. The MANKO Association,[15] for instance, received a training from the Johns Hopkins Bloomberg School of Public Health, which was financed by Mike Bloomberg's Philanthropies. Also, for the consultation of ongoing activities, MANKO created a Council of Experts within "Senior's Voice" magazine (*Głos Seniora Portal Nowoczesnego Seniora*[16]). It is composed of specialists and practitioners from universities and various organisations, as well as some parliament members. Also, other initiatives of the MANKO Association performed in collaboration with multiple organisations from other sectors: Senioriada and Senior's Days, local events that involve educational actions (lectures) and health screening opportunities, are performed together with the health sector. A discount "Nationwide Senior's Card" is issued in collaboration with various enterprises as well as health care providers[17].

Another interesting initiative comes from the Organisation "Forum 50+ Seniors of the XXI century", an independent coalition of 22 NGOs that has been in operation since 2011 and that works primarily as an advocacy organisation for the interests of older people.[18] Interestingly, it was an NGO – the ProEthica Association – that developed a *Model of social services for the elderly* within the central-governmental ASOS programme [17].

Limitations and barriers in health promotion activities for older people in the voluntary sector

The list of the main problems/barriers for NGOs active in the field of health promotion for older people, largely based on the pilot research interviews and supported by the literature review [13–15, 18], is long. It includes:

- the lack of financial resource stability but also the lack of effective fundraising strategies;
- the lack of human resources and human resource management skills (difficulties in acquiring new members and volunteers, deficits in volunteer recruitment strategies);
- the lack of cooperation or formulation of a coherent position on a partnership basis within the sector;
- the lack of public governance oriented towards horizontal (and not only vertical) cooperation between sectors [19];
- difficulties managing delegated tasks – drastically insufficient financing for the employment of managerial staff, excessive bureaucratic burdens, complicated administrative work, very short deadlines for amendments, a problematic financing timetable (public task performance subsidies are supposed to serve for a calendar year), the obligation for a significant self-contribution (from 10 to 30% of the entirety of the programme value, considering the fact that financial capital is what the voluntary sector is not supposed to offer);
- the lack of legal regulations for Universities of the Third Age concerning quality assurance;
- the lack of sufficient information and promotion of NGO activities, especially in the local media, resulting in an idealised and burdensome public perception of volunteering activities (NGOs are perceived as large philanthropic institutions; work in NGOs should not be payed) and some degree of social distrust of the financial operations of NGOs;
- problems with older people's attitudes – elderly people often are pretentious and unappreciative of NGOs activities and distrust volunteers and NGOs as suspicious and maybe even scams.

3.3. Health Promotion for Older People in the health sector

Role of the health sector in health promotion for older people

The general rule of Polish Constitution states that the whole population should receive the same access to health services – the scope and type of services cannot differ based on the territory of the country. Obviously there are specific needs in some local areas and those needs may be satisfied without infringement of the rule mentioned above. Requirements on educational and prophylactic activities at the primary care level concern proper health needs identification and should implement existing programmes (elaborated by a public body). Such activities include, among others, prophylaxis of cardiovascular diseases, oncological problems, osteoporosis, family stress and conflicts, and violence. All the mentioned areas concern the older population and should be undertaken adequately to the indicated health needs and health status – on the basis of available epidemiological data or the health needs maps that are now being introduced into the system.

Since 1 January 2015, on the basis of the systemic legislation amendment of the Law on Health care services financed from public sources, the NFZ may elaborate, implement, realise and finance services other than the strictly medical or therapeutic which serve the whole population or a particular group of beneficiaries. Keeping in mind the WHO strategies,[19] as well as the basic Polish regulations on the matter – the ordinances of the NFZ President,[20] the proper place for health promotion programmes would be primary care mostly provided by individual doctors' practices or so-called NZOZ – non-public health care units. According to the NFZ report current primary care potential in different regions differs quite significantly, mainly in the spheres of placement, organisation and scope of activity – the subjective complexity of contracts; providers' potential

concentration have to be underlined particularly [20]. Such situations, in the view of the NFZ, result from the "petrified" first Sickness Funds contracts that became so persistent – despite the process of unification of contracts, methods and levels of primary care health service financing. This seems to have also had a decisive impact on health promotion because the basic legal act on health care services financed from public funds, which indicates the type of services included into the guaranteed health services basket,[21] does not explicitly use the term of health promotion, not to mention health promotion for older people.

Cooperation of health providers with other sectors

Different forms of cooperation may be indicated based on the National Health Programme that constitutes a foundation for detailed health promotion programmes. Health promotion programmes are mainly implemented in health sector institutions with primary care providers as the point of first contact. In this context the cooperation between the primary care unit and medical professionals, such as community nurses and midwives (often employed as people responsible for health promotion – health promoters – in the primary care unit), is crucial for the success of the programme. This primarily regards doctors, nurses and other professional personnel of primary care (specialists, ambulatories, psychological health units, educational institutions, social assistance centres, local administration and territorial governments as well as other sites and professionals acting in a given territory are also mentioned).

The next type of inter-sectorial cooperation concerns local social involvement. This focuses on the activation of the local population and its representatives: associations, community bodies and organs, NGO's acting locally, Koła Gospodyń Wiejskich (popular social clubs for women living in the country) and local volunteer fire brigades. Such cooperation includes varied activities: organisation of educational and cultural events focused on health promotion issues, discussion meetings (at schools, kindergartens, cultural centres or clubs in the suburbs), individual contact with doctors and nurses, psychologists, community nurses, social workers and other professionals devoted to health advisory and concentrated on health risk prevention and enabling citizens' contact with health providers, medical practices and specialists.

Financing health promotion services in the health sector

Primary health providers deliver health care services on the basis of general provisions and contracts with the National Health Fund. From the very beginning of the systemic reforms, health promotion was planned to be included in the package of primary care main liabilities [22]. The legislation, however, does not directly indicate particular services, but it constitutes a legal basis for the executive regulations of the Ministry of Health called the "basket regulations." Subsequently, these provisions are concretely specified in particular contracts with the National Health Fund, acting as a public payer.

Examples of health sector activities in health promotion for older people

Regarding the health sector, and specifically primary care units, the indication of good practices is really difficult due to the extremely limited programmes of health promotion which are addressed directly to the older population. Among the programmes offered by the Ministry of Health which crucially concern the scope of primary care liabilities and are focused on the population 65+, especially important is the National Programme for fighting oncological diseases and its subsidiary, the Programme of Early Detection of Breast Cancer – addressed at women 50–69. The programme's nature relates more to intervention but it encompasses different activities concerning prevention, like educational and informative actions. Due to the introduction of new legislation concerning oncological patients in 2015, new obligations were assigned to primary care.

Since 2011, the National Programme for civilisation diseases (overweight, obesity, cardiovascular diseases, cancers and diabetes) has been being implemented. Among its different components, two concern health promotion activities: Module I: the Programme for the prevention of obesity and chronic non-communicable diseases by means of nursing improvement and physical activity (POL-HEALTH), and Module II: the Programme for prevention and treatment of Diabetes in Poland. The ministry of Health also introduced the Programme for early prevention of genitourinary cancers among men aged 45+. Every mentioned programme has to be realised with the engagement of primary care.

Since 2012, a new medical procedure has been included in the health sector: complex geriatric evaluation (COG). It is provided for hospital patients but also has the potential to influence further treatment at the primary care level. Due to COG, the knowledge of patients' needs and states should be improved and also health promotion addressed in later stages should have better effects.

Nevertheless, the role of primary care should be considered crucial in light of the approach presented by the Interdisciplinary School of Health Promotion for Seniors [23]: primary care doctors and nurses are the best individuals to manage coordination of different initiatives in this context and the primary care unit is the most adequate site for action. One may fully agree that the initiatives and activities of health promotion are possible only due to the personal motivation, engagement and professional experience of key actors and funders. It is also true that the sustainability of health promotion projects depends on this. "The Golden Age" programme in Krakow (mentioned earlier) may be presented as an example of a programme related to primary care in regard to health promotion for older people. It is addressed to physicians and nurses, not to older persons themselves (it offers special trainings for professionals).

Limitations and barriers in health sector involvement in health promotion programmes for older people

The pilot research performed in Poland and the literature review helped to identify the main limitations and

barriers concerning health sector involvement in health promotion for older people, with a focus on primary care problems. Despite the very basic problem, a generally low level of financing for health promotion services, the following obstacles should be mentioned as barriers and limitations:

- the lack of qualified medical personnel[22] – doctors and nurses are not qualified in some areas (dietary advice, adequately proposed physical activities to respond to specific problems, assisted and motivated lifestyle change);
- the lack of time for educational and advisory visits (medical doctors often underline that they have no time for health promotion services because they do not have enough time for medical treatment in cases of illness);
- the lack of well prepared and competent health educators - doctors and nurses do not have to be involved in all health promotion activities. The necessity for introduction of health educator positions may be justified economically [24] due to arguments concerning optimisation of health care expenditures [25] and the obvious potential benefits for patients [27]. But also the nature of health education justifies this necessity. The WHO defines health education as reasonable education possibilities including different communication forms which should be created with the aim of improving understanding and using knowledge to improve individual and population health [28, 29];
- unclear rules for payment for health promotion services (no payment in reality);
- the dominating stereotype in relation to the population over 65—that it is too late for health promotion to face many health problems which exist at this stage, such that regular checks of medical parameters and subsequent medical treatment has to prevail; such a strictly medical approach results from the model of medical doctors' education, focused on diseases, diagnoses and treatment, but rarely including a wider perspective.

Conclusions and recommendations

Since 1989, different reform activities were also focused on decentralisation in the health area. Much of the authority over the health sector was transferred from the central level (the Ministry of Health and other health related governmental agencies) down to the regional and local level (voivodships, counties and municipalities). Publicly owned health facilities were given autonomy and a significant number of them, especially outpatient care units, have been privatized. The system of tax-based financing of health care was replaced by a quasi-insurance system with new payment mechanisms for health care providers. Moreover, the system was opened to grassroots initiatives and hundreds of voluntary entities called public benefit organisations in Poland were established.

The general systemic reforms in the state system, the economy and in the health sector affected the sphere of public health as well. The recovered autonomy and freedom of territorial self-government entities, as well as private non-profit initiatives, resulted in thousands of new programmes and services in health promotion and disease prevention. However, the abundance of (often very interesting) new programmes, projects and actions which are frequently directly related to health promotion, does not wholly alleviate the ills of the new reality. Institutions promoting and developing modern (i.e. efficient and effective) health promotion encounter numerous obstacles, such as the limited ability to coordinate cross-sectoral cooperation, low funding for research and practical activity and, last but not least, similarly to many other countries, still a relatively low degree of health awareness among the general public and limited interest in public health among health care providers.

As our research shows, the lack of coordination between decentralised institutions seems to be the crucial problem in general, but especially in the sphere of health promotion interventions for older people. As in other countries, health promotion and health education are grouped primarily, but not exclusively, within the health care system. Therefore, most legislative regulations concerning them are acts adopted in the area of health care. And this is despite the fact that Article 3 of the Law on public health mentions that the tasks of public health are to be carried out, in cross-sectoral cooperation, by government bodies, state entities including executive agencies, National Health Fund units and local government bodies carrying out their own mandatory tasks in health prevention or health promotion. Additionally, tasks in the field of public health can also be undertaken by entities whose statutory objectives or activities concern matters included in the public health tasks, i.e.by churches and religious associations, social cooperatives or local government bodies' cooperatives.

The diversity of organisations performing different tasks makes it challenging to identify the real sources of funding for health promotion. The abundance of entities is accompanied by a variety of potential sources of funding, both public and private, with financial flows that are equally diverse. Public funds go not only to public institutions but also, through grants and subsidies, to private entities performing tasks related to health promotion, education, and preventive health care. Public institutions in turn benefit on a large scale from the financial aid of private benefactors. At the central government (macro) level, the Polish statistics show only aggregated numbers – expenditures for public health and prevention. There are no separate aggregated data on expenditures for health promotion activities, not to mention data on funding health promotion for older people. Hence, more insight into funding health promotion for older people can be provided by identifying concrete programmes in different sectors by different institutions and organisations and showing their funding sources and used mechanisms.

In Poland, three sectors seem to play a major role in providing health promotion interventions for older people: the sector of local governments and municipalities, the voluntary sector and the health sector. In all these

sectors we can identify very interesting programmes and activities. Some of them have been mentioned. Unfortunately it is still a great challenge to bring institutions from different sectors around one table to develop coordinated and coherent strategies and programmes in health promotion, even if they are obliged to cooperate. The territorial and local government plays a crucial role in developing community health promotion and prevention programmes (impact raising public awareness in the field of "healthy ageing," the promotion of a healthy lifestyle, etc.) and it is very often the creator of education activities for older people but it needs health providers and NGOs for implementation of its ideas. However, many NGOs (including the Manko Association and the Universities of the Third Age mentioned above) often concentrate their activities more on "active ageing" for healthier and privileged people and not directly on "healthy ageing" for people with health problems. Of course, physical and intellectual activity reduce the risks for older people and the prevalence of different diseases, but what we need is also the direct prevention of diseases and the promotion of healthy lifestyle directed at unhealthier groups.

Also the cooperation and coordination between the different levels of territorial self-government, and territorial self-governments and the central government seem to be very weak. Taking into account the scarcity of the real and financial resources on one side and the large number of different initiatives carried out by diverse organisations (state, territorial administration, health care providers, etc.) on the other, there is no need for more separate actions and programmes in the field of health promotion for older people in Poland. What is needed is the identification of extreme over- and under-provision of fields with health promotion services and better coordination of different programmes and activities. The precondition to achieve this is the implementation of evidence-based coordination institutions and mechanisms which are able to bring together all the stakeholders who are active in the sphere of health promotion/health promotion for older people. Also a comprehensive database of all programmes and activities aimed at improving the socio-economic and health status of the elderly implemented in Poland by diverse organisations is needed. While there are few self-government associations oriented towards improving cooperation and experience exchange in this field, there is a need for greater coordination and information exchange of plans and financial possibilities.

The lack of financial resources and intra- as well cross-sectoral cooperation are not the only significant barriers to developing effective and efficient health promotion programmes for older people. Especially in the health sector, there is a dominant stereotype that for the population over 65 that faces many health problems, it is a bit too late for health promotion and medical treatment has to prevail. The first comprehensive activities in health promotion for older people have been taken only very lately. And even now the majority of policy makers and decision makers in the health sector are concentrating their attention on health problems and disease prevention for younger people.

Another limitation identified in all the sectors is the lack of human resources (e.g. competent health educators) and human resource management as well as the communication skills needed for developing and implementing successful projects. The voluntary sector also makes claims about excessive bureaucratic burdens, complicated administrative procedures, short deadlines for amendments, a problematic financing timetable and problems with obligatory financial self-contribution. As was indicated in interviews with voluntary sector practitioners, there is also a problem with the attitudes of older people: elderly people distrust volunteers, they are more pretentious and are not ready to change their lifestyle or diet or they are not even willing to participate in the programmes offered by public institutions.

Bearing in mind all the limitations, barriers and problems in planning, financing and implementing health promotion activities for older people, provided by both public and private institutions, the situation seems to be challenging and difficult. As a middle developed country in transition, Poland cannot spend the same amount of money and devote the same real resources to health care in general and health promotion in particular as more wealthy Western European countries. On the other hand, the growing number of initiatives, both public (the central government, territorial self-governments, other public institutions such as the NFZ) and private (NGOs, Universities of the Third Age, foundations) have provided us with some hope for future development. A new impulse for developing and fostering health promotion ideas is expected to come from the new Law on Public Health adopted in 2015 that lists, among other things, health promotion as an important public task and, to some extent, defines the responsibilities of public and private institutions for health promotion.

In view of the large number of widely dispersed programmes, it is necessary to integrate selected local public health programmes to achieve better results and improve their cost-effectiveness. A necessary condition to improve the effective use of resources is also the implementation of a system for monitoring and evaluating national and local programmes and their effects. Without the introduction of mandatory, comprehensive cost-effectiveness analysis and quality control instruments, it will not be possible to identify the best practices and subsequently eliminate or modify programmes which are not cost-effective. Building a publicly accessible database of best practices to address selected problem areas, with examples of policies that have a proven record of efficiency, could also facilitate health promotion actions.

Nevertheless, a stable source of financing of health promotion programmes for the elderly is needed. This is especially important for local government units, which often face budget deficits, and for the voluntary sector. Public Benefit Organisations financing and public service contracting rules should be arranged in a more sustainable way which allows reasonable prospective annual budgeting. Contracting public services to PBOs should also be less reliant on PBOs self-contributions. Also, new instruments triggering positive incentives for intensifica-

tion of health promotion activities in the health sector are needed as the existing methods of payment for health services do not correspond with the idea of health promotion service delivery at primary care units.

Last but not least, even if we provide older people with the best and most effective health promotion services, we cannot prevent the fact that their health status will be poorer than the health status of the younger population. The comprehensive conception of "healthy and active ageing" should accept this by proposing solutions which fully integrate older, unhealthy and disabled people in social life.

Notes

[1] The ratio between the number of persons aged 65 and over (age when they are generally economically inactive) and the number of persons aged between 15 and 64. The value is expressed per 100 persons of working age (15–64).

[2] This includes the 66 urban municipalities (big cities) with a special status whereby they have responsibilities usually exer-cised by counties.

[3] Swiss Contribution and WWPE (2016), Realizacja projektów w ramach Szwajcarsko-Polskiego Programu Współpracy – Wytyczne dla beneficjentów Priorytetu nr 1 i nr 2, http://cppc.gov.pl/be2/files/documents/Szwajcar/SPPW_Wytyczne_dla_IR_wersjazatw_21.02.2012.pdf; accessed: 02.04.2016.

[4] Marshal Office acts as the subsidiary body of the Board of Voivodship and the Marshal of voiwodship.

[5] http://www.ssd.opolskie.pl/page/22,zlota-jesien.html; accessed: 07.04.2016.

[6] Molnár Györffyné [8], www.zze-freiburg.de/assets/pdf/Toolbox-of-tested-solutions-Active-Ageing.pdf; accessed: 08.04.2016.

[7] www.dlaseniora.krakow.pl; accessed: 08.04.2016.

[8] The total budget of the project is approx. PLN 1.5 million and the municipality's own fund is nearly PLN 300 thousand. The project ran from May 2015 till April 2016.

[9] MRPiPS, https://www.mpips.gov.pl/seniorzyaktywne-starzenie/rzadowy-programme-asos/; accessed: 08.04.2016.

[10] MRPiPS, http://senior.gov.pl/programme_senior_wigor; accessed: 08.04.2016.

[11] http://bazy.ngo.pl/; accessed: 08.04.2016.

[12] http://www.mpips.gov.pl/bip/wykaz-organizacji-pozytku-publicznego/; accessed: 08.04.2016.

[13] http://bazy.ngo.pl/, http://www.mpips.gov.pl/bip/wykaz-organizacji-pozytku-publicznego/; accessed: 08.04.2016.

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[16] Glos Seniora/Serwis Nowoczesnego Seniora, http://glosseniora.pl/; accessed: 08.04.2016.

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[19] E.g.: WHO Global Strategy for Health for All by the Year 2000 [21].

[20] DecreeNr 85/2011/DSOZ of the National Health Fund President from 17 November on the conditions for arrangements and realisation of contracts for health service delivery: primary care type (www.nfz.gov.pl/new/?katnr_3&dzialnr+12&srtnr+4688; accessed: July 2015); Decree Nr 98/2012/DSOZ of the National Health Fund President from 21 January 2012 on the conditions for arrangements and realisation of contracts for health service delivery: Prophylaxis health programmes.

[21] Ministry of health regulation on guaranteed primary care health services dated 24 September 2013; The list of guaranteed primary care health services and realisation conditions, Attachment no 1 to the Ministry of health regulation on guaranteed pri-mary care health services from 24 September 2013.

[22] The lack of qualified medical professionals also stifles other public health activities [26].

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Healthy ageing as a visible public health activity and governmental responsibility. Health Promotion for Older People in the Czech Republic. Institutional and financial dimension

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Abstract

The health status of the Czech population has been improving over the past decades. The life expectancy increased from 67.6 for men/75.5 for women in 1990 to 75.9 for men/82.1 for women in 2014, becoming one of the highest in the Central and Eastern European region. Still, the older population faces many health risks related to obesity, high alcohol consumption, physical inactivity and smoking. Over half of the population above the age of 65 suffers from long-lasting illnesses and over half of the population above the age of 75 reports limitation in activities.

Health promotion for older people in the Czech Republic is growing in importance. There have been nationwide health promotion programmes against the main civilisation diseases, which older people could benefit from. In recent years two strategic programmes: the National Strategy for Health Protection and Promotion and Disease Prevention and the National Action Plan for Positive Ageing for the period of 2013–2017 came into existence with healthy ageing being an important target for both of them.

Health promotion policy is strongly centralised, supervised on the one hand by the Ministry of Health and the National Institute of Public Health and on the other hand by the Ministry of Labour and Social Affairs. At the same time, the activity of local governments and – especially – non-governmental organisations is important in supporting visible health promotion programmes for older people at the local level.

Key words: **public health, Health Promotion for Older People, healthy ageing, central government, local governments, non-governmental organisations, Czech Republic**

Introduction

The objective of the report is to assess health promotion policy and provide an overview of activities in the area of health promotion for older people in the context of the health care system and population changes in the Czech Republic. The report contains a short description of the main features of the health care system, followed by brief recognition of the demographic changes and a description of the main health problems of the older population. Furthermore, ageing policy is described and examples of health promotion activities for older people are given.

The assessment is based on the literature, policy and statistical databases overview in the health promotion field. The reports and articles cited have been taken from PubMED database; policy documents have been taken from the websites of the Czech Ministry of Health, Ministry of Labour and Social Affairs and the National Institute of Public Health. Statistical databases used include OECD Health data, Eurostat data based on EU-SILC survey and data of the Czech Statistical Office.

1. The health care system and public health policy in the Czech Republic

The health care system in the Czech Republic is rooted in the 19th century in the Austro-Hungarian empire and traditionally, access to health services and funding were based on Bismarckian type insurance plans. This was abandoned in the communist era, firstly when health insurance funds were unified in 1948 and secondly when the insurance based system was replaced in 1952 with the Semaskho model, funded from the central budget [1]. After the Velvet Revolution in the Czechoslovakia, health care system reform was one of the main priorities in redesigning the welfare state [2]. New health care laws were passed and a social health insurance system was reintroduced already in 1991/1992 with a number of quasi-funded, self-governed health insurance funds acting as payers and purchasers of medical services [1]. Initially numerous health insurance funds were unable to meet strict market criteria and due to service overuse, resulting in the health care system deficit, some of them collapsed, others merged what resulted in limiting the number of health insurers in the following years [3]. By 2014 the number of health insurance funds had decreased to seven [1]. The health insurance premium is compulsory. For employees it is shared between the employee and the employer [4], while self-employed workers contribute a fixed percentage of their profits. For economically inactive persons, contributions are paid by the state [5].

The total health expenditure in the Czech Republic account for 7.5% of the GDP and have increased in relation to the GDP by one third over the past 15 years (**Table I**), though the level of expenditure is not high compared to other European countries (i.e. in Germany – 11.1% of the GDP, Netherlands – 10.8% of the GDP, Poland – 6.3% of the GDP). The majority of expenditures (83.5%) are covered by the general public budget and, although this share has slightly decreased over the past years, it remains very high. Expenditures related to public health and prevention are small, constituting about 0.2% of the GDP [5] and 3% of the total health expenditure. Despite being at a very low level, these expenditures have doubled since 2000.

Public health activities are supervised by the National Institute of Public Health (NIPH – SZÚ), established, strikingly early, 1921. During the second half of the 20th century, in communist Czechoslovakia, public health concentrated on disease control and prevention [6]. Since the 1960s the behavioural aspects of health, health education and information have become important elements of public health policy. In the 1990s in the Czech Republic public health was reshaped to be in line with the recommendations of the Ottawa charter (1986) with even more attention given to public health promotion and information. Health protection and right to health care is also guaranteed by the Charter of Human Rights and Freedoms which is a part of the Czech Constitution. Several international health promotion programmes were initiated, although not all of them were completed successfully, mainly due to poor citizen response, a lack of social networking and social capital in the society in the process of the political and economic transformation [6]. Nowadays the NIPH is the main public health institution, supervised by the Ministry of Health with the chief public health officer being the deputy of minister of health. NIPH responsibilities are set by the Public Health Act,[1] adopted in 2000 (with further amendments). They include coordination and planning of public health activities, pre-

	2000	2005	2007	2010		2012	2013	2014	2015	Change 2000 to 2013	Change 2007 to 2013
Current health expenditure per capita. Constant prices OECD base year in koruna	16,170.80	21,956.50	23,149.60	26,208.80		26,835.80	28,318.50	29,462.80	30,208.50	86.8%	30.5%
Current health expenditure as % of GDP	5.7	6.4	6.0	6.9		7.1	7.8	7.7	7.5	31.6%	25.0%
Share of general government in current health expenditures	89.8	86.8	84.7	83.3		83.7	84.1	83.8	83.5	–7.0%	–1.4%
Share of prevention and public health services in current expenditure on health	1.6	1.7	2.3	2.5		2.1	2.7	3.2	n.a.	100.0%	39.1%

Table I. *Main health care system indicators.*

Source: OCED Health data, http://stats.oecd.org/index.aspx?DataSetCode=HEALTH_STAT#; accessed: 10.09.2016.

vention of communicable diseases, research, monitoring of the population's health, collecting epidemiological data on the main communicable and non-communicable chronic diseases and supervising occupational safety and sanitation (drinking water, food and catering). Under the umbrella of its activities, the NIPH coordinates national health policy programmes oriented towards the improvement of adults' and older people's health. Its activities range from nationwide programmes to individual consultancies. The thematic range of activities is wide, also covering programmes oriented towards health improvement, information and promoting a healthy lifestyle for older people [1].

In the Public Health Act, health protection and promotion are defined as a sum of activities and measures aimed at the protection of healthy living and working conditions, prevention of the spread of infectious diseases and the high prevalence of civilisation diseases and decreasing occupational health risks and occupational diseases. Besides the act on public health, which is the most important legal regulation in this field in the Czech Republic, the legal framework for public health is created by the governmental resolution on Long-term programmes for improvement of the population's health in the Czech Republic – Health for All in the 21st Century,[2] regulations on environmental health[3] and regulations on health in the workplace[4] (occupational health and work safety).

2. The demographic situation and the health status of older people

The health status of the Czech population has been improving over the past decades (**Box 1**). The life expectancy increased from 67.6 for men/75.5 for women in 1990 to 75.9 for men/82.1 for women in 2014, becoming one of the highest in the Central and Eastern European region. In the population aged 65 years, life expectancy improved from 11.7 for men/15.4 for women in 1990 to 16.2 for men/19.9 for women in 2014 [1].

The main reason for the remarkable health improvement was the decrease of cardiovascular system disease mortality in the total population [6]. Health improvement, although significant, does not correlate to living in older age in good health and a high quality of life, as almost half of time lived above the age of 65 involves the occurrence of morbidity (or multimorbidity) and, in some cases, also disability and limitations in everyday activities (**Box 2**).

3. Institutional settings for health promotion and prevention

Prevention and health promotion is an important policy field with a number of institutions involved in health promotion in the Czech Republic. The central government level institutions responsible for priority set-

The Czech Republic has entered the ageing phase with the share of its population aged 65–79 slightly above the EU-28 average (13.9% compared to 13.4%) in 2015. The proportion of the oldest old (80+) in the population accounts for 4.0% in 2015 and is still below the EU-28 average of 5.4%. Given the low birth rates and increase in longevity, the share of older people (65+) in the Czech population is foreseen to increase to 28.6% by 2060. At the same time, the proportion of the oldest old is foreseen to almost triple (11.4%) in the next 45 years. The old age dependency ratio is expected to grow from 26.6 in 2015 to 48.2 in 2060.
The life expectancy at birth of the Czech population has been strongly increasing over the past two decades. In 2014, life expectancy (LE) at birth was 75.9 years for men and 82.1 for women. Healthy life years (HLY) at birth are estimated as 65.0 for females (79.2% of total life expectancy) and 63.4 for males (83.6% of the total life expectancy). Life expectancy at age 65 is 19.9 years for females and 16.2 years for meals. Healthy life years constitute 46.7% (9.3 years) of this period for women and 52.5% (8.5 years) for men.

Box 1. *Population ageing indicators.*

Source: Based on Eurostat data, http://ec.europa.eu/eurostat/data/database; accessed: 14.10.2016.

Mortality for males aged 65+ (5,469/100,000) is much higher than for females (3,559/100,000) in the Czech Republic. The main causes of death are cardiovascular system diseases (48% of deaths in males and 53% in females), followed by cancers (26% of deaths in males and 22% in females) and respiratory system diseases (7% of deaths in males and 11% in females).
Morbidity in the older population is high and increases with age. More than half of the population aged 65–74 reports long-standing illness or health problem (49.9% of men/52.6% of women). At the age of 85 the share raises to more than two thirds (77.5% of men/79.2% of women). The most common diseases in the older population are hypertension, arthritis, musculoskeletal disorders, chronic headaches and allergies. Diabetes (type 1 and type 2) is becoming a significant health problem, with a prevalence of 8% in the total population, which is above the OECD average of 6.9% in 2013 [7]. Seniors also often complain of suffering from sleep disorders, fatigue and chronic pain that negatively impacts quality of life [6].
In 2014, 37% of men/39% of women aged 65-74 reported some or severe limitations in regular activities due to health problems. The share of people with functional limitations increases with age. At the age of 75–84, more than half (54.6% of men/59.9% of women) and above the age of 85 two thirds of older people report long-standing limitations in everyday life (72.7% of men/77.3% of women).
The main risk factors of poor health in the adult population are high tobacco consumption, high consumption of alcohol and obesity. More than every fifth adult (22%) reported smoking daily in 2013. The consumption of pure alcohol amounts to 11.5 litres per capita annually and is one of the highest in Europe. Obesity is becoming a significant health problem, increasing from 14% of obese adults in the population in 2000 to 21% in 2010 which results in a higher risk of diabetes and cardiovascular system diseases. According to the European Health Interview Survey, in the population aged 65 to 74, 25% of males/36% of females were obese (BMI greater than 30) in 2008. In the population above the age of 75 this share was also high, amounting to 11% for males/23% for females.

Box 2. *Health status of the older population.*

Source: Based on European Health for All database (HFA-DB) WHO Regional Office for Europe, http://data.euro.who.int/hfadb/; accessed: 10.10.2016; Eurostat, EU-SILC data, http://ec.europa.eu/eurostat/data/database; accessed: 10.10.2015.

ting, policy initiative and planning include the Ministry of Health of the Czech Republic, the National Institute of Public Health and the Ministry of Labour and Social Affairs. Education and research in public health is the responsibility of universities, with especially significant roles taken by the Charles University in Prague and Masaryk University in Brno. There are also several research institutes that provide comprehensive information on issues related to population ageing, long-term care, health status and quality of life in older age, i.e. the International Longevity Centre – The Czech Republic, oriented towards information, education and research on active and healthy ageing;[5] the International Clinical Research Centre (ICRC) which is an independent research institution at St. Anne's Hospital in Brno performing clinical research on cardiology and neurology in the adult and older populations; and the Quality of Life Clinical Research Centre dedicated to promoting clinical research and education in the field of quality of life. An important medical profession organisation dealing with education and research on ageing and public health problems is the Czech Society for Gerontology and Geriatrics[6] established in the 1950s. There are also other associations actively involved in health promotion activities: the Czech Society for Oncology is very active in promoting the National Cancer Control Programme; the Czech Diabetes Society supports the National Diabetes Programme, etc.

Health promotion in the health sector

There are several health sector institutions involved in health promotion and prevention in the Czech Republic. Strategic planning of activities lies at the governmental level, supervised by the Ministry of Health and managed by the National Institute of Public Health. Within the National Institute of Public Health there are six departments: the Centre for Health and the Environment, the Centre for Health, Nutrition and Food, the Centre for Industrial Hygiene and Occupational Health, the Centre for Public Health Promotion, the Centre for Epidemiology and Microbiology and the Centre of Toxicology and Health Safety. Regional public health institutes and regional public health authorities are subordinate to the National Institute of Public Health.

Locally, recognition of health needs and implementation of prevention activities is supervised by district public health authorities and public health institutes. Activities are implemented at the local level and take place mainly within health care units. The health sector in the Czech Republic is hospital oriented, although a lot of attention has been given in recent years to strengthening the role of primary care in health promotion and prevention [7]. Primary care physicians are responsible for treatment of patients and disease prevention. According to a government resolution, every two years insurers, together with primary care physicians, are obliged to ensure access for all eligible adults to preventative measures, such as blood pressure screening, tests for blood sugar, cholesterol measures and urinalysis. An electrocardiogram should be performed in every adult, 40 or older, every 4 years. The coverage and enactment of these measures, however, is not monitored.

There are several nationwide health promotion and prevention programmes targeted at the whole population, with older people being an important group of beneficiaries. Some of the health promotion programmes aimed at improvement of the population's health status were established in the 1990s and 2000s, such as the Healthy School and Healthy Cities Network, Healthy Family, Healthy Hospital, Healthy Workplace [6]. Health promotion activities are enacted within larger strategies addressing specific conditions or health determinants (i.e. the National Cancer Programme, the Food Safety and Nutrition Strategy) as well as under the authority of annual editions of the National Health Programme – Health Promotion Projects, started in 1994. Within the state subvention of Health Promotion Projects, activities targeted at older population are also funded. In 2004 another grant programme entitled the Healthy Ageing Project was launched, however the age specific focus was abandoned after only three years [8]. Within the two projects, subsidies for health promotion and prevention activities have been granted to third sector organisations, research institutes, religious organisations or local governments (municipalities) for one year programmes. Activities for seniors supported with the state subvention have included information and education programmes, workshops, counselling, rental of health aids or appliances. Both grant projects were administered jointly by the Ministry of Health and the National Institute of Public Health.

Prevention of cardiovascular system diseases

Activities in prevention of cardiovascular diseases in the Czech Republic began in 1992 with the Programme for Reduction of Cardiovascular and Cerebrovascular Disease. The programme came into existence through the cooperation of three American and three Czech Institutes. It was led by the University of California at San Francisco while participants from the Czech side included the National Institute of Public Health (NIPH), the Institute for Clinical and Experimental Medicine (IKEM) and the Second Medical Clinic of the Third Medical Faculty of Charles University (SMC). The consortium managed to establish three clinics in Prague and Litomerice as well as a community intervention programme in Dubec[7] addressing the risk factors for cardiovascular system diseases (a high fat diet, tobacco use etc.). In 1994 the pilot programme was a thorough information campaign and training of policy makers in health and prevention for the whole country. Until 1998 the programme was financed mainly from the US AID programme, with support from the Czech Ministry of Health and other foundations. In 1998 management and funding of the programme was fully overtaken by the Czech Ministry of Health. This programme was a cornerstone in cardiovascular disease prevention in the Czech Republic.

Currently, activities concerning cardiovascular disease prevention are continued under the National Health Plan – Health Promotion Projects, supervised by the Ministry of Health. An example of such activities are projects granted in 2016 under the umbrella of the Kardiovize 2030 prevention scheme which aims at identifying and addressing the actual health risks of Brno's citizens.[8] The first project phase concerns mapping risks related to cardiovascular system diseases and the second phase concerns targeting those risks with adequate health interventions. Two projects are funded in 2016 aimed at raising awareness of the negative health effects of smoking among students and raising awareness of lifestyle factors related to an increased risk of cardiovascular system diseases. The projects are managed by the International Clinical Research Centre.

Prevention of cancer

Prevention of cancer morbidity and mortality is undertaken within the **National Cancer Control Programme.** The aims of the programme include lowering the incidence and mortality rate of tumorous diseases and improving the quality of life of ill people with cancer, as well as rationalisation of diagnosis and treatment costs of cancerous diseases in the Czech Republic. The activities performed within the cancer control programme are very broad, starting with collecting information and monitoring cancer prevalence, organising cancer screening, organising a network of nationwide cancer treatment centres to assess the economic costs and HTA projects in cancer treatment.[9] Three cancer screening programmes have been established over the last 15 years: breast cancer screening (2002), cervical cancer screening (2008) and colorectal cancer screening (2009). A network of comprehensive cancer centres was established in 2006. Comprehensive cancer centres are health care facilities which provide care to cancer patients and fulfil the criteria set by the Czech Society for Oncology. The network consists of highly specialised centres as well as district hospitals, specialised outpatient clinics and other health units.[10] Since 1977 a national cancer registry has been in place (Czech National Cancer Registry).

Prevention of diabetes

Another nationwide public health programme, important from the population ageing point of view, is **the National Diabetes Programme 2012–2022**. The goals of the programme include prevention of type 2 diabetes with special attention given to obesity prevention, as the main risk factor for type 2 diabetes; systematic active screening of diabetes; improvement in the health outcomes of type 2 diabetes treatment; improvement in screening of late diabetes complications and its treatments; formation of a system for quality control and cooperation in treatment of diabetes in the health care system and cooperation with professional societies, the Ministry of Health and insurance companies. One of the main activities of the programme is stimulating the involvement of general practitioners in diabetes prevention and treatment as well as educating physicians and patients on issues related to diabetes prevention, treatment and the risks related to the potential complications of diabetes. The Programme was established in cooperation with the Czech Diabetes Society, the Diabetes Association of the Czech Republic and the Society of General Practitioners as well as being supported by other associations of medical professionals. There are several other programmes targeted at obesity prevention and activation of the population (i.e. the Food Safety and Nutrition Strategy 2014–2020, an action plan to promote physical activity in the Czech Republic from 2016–2020 [under preparation] and the National Strategy for Cycling Development 2013–2020) that support the activities of the National Diabetes Programme's other prevention programmes.

Pochod proti Alzheimerově chorobě **(March against Alzheimer's disease)**
On the International Day of Alzheimer's Disease (September 21st) an information and activation campaign took place in the major cities of the Czech Republic.[11] In Praha, Plzeň, Jihlava, and Frýdek-Mistek a march against Alzheimer's disease was conducted, grouping numerous citizens, mostly of an advanced age. During the march, which wound through large parks, seniors were informed of the risks and symptoms related to Alzheimer's disease and dementia. The march was preceded with an information campaign in the media (TV spots, social media, youtube) and on the streets of larger towns (posters). Participants of the march received information leaflets and invitations to local events. An information campaign on the risks and symptoms of Alzheimer's diseases, combined with physical activity, has been conducted for the past several years (2014, 2015 and 2016).

Parky v pohybu **(Parks in motion)**
In 2016/2017 an action promoting outside sport activities among various population groups, with special attention given to seniors, is being undertaken.[12] In towns of the Czech Republic, seniors are being invited to participate in organised trainings in parks. The trainings are undertaken regularly and supervised by a professional trainer. So far activities were performed in Praha, Olomouc, Přerov. The goal of the programme is to promote sport among older people and to prevent diseases for which inactivity is a risk factor, especially diabetes. Information on organised sport sessions is being spread locally on posters and via internet (social media, the project web-site). The project is financed by the National Health Plan of the Ministry of Health 2016.

60 a víc neznamená nic! **(60 will not change a thing!)**
This project took place in 2010/2011 in the city of Valašské Meziříčí and aimed at promoting exercise and sport activities, enabling joint meetings and sharing the experiences of people above the age of 60.[13] Participants could choose from 16 sport activities, including swimming in an indoor pool, a gym work out, spinning class, an autumn walk or even Zumba dancing classes. Activities were undertaken regularly, once a week for the period of two years. Educationally, the project had ambitions of enabling an exchange of views and discussion between different generations. Participants received trainings in communication skills in various situations, health education, use of technology and the ability to recognise and resist manipulation by advertising and the media.

Box 3. *Examples of health promotion and prevention activities for older people undertaken by the NIPH and local governments. Source: Own work.*

Health Promotion for Older People

While the above programmes target the total population and older people might be an important group of beneficiaries, there are also various programmes and projects in place specifically addressing the older population. These programmes aim to inform and educate regarding diseases specific to older age and their risk factors and to promote healthy behaviour. Several initiatives in this field have been undertaken in recent years by the National Institute of Public Health, Public Health Promotion Centre in cooperation with local authorities. Examples of these activities are shown below (**Box 3**).

Next to the central administration and local governments, non-governmental organisations, in many cases patient organisations (i.e. the Czech Alzheimer's society), are also very active in health promotion for seniors, the prevention of diseases, including the prevention of cognitive disorders, and activating seniors. Activities are often performed in day care centres run by local third sector organisations. Projects are undertaken in cooperation with local governments and are supported with governmental and international resources: the European Social Fund and the Norwegian Fund. Although the projects are organised based on time-fixed budgets related to funding availability, examples of organisations actively operating since the 1990s can be found. Innovative health promotion project have been piloted in older persons with dementia covering activities such as reminiscence therapy, dance therapy, gardening therapy [9]. Examples of such activities are presented below (**Box 4**).

Barriers to prevention and health promotion activities

Health promotion and prevention of diseases has not always been a policy priority in the Czech Republic. Only recently has the new concept of health promotion and the need for addressing different population groups with health promotion and prevention activities been conceptualised and operationalised [6] in national strategies and health plans, which although delayed are actively implemented. There are various barriers to planning and organising successful health promotion programmes. They include still insufficient research and recognition of needs in the health promotion field [6]. Andel [10] points to the insufficiency of longitudinal, population based studies that would allow the recognition of various aspects of ageing that could be a basis for formulating adequate health policy. On the other hand, there are cases when data is available (i.e. National Cancer Registry data), but it is not being sufficiently used [7]. There also problems with the implementation of health promotion and prevention activities and their sustainability. Whilst there are various programmes, they are not systematically coordinated and under the National Health Plan they are often granted for only a year or two, with no follow up. Another barrier is poor responsiveness from the (potential) beneficiaries. Cancer screenings undertaken in the National Cancer Prevention programme typically have low response rates with less than half of the potential beneficiaries of the programme participating [7].

Health promotion in the social sector

An important sector providing care to older people in the Czech Republic is that of social assistance, with social services and residential care granted to dependent people based on a dependency test. The provision of social services in the Czech Republic is defined by the Law on Social Services.[16] This regulates the conditions for providing assistance and support to individuals in difficult social situations through social services and care allowances. The main objectives of the social services are: (1) reducing the social and health risks of users of the social services; (2) developing the abilities of those users, and (3) improving or at least maintaining the self-sufficiency of clients of social services. Social counselling, social care and social prevention represent the basic

Život 90 **(Life 90)**
This organisation, established in 1990, runs a community care centre in Praha and organises numerous programmes: free telephone assistance in case of crisis (so called Senior telephone), programmes aimed at stress relief, support for lonely people and depression prevention, emergency calls, nursing and personal care services, respite care services for older care providers and transportation, as well as a senior academy.[14] The NGO organises activities for seniors, such as a dancing club, language courses and physical activity events. An example of the latter is a race for seniors **Seniorská mile (Senior miles)** organised in September 2016 in the Letna district (Praha).

EURAG Memory Training Centre
This is an organisation accredited by the Ministry of Labour and Social Affairs and sponsored by the Czech Society for Memory Training and Brain Jogging.[15] Its goal is to enable seniors to apply techniques and strategies for remembering in their daily activities in order to support their independence. The Centre organises workshops and seminars for professionals and seniors every year to promote memory training methods. The first systematic workshops for memory trainers were organised in 1994. Now, the organisation continues with memory trainings for seniors and other interested parties, providing two sessions of workshops per year.

GEMA – Projekt Centra na Podporu Zdraví **(GEMA – the Centre for Health Support)**
This project, supported by senior organisations, the Czech Alzheimer's society and professionals in geriatrics and gerontology, aims at health promotion for seniors, development of gerontology, geriatrics and increasing the quality of care for the chronically ill in the Czech Republic. Activities within the project cover dance sessions, English classes and establishing an internet café for seniors as well as establishing a web-site (http://www.starnout-je-normalni.cz) aimed at popularisation of information related to the ageing process and providing information on current project activities. The project is supported with public and private funds and has been providing activities for the last 15 years.

Box 4. *Examples of NGO activities in the field of health promotion for older people.*
Source: Own work.

types of social services. There is a very broad range of activities providing social services. These may include social counselling, educational and motivational activities, assistance with common activities of self-care and social welfare services etc. [11].

The state social support system is a non-contributory system which is financed from the state budget and administered by the assigned state bodies. Social service providers are: municipalities and regions, who look to form suitable conditions for the development of social services, in particular by researching people's real needs and the resources necessary to satisfy such needs, and who also set up organisations to provide social services; non-governmental non-profit organisations and individuals who provide a wide spectrum of services; and the Ministry of Labour and Social Affairs who is the incorporator of five specialised social care institutions. In the social area, self-governments (municipalities, regions), NGOs and other organisations have an opportunity to use funding from the European Social Fund. For some types of social services the municipalities and regions issue resolutions on services to be provided in administrative proceedings. This concerns, in particular, domiciliary care services and services associated with living in elderly homes. If an NGO is the service provider, the user enters into a contract with this provider. The resolution, or the contract, also includes a clause concerning the user's financial participation in the service provided.

The system of care for seniors who need a certain type of care is provided primarily by health and social services, which are not sufficiently interlaced. Out of the total number of 5,240 social services (National Action Plan 2014), 1,640 primarily target seniors, which accounts for 31% of the total volume of provided social services. In the abovementioned number of services focused mainly on seniors, 703 were residential care activities and 937 non-residential care activities. The Czech Republic offers basically two types of special housing solutions to older people who require more or less regular and extensive assistance from another person due to their age or chronic illness. These are domiciliary care service homes and homes for the elderly (residential homes). In addition to these special housing forms, there is one type of field-based social care services, i.e. domiciliary care services. Domiciliary care services mainly engage in tasks connected with practical assistance and help with self-maintenance, and are of crucial importance when considering promotion of healthy ageing. This kind of social care service is often complemented by medical home care [12].

Social personal care services are the most important services granted to older and dependent people based on the activities of daily living (ADL) dependency test and can be received either in home care, day-care or residential care. Most importantly, they are not directly linked to health promotion programmes or prevention activities but, while provided by medical or care professionals, they can be combined with advice and support regarding healthy lifestyle; undertaking and recommending activities suitable for seniors and dependent people. The scope of such activities has not, however, been assessed.

4. Sources of health promotion financing

Total expenditures on prevention in the Czech Republic are low, constituting about 3% of total health expenditures. However, according to the National Health Accounts, prevention related expenditures have been increasing over recent years more steeply than total health care expenditures (14% between 2010 and 2014 compared to 3% between 2010 and 2014). Expenditures on prevention programmes cover information and counselling, vaccination programmes, early detection of diseases and diagnosis including various types of screening, diagnostic tests and medical examinations as well as general population health monitoring (**Table II**).

The structure of expenditures on prevention is stable, with the largest share of expenditures (65–66%) related to general population health monitoring, followed by expenditures on early detection programmes (15–16%). Expenditures on vaccinations constitute about 14% of the total expenditures on prevention. The smallest share of expenditures (5–7%) is related to information and counselling programmes, though it has been strongly increasing (by 30%) between 2010 and 2014 (**Figure 1**).

	2010	2011	2012	2013	2014	*Change 2010–2014 (2010=100)*
Preventive care	9,990	10,364	10,595	10,765	11,433	*114*
Information and counselling	487	497	626	629	637	*131*
Vaccinations	1,389	1,432	1,484	1,458	1,576	*113*
Early detection and diagnosis	1,573	1,554	1,586	1,644	1,659	*105*
Health monitoring	6,541	6,881	6,900	7,034	7,561	*116*
Total health care expenditures	339,852	342,753	347,605	348,860	350,411	*103*

Table II. *Expenditures on preventive care in the Czech Republic 2010–2014 (mln CZK).*
Source: ČSÚ 2016, Zdravotnické účty ČR 2010–2014.

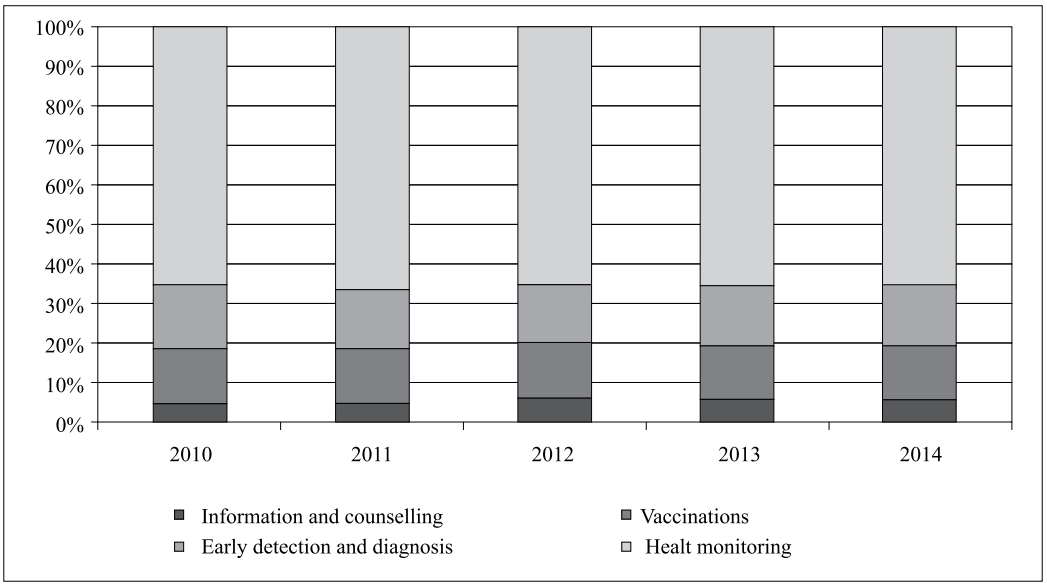

Figure 1. *Structure of expenditures on preventive care 2010–2014.*
Source: ČSÚ 2016, Zdravotnické účty ČR 2010–2014.

According to the National Health Accounts data preventive care in the Czech Republic is funded mainly from public sources (78%). 81% of public funding comes from the social health insurance system and 17% from the state budget. Only a small share of preventive care (less than 2%) is funded out of the local government budget. About 22% of preventive activities are funded from private (including corporate) sources (**Table III**).

The structure of financing depends on the type of prevention activity. Information and counselling programmes are financed predominantly from the health insurance system (98.7%), with only 0.5% of sources from the state budget and 0.8% from local budgets. Vaccinations are financed mostly from the state budget (96%), while 2.1% of financial resources come from local budgets and 2% from the health insurance system. Early detection and diagnosis programmes are, on the other hand, financed mostly from the health insurance funds (86.4%) while 7.4% of financial resources come from the state budget and 6.2% from local budgets. Only health monitoring is reported to be financed jointly from public and private sources. 65.9% of financial resources related to health monitoring come from the health insurance system and 34.1% from companies.

In the social sector expenditures related to prevention are marginal, constituting about 2–3% of total social sector long-term care expenditures [13, 14].

	Preventive care	Information and counselling	Vaccinations	Early detection and diagnosis	Health monitoring
Public sources	**8,202**	**637**	**1,325**	**1,659**	**4,581**
Including:		*Structure of total expenditure (%)*			
State budget	1,398	*0.5*	*96.0*	*7.4*	*0*
Local budgets	136	*0.8*	*2.1*	*6.2*	*0*
Health insurance	6,668	*98.7*	*2.0*	*86.4*	*65.9*
Private sources	**2,374**	**0**	**0**	**0**	**2,374**
Including:		*Structure of total expenditure (%)*			
Private insurance	0	*0*	*0*	*0*	*0*
Non-profit organisations	0	*0*	*0*	*0*	*0*
Company sources	2,374	*0*	*0*	*0*	*34.1*
Household	0	*0*	*0*	*0*	*0*

Table III. *Funding of preventive care by source (mln CZK).*
Source: ČSÚ 2016, Zdravotnické účty ČR 2010–2014.

5. National ageing and health promotion policy

There are two strategic governmental programmes that formulate policy towards healthy and active ageing in the Czech Republic: adopted in 2014 and based on the WHO Health 2020 policy, the *Health 2020 – National Strategy for Health Protection and Promotion and Disease Prevention* and, adopted in 2012 (further updated in 2014), the *National Plan for Positive Ageing for the period 2013–2017*. It should be underlined however that while these two documents are the most recent, health promotion, prevention of disease and ageing issues have been in the spotlight of national policy since the early 2000s. The National Strategy for Health Protection is a follow up to the Long-term Programme for Improving the Health of the Population of the Czech Republic – Health for All in the 21st Century, endorsed by the government in 2002, and the Conceptual Framework for the Public Health Network and Primary Prevention in Public Health Protection, adopted in 2013. At the same time, the National Plan for Positive Ageing was preceded by the National Programme of Preparation for Ageing 2003–2007, which continued in its second edition, the National Programme of Preparation for Ageing 2007–2012.[17] The two current main nationwide policy documents are linked, referring to each other's strategic objectives and planned activities.

The National Strategy for Health Protection and Promotion and Disease Prevention is a strategic document prepared by the Czech Ministry of Health in cooperation with the National Institute of Public Health and consulted with other ministries [15]. It constitutes a framework for the national level activities of different sectors with disease prevention and health promotion components and for establishing regional level disease prevention and health promotion programmes. The National Strategy is planned as an umbrella document tackling various activities that include elements of disease prevention, health protection and building up an integrated health care system. The overall goals of the programme focus on improving the health and well-being of the population by reducing mortality, reducing health inequalities and strengthening the role of public health in national and regional policy. Its objectives tackle health risks and the need for improvement of health services in disease prevention and health promotion on the one hand and are oriented on mechanisms for health investments on the other hand.

These objectives serve as a basis for formulating action plans in specific areas of health promotion and disease prevention. Actions are expected to be financed using funds provided within the European Structural and Investment fund for health care in the period of 2014–2020 as well as subsidies from the European Commission financial programme – The Third EU Health Programme 2014–2020 [15].

Healthy ageing is one of the 21 targets of the Health 2020 policy, under the priority of investing in health and disease prevention in the course of life. An aim of activities in the healthy ageing field is to prevent diseases which occur most commonly in older age, addressing the risk factors of these diseases, empowering older people, providing a safe and suitable environment and their health potential. Activities and programmes for older people could be also organised under the framework of other targets, such as: reducing communicable diseases, reducing non-communicable diseases, healthier living in communities, etc.

The second, inter-departmental strategic document with respect to ageing is the National Action Plan for Positive Ageing for the period of 2013–2017 prepared by the Ministry of Labour and Social Affairs [16]. The main goals of the programme refer to the fields of active ageing and human rights. They include strengthening national, regional and local policies in preparation for ageing, ensuring and protecting the human rights of older people, strengthening access to and use of lifelong learning by older people, supporting participation in the labour market by older workers and seniors, supporting volunteering by older people and intergenerational cooperation, improving the quality of life of older people with relevant infrastructure, access to housing and public facilities enabling participation in social life. Healthy ageing and care for older people are among the last, but not the least of the priorities listed in the NAP. Activities promoting a healthy lifestyle for older people and prevention of disease are perceived as prerequisites for a prolonged life, active ageing and high quality of later stages of life. Activities within the programme are financed from national and international subsidies, including European Commission funds, the Norwegian Fund and the Programme of Swiss – Czech Cooperation. Whilst strategies are elaborated, they face difficulties in implementation, including lack of adequate financing and organisation deficiencies.

A nation level organisation representing older people is the Government Council for Older Persons and Population Ageing, installed in 2006 in the Ministry of Labour and Social Affairs. The council consists of representatives of the government, NGOs, health insurance companies and other social partners. Its four working groups concentrate on the following priorities: (1) support of employment, lifelong learning and social security, (2) improvement of health and social services for seniors, (3) awareness raising and anti-discrimination, (4) housing and residential social services [6].

Summary and conclusions

The Czech population has entered an ageing phase with a sharp increase in the proportion of older people in the population in recent years. The health status of older people has been improving, which is reflected in rising life expectancy, but several risk factors related to an unhealthy diet and the risk of obesity, high alcohol consumption and smoking raise concerns in relation to the possibilities of morbidity compression in older age and the improvement of quality of life of older people.

Health promotion in health care policy is a field of growing importance, although expenditures on health

promotion programmes are low in relation to total health care expenditures or GDP. Health promotion for older people has been getting more and more attention in the national public health and ageing policy in recent years. Healthy ageing measures have been explicitly included in the two crucial health promotion, prevention and ageing strategies: the National Strategy for Health Protection and Promotion and Disease Prevention and the National Action Plan for Positive Ageing for the period of 2013–2017. The existence of these two strategies enables implementation of various health promotion, disease prevention and activation programmes towards the older population, using national and international (mainly European) funds. Additionally, older people are beneficiaries of nationwide preventive programmes that target risks related to cardiovascular diseases, cancers and diabetes.

Governmental level institutions are responsible for drafting health promotion policy, especially the Ministry of Health and its direct subordinate, the National Institute of Public Health. An important role with respect to ageing is performed by the Ministry of Labour and Social Affairs, responsible for national plans for preparation for ageing and supervision of long-term care policy (social services). Whilst national programmes on health promotion and prevention, including those for older people, are in place, efforts are still needed to support regional and local governments as well as third sector organisations in implementation and management of activities aimed at health promotion for older people. As activities in health promotion are undertaken in health and social sector, it is of special importance for health promotion for older people to strengthen cross-sectoral cooperation between health services and social services, especially at the local level, as they share the same objective of improvement of the quality of life of older people.

Local, non-governmental organisations are crucial actors, upon whom successful implementation of promotion actions depends. They typically cooperate closely with the local administration and are often involved in provision of social services. At the same time they actively spread information on health risks and organise workshops and trainings for seniors that prevent social isolation, physical inactivity and cognitive dysfunctions, which are significant risk factors for the occurrence of many diseases common in older age. Their activities for seniors, often one of the links between health and social sector actions, should be further supported.

Notes

[1] Act No 258/2000 Call.

[2] Government resolution no. 1046/2002.

[3] Government resolution no. 810.

[4] Government resolution no. 273/1992.

[5] http://www.ilc-alliance.org/index.php/members/details/ilc-czech_republic.

[6] http://www.cggs.cz/cz/Home/.

[7] http://www.ceche.org/programs/cze-cvd/cvdsum.htm.

[8] http://www.fnusa-icrc.org/en/about-us/news/706-the-national-health-programme-grants-for-kardiovize-2030.html.

[9] http://www.onconet.cz/index-en.php?pg=data-projects.

[10] http://www.onconet.cz/index-en.php?pg=comprehensive-cancer-care.

[11] http://www.szu.cz/21-zari-mezinarodni-den-alzheimerovy-choroby.

[12] http://parkyvpohybu.wixsite.com/vyzva/vyzva-pro-vsechny.

[13] http://www.valasskemezirici.cz/60-a-vic-neznamena-nic/d-3312.

[14] http://www.zivot90.cz.

[15] http://www.trenovanipameti.cz/index.php?option=com_content&view=article&id=67:eurag-mtc&catid=2:nezarazeno&Itemid=138&lang=en.

[16] Act No. 108/2006 Coll.

[17] http://www.mpsv.cz/en/4539.

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Health Promotion for Older People in Hungary: The need for more action

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Abstract

The health status of the Hungarian population is relatively poor, compared to other countries of similar socio-economic development. Unhealthy diet, smoking, alcohol consumption and low physical activity are important risk factors leading to cardiovascular system diseases – the main cause of death in the general population and among people 65+ in Hungary. Yet, the OECD health statistics indicate that Hungary belongs to a group of countries with the lowest per capita expenditure on prevention and public health and that the level of this expenditure is decreasing.

In Hungary, there is no legislation specifically dedicated to public health (Public Health Act) and the matters of public health and health promotion are regulated by various legal documents. The directions for public health policy are set in National Public Health Programmes. To address the problem of the ageing population, in 2009 a National Ageing Strategy (2009–2034) was adopted. The Strategy stresses the need to develop programmes for prevention, rehabilitation and health promotion for older people.

The main actor in public health policy is the central government, namely its agency the National Public Health and Medical Officer Service. Also, territorial governments play an important role, though they have limited financial capacity to spend on health promotion and they need to rely on external unstable sources of funds when implementing health programmes for older people. NGOs might be important partners for health promotion along with public authorities. However, they require more financial and infrastructural support to be able to perform more activities in the field of health promotion for older people.

Key words: **public health, health promotion, older people, healthy ageing, Hungary**

Introduction

The objective of this paper is to present basic information on the organisation and financing of health promotion in Hungary, with the focus on health promotion for older people. Selected activities (good practices) of territorial self-governments and NGOs are described, as these institutions have been recognised as key stakeholders in health promotion for older people in Hungary (for more details on the selection of key institutions involved in health promotion for older people in Hungary, see [1]).

Data were collected from desk research. The main sources used were: comparative databases provided by international organisations (particularly by the EU, the OECD and the WHO), scientific papers and grey literature as well as other national materials, including government reports, strategic documents and legal regulations. Moreover, semi-structured interviews with national experts were performed in March–June 2016 based on

pre-developed guide. The experts indicated good practises of territorial self-governments and NGOs in the area of health promotion for older people and gave in-depth information on these activities.

1. General context

Hungary is a high income country, according to the World Bank categorization, located in central Europe. The country is divided into 19 counties (megye) and the capital city Budapest. The counties are further subdivided into municipalities (települések – cities [város] – 328 and villages [község, nagyközség] – 3,126). Budapest is subdivided into 23 districts. Hungary has a population of nearly 10 million inhabitants and more than one quarter of the population lives in the Budapest metropolitan area.

During socialism, the health care system in Hungary, as in other Central and Eastern European countries, was built on the Semashko model with the state in the dominant role. After the political changes of 1990, the Bismarck model was introduced with a single Health Insurance Fund (HIF) administered by the National Health Insurance Fund Administration (NHIFA). NHIFA has been facing continuous deficit since its foundation in 1993 [2]. Since 2010, when center-right government took office, the role of the central government in the provision and financing of health care services has been again strengthened, and HIF budget has been recently reintegrated into the central government budget [3].

Total health expenditure accounts for 7.4% of GDP (2013) which is below the EU-28 average but higher than in many countries of the Central and Eastern European region (e.g. Poland, Czech Republic). Approximately 65% of the expenditure comes from public sources. The share of public funding has decreased in the last decade and it is relatively low, compared to other OECD countries. Private expenditure is mostly made up of out-of-pocket payments. A vast majority of health resources (95%) is devoted to financing individual health care services and goods (curative care, rehabilitative care, long-term care, ancillary services and medical goods) while collective services (prevention and public health services as well as health administration) take 5%. The expenditure on prevention and public health services in 2013 accounted for 2.7% of the total current health expenditure which is lower by 2.3 percentage points than it was in 2000 (see **Table I**).

2. Demographic and epidemiologic context

The share of the older population (65+) in Hungary is slightly below the EU-28 average (see **Box 1**). However, it is foreseen that an unfavourable demographic tendency will result in a significant increase in the old age dependency ratio from 26.4% in 2015 to 52.4% in 2060. The health status of the Hungarian population is exceptionally low given the general socio-economic development of the country.

The poor health of the Hungarian population has been a highly visible problem for many years. In the first decades of the post-war communist period, efforts in the area of public health (widespread immunisation programmes, public hygiene programmes) resulted in bringing communicable diseases under control and increasing the life expectancy of the Hungarian population [4]. However, starting from the mid-1960s, sanitary and epidemiological services failed to respond to the new health challenges, i.e. non-communicable diseases. This unfavourable trend also continued in the first years after the political change of 1990, when a decline in health status was observed, leaving Hungary not only behind Western European countries, but also some central European countries like Poland and the Czech Republic.

	2000	2005	2007	2010	2012	2013	Change 2013 to 2000	Change 2013 to 2007
GDP per capita, Forint, Thousands (GDP price level, 2005)	1,779.5	2,213.9	2,320.6	2,217.1	2,241.7	2,282.2	+28.3%	–1.6%
Total current health expenditure (TCHE) per capita, Hungarian Forints, Thousands (constant prices, 2005)	120.9	178.9	169.1	169.8	169.1	168.2	+39.1%	–0.5%
Total current health expenditure (% of GDP)	6.8	8.1	7.3	7.7	7.5	7.4	+0.6 pp	+0.1 pp
Public expenditure (% TCHE)	69.6	69.5	66.8	64.7	62.9	64.6	–5 pp	–2.2
Individual health care (% of TCHE)	92.7	93.5	93.9	93.3	95.3	95.2	+2.5 pp	+1.3 pp
Collective health care (% of TCHE)	7.3	6.5	6.1	6.7	4.7	4.8	–2.5 pp	–1.3 pp
Prevention and public health (% of TCHE)	5.0	4.5	4.3	4.5	2.8	2.7	–2.3 pp	–1.6 pp

Table I. *Health system indicators.*

Source: Based on OECD Health Statistics, http://stats.oecd.org/index.aspx?DataSetCode=HEALTH_STAT#; accessed: 18.06.2016.

In 2014, the share of the older population (65+) in Hungary amounts to 17.5% and is below the EU-28 average of 18.5%. 13.4% of the population is aged 65–74 and 4.2% are the oldest of the old (80+). The proportion of the population aged 65 to 74 in Hungary is equal to the EU-28 average and the proportion of the oldest people is slightly below the EU-28 average of 5.1% in 2014 [5]. The average life expectancy (LE) at birth for females accounts to 79.1 years of life and is below the EU-28 level of 83.3 years of life. The healthy life years (HLY) for women are estimated at 60.1 (about 76% of the average female lifespan). The average LE at birth for men is 72.1 years, which is rather low compared to the EU-28 average of 77.8. Healthy life years (HLY) are estimated at 59.1 (which is about 82% of the average male lifespan). It is worth noting that the gap between the LE of men and women is as large as 7 years of life in the case of LE at birth and almost 4 years of life for the population at the age of 65. The average LE at the age of 65 is 18.4 years for women and 14.5 years for men, which is below the EU-28 averages of 21.3 for women and 17.9 for men. It is estimated that Hungarian women tend to spend only 32% and Hungarian men 42% of this time in good health and without disability (HLY at the age of 65).

Due to the increase in the average life expectancy and the decrease in the fertility rate, the proportion of older people (65+) in the population is foreseen to increase from 17.5% in 2014 to 29.4% in 2060. The share of people aged 80 or more in the population is foreseen to triple: from 4.2% to 12.8%. This unfavourable demographic tendency will result in an increase in the old age dependency[1] ratio from 26.4% in 2015 to 52.4% in 2060.

Box 1. *Demography.*
Source: Own work.

Presently, the life expectancy at birth for Hungarian men (72.1 years) is nearly 6 years less than the EU-28 average (Box 1). The life expectancy of Hungarian women (79.1 years) is 4 years shorter than among their counterparts in the EU-28. Additional reasons for concern are geographical and social health inequalities [4]. The health status of the older population has also been proven to be worse than in other European countries (**Box 2**). The European Health and Social Integration Survey (EHSIS) revealed that the prevalence of disability in the Hungarian population of older people is the highest out of all 28 analysed countries (see **Figure 1**).

Although some efforts have been undertaken, risk factors such as unhealthy diet, smoking, alcohol consumption and low physical activity are important factors shaping the health status of the Hungarian population. They lead to cardiovascular system diseases – the main cause of death in the general population and among people 65+ (see Box 2).

3. Legal framework for public health and health promotion in Hungary

The first important law in Hungary concerning health was passed in 1876 (Act XIV on Public Health). Although titled the Act on Public Health, this act, which declared the state responsible for the health of the population, dealt generally with health protection and the organisation of health care. Nevertheless, public health issues, such as preventing infectious diseases, ensuring access to clean water, housing sanitation, etc. were also covered by this legislation [8]. During the communist period, when the focus was still on communicable diseases, the functioning of the main sanitation institution was regulated by the Council of Ministers Decree No 173/1951 (IX.16) on the organisation of the State Supervisory Agency for Public Hygiene and Infectious Diseases.

In 2014, the overall mortality level in the population 65+ is 6,502 deaths per 100,000 population in men and 4,211 deaths per 100,000 in women [6]. The main causes of mortality in the older population (65+) are cardiovascular system diseases, constituting about 52% of male (3,392/100,000 population) and 58% (2,458/100,000 population) of female deaths. Cancers are the cause of about one fourth of deaths in men (1,642/100,000 population) and one fifth of deaths in women (868/100,000 population). Respiratory system diseases account for about 7% of male (447/100,000 population) and 5% of female (207/100,000 population) deaths of the population 65+.

Older people in Hungary report being in poor health status. 32.4% of people aged 65–74, 48.8% of people aged 75–84 and 61.2% of people above 80 years of age assessed their health status as bad or very bad (EU-SILC data of 2014) [5]. Less than 20% of people aged 65–74, 8% of people aged 75–84 and less than 6% of people above the age of 85 report being in good or better than good health. Long-standing illnesses were reported by 77.6% of the population 65+ in 2014. Chronic conditions are slightly more common among older women (79.7%) than men (73.8%) though the difference between the sexes is not large. The proportion of older people with chronic conditions increases with age. As much as 87.3% of people aged 85 or more report suffering from long-standing illnesses. Corporal impairments are the most widespread affecting approximately half of the population aged 60 to 70 and are more frequent with increasing age as almost 80% of people 80+ declare impairments. Vision and hearing disorders occur in about 10% of people aged 60 to 70 and in half of the population 80+ [7]. Activity limitations caused by health problems are reported by 53.4% of people aged 65–74, 72% of people aged 75–84 and 83.9% of people aged 85 or more in 2013 [5]. Long-standing activity limitations are reported more frequently by women than men (56%, 76% and 86% of women vs. 50%, 65% and 80% of men in their respective age groups). The main risk factors of poor health include obesity and inadequate nutrition, lack of physical activity and smoking.

Box 2. *Health status.*
Source: Own work.

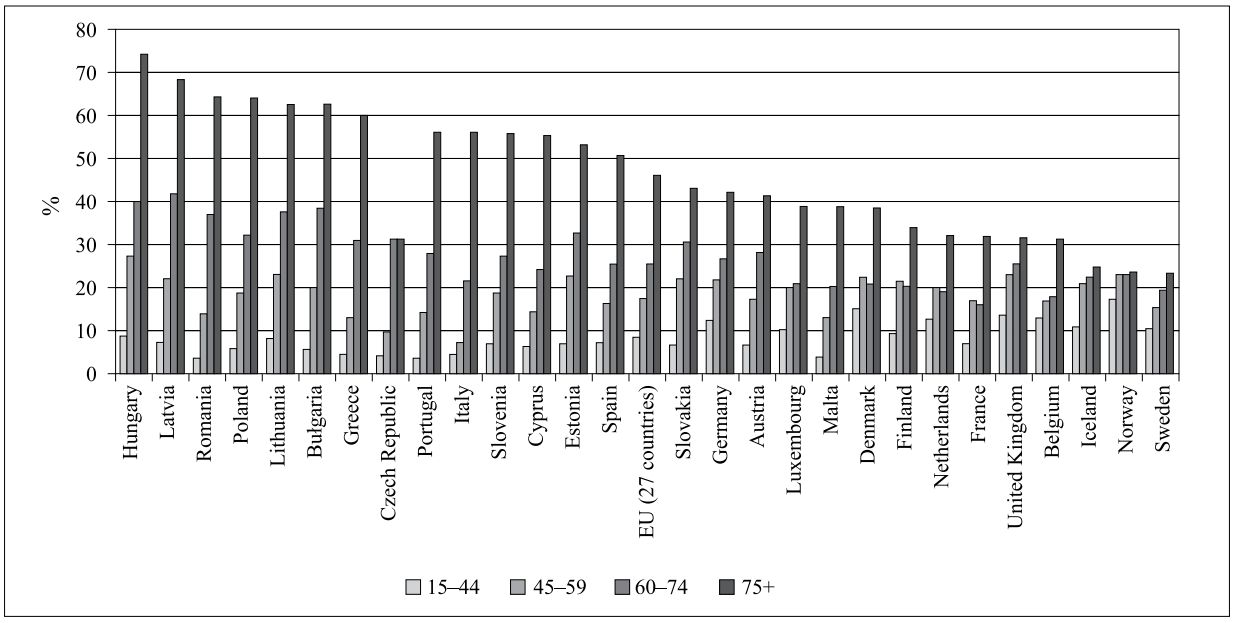

Figure 1. *Percentage of disabled by country and age, 2012.*

Source: Eurostat. European health and social integration survey (EHSIS), http://ec.europa.eu/eurostat/cache/metadata/en/hlth_dsb_prve_esms.htm; accessed: 15.12.2016.

Despite the presence of a variety of legislation related to public health and health promotion, Hungary has not yet developed legislation specifically dedicated to public health (Public Health Act). Presently, the legislation which established the main public health institution in Hungary, which is considered the main legislation in the area of public health, is Act XI of 1991 on the National Public Health and Medical Officer Service and the Government, along with Decree No. 362/2006 on the National Public Health and Medical Officer Service and the Designation of the Pharmaceutical Public Administration Authority[2].

Also, some public health issues are regulated in more general laws on health and health care, such as Act CLIV of 1997 on Health, Act LXXXIII of 1997 on the Services of Compulsory Health Insurance and Act CXXIII of 2015 on Basic Health Care Services. These acts define the health rights of Hungarian citizens, specify the basic service package under the Hungarian health insurance (including health prevention services), and regulate the provision and financing of health care services and the responsibilities of the main public actors. Occupational health protection and the responsibility of employers in protecting the health of their employees are regulated by Act XCIII of 1993 on Occupational Safety. It is also worth mentioning regulations on selected health promotion issues, like the CIII of 2011 on Taxes on Unhealthy Food and Beverages which introduced an earmarked tax for health (see **Box 3**).

- Taxes on Unhealthy Food and Beverages:

Act CIII of 2011 on Taxes on Unhealthy Food and Beverages
It introduces earmarked taxes for the financing of public health programs and health care services. The levy is imposed on high sugar content soft drinks, caffeine added energy drinks, high sugar candies and chocolate products, and some salty snacks and condiments.

- Smoking:

Act CXXXIV of 2012 on Reducing the Prevalence of Smoking Among Young People and Retail Sale of Tobacco Products.
Modifications of Act XLII of 1999 on the Protection of Non-Smokers and Certain Rules on the Consumption and Distribution of Tobacco Products.

- Health education in schools:

Act CXC of 2011 on National Public Education.
It introduces health education in schools. It obliged the educational institution to create a healthy and secure environment for teaching, promote healthy behaviour (healthy diet and regular physical activity), and to organize regular health checks for children and students (dental, ocular and general screening).

- Public catering in schools:

Decree 37/2014 (IV.30.) on Nutritional Regulations in Public Catering.
It regulates the provision of food by Public Catering Providers and institutions. It specified the amount and quality of food to be provide (forbidding some unhealthy products).

Box 3. *Important public health legislation since 2010.*

Source: Own work.

The directions for public health policy are set in National Public Health Programmes. The first comprehensive programme was launched as a government resolution in 1994 [9]. It was followed by a renewed public health programme in 2001 'For a Healthy Nation' and in 2003 (after the change of government in 2002), the 'National Programme for a Decade of Health' which set priorities and defined actions for 10 years [10]. The implementation of national public health programmes and the achievements of the defined health objectives have, however, often been hindered by a lack of long-term political support, inadequate financing or insufficient institutional capacity [9].The new national health programme has not been established yet, though a need for such a programme has been indicated in another strategic document on health care established in 2015, 'Healthy Hungary 2014–2020' [11].

Health promotion and disease prevention among the older population in Hungary, has long been recognised as an important health issue which requires more public effort. In 1996, the Committee for Elderly People was established in the Ministry of Health. The committee prepared the Elderly People's Charter. In 2001, the Commissioner of Health Care for Elderly People was assigned with the responsibility of preparing a health care programme for older people based on the charter [12]. In 2003, the ten-year National Public Health Programme 'National Programme for a Decade of Health' was launched with special attention given to problems related to ageing [13]. In 2007, the National Implementation Plan for healthy ageing was prepared, which resulted in various activities promoting healthy nutrition, physical activity and mental health among older people [12].

In 2009 a National Ageing Strategy (2009–2034) was developed and approved by the Hungarian Parliament [14]. The long-term goals defined in this document include: aligning life expectancy with the EU average; increasing the number of years spent in good health; keeping active in life longer; ensuring financial security in old age; promoting social integration; harmonising different services (healthcare, social, educational, cultural, etc.) considering the interests and needs of the elderly and old people; supporting lifelong learning; promoting active ageing (meaning not only labour activity, but also social, cultural, and civil activity); calling the attention of younger generations to 'age management' and changing the social attitude regarding ageing in an economic and social sense [15]. The Strategy stresses the need to develop programmes for prevention, rehabilitation, health promotion and sports for senior people and underlines the importance of physical activity for older people's health.

4. Financing public health and health promotion in Hungary

The OECD health statistics indicate that Hungary, together with other CEE countries, Greece and Mexico, belongs to a group of countries with the lowest expenditure on prevention and public health (see **Figure 2**).[3] In 2013 the expenditure was 47.3 US$ PPP. In the last decade, there has been a decrease in spending on prevention and public health in Hungary. Between 2005 and 2013 the real expenditure per capita decreased by more than 40% (from 63 US$ PPP to 36 US$ PPP) (**Table II**).

There are various sources of funds for prevention and public health in Hungary **(Figure 3** and **Figure 4)**. The expenditure from public sources accounts for 57% of total expenditure on prevention and public health, though the share of the public expenditure has declined in recent years (by approx. 8 percentage points since 2005)

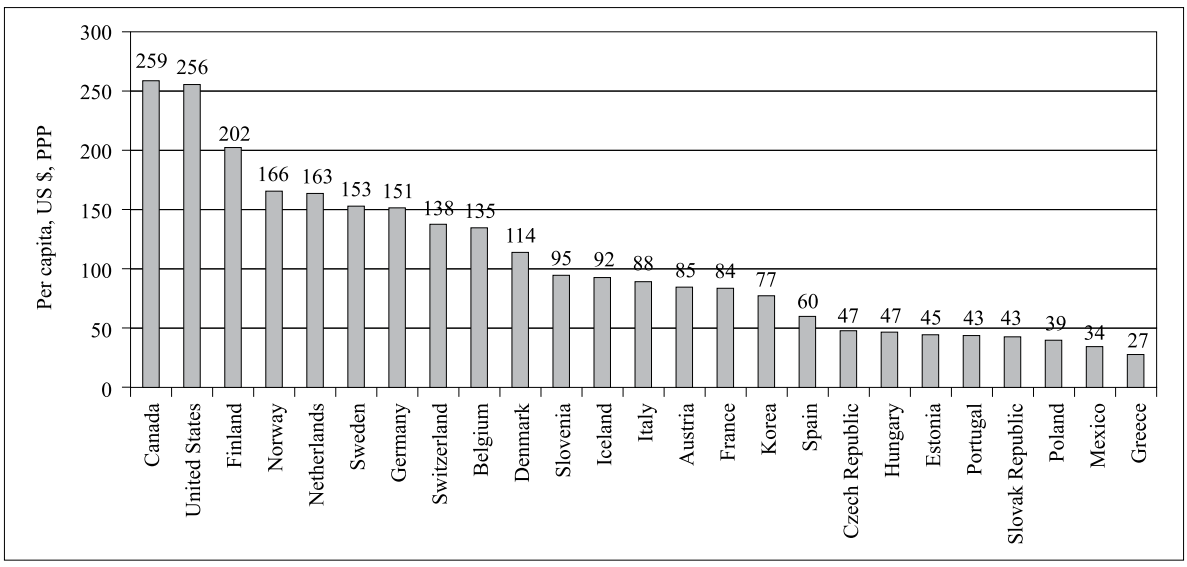

Figure 2. *Expenditure on prevention and public health per capita (US$ PPP) in 2013 in OECD countries.*
Source: Based on OECD Health Statistics, http://stats.oecd.org/index.aspx?DataSetCode=HEALTH_STAT#; accessed: 18.06.2016.

	2005	2006	2007	2008	2009	2010	2011	2012	2013
Total expenditure on prevention and public health (Hungarian Forints, Millions)	81,140.8	81,155.5	78,225.8	80,409	87,522.8	79,220.9	71,015.1	59,630.3	60,467
Per capita, US$ PPP	62.6	62.7	59.2	61.9	69.6	63.1	57.1	47	47.3
Per capita, US$ PPP (constant prices, 2005)	62.6	60.5	55.5	54.4	57.1	50.7	44.6	36.4	36
Public expenditure									
Social health insurance (Hungarian Forints, Millions)	17,001.2	18,711.4	18,679.8	18,667.2	18,736.7	19,066	18,895.1	18,276.7	20,697.8
Social health insurance (% of total health expenditure of social health insurance fund)	1.6	1.6	1.8	1.7	1.7	1.6	1.6	1.6	1.7
Central government (Hungarian Forints, Millions)	30,739.3	30,492.1	26,425.6	27,157.7	25,626.2	29,304.5	19,573.4	n.d.	n.d.
Central government (% of total health expenditure of central government)	36.9	35.4	27.6	28.3	29.4	29.1	19.6	n.d.	n.d.
Territorial government (Hungarian Forints, Millions)	5,207.5	3,942.8	4,402.7	4,928.1	3,200.5	3,747.9	4,501.9	n.d.	n.d.
Territorial government (% of total health expenditure of territorial government)	7	5.6	5.1	5.4	3.4	5.8	6.4	n.d.	n.d.
Private expenditure									
Non-profit organisations (Hungarian Forints, Millions)	6,430.7	6,673.7	7,683.9	6,538.2	8,040.9	7,701.8	7,900.9	6,665.3	7,798.1
Non-profit organisations (% of total health expenditure of non-profit organisations)	23.9	20.6	23.5	20	22.4	19.7	19.8	18.6	22.2
Corporations (Hungarian Forints, Millions)	16,257.1	16,375.5	17,263.2	16,402	26,815.2	14,313.3	15,064.9	14,417.9	13,121.5
Corporations (% of total health expenditure of corporations)	42.8	33.8	30.5	27.1	34.2	20.3	18.8	19.7	20.4
Households out-of-pocket expenditure (Hungarian Forints, Millions)	3,376.3	2,944.4	2,932.7	5,701.4	4,186.5	4,106	4,224.2	3,966.5	5,052.9
Households out-of-pocket (% of total health expenditure of households)	0.7	0.6	0.6	1.1	0.8	0.7	0.7	0.6	0.8
Private insurance (Hungarian Forints, Millions)	2,128.8	2,015.5	837.9	1,014.4	916.8	981.5	854.7	150.3	0.3
Private insurance (% of total health expenditure of private insurers)	10.5	6.7	2.1	2.4	1.7	1.7	1.5	0.3	0

Table II. *Expenditure on prevention and public health in Hungary.*

Source: Based on OECD Health Statistics, http://stats.oecd.org/index.aspx?DataSetCode=HEALTH_STAT#; accessed: 18.06.2016.

(Figure 4). Public sources include tax revenues, namely general taxes and taxes on unhealthy food and beverages, introduced in 2011, which also contribute to the health budget [17]. There is no specific allocation of the revenues from excise taxes on tobacco and alcohol to public health, though this has been under political discussion [4]. Some resources from the Health Insurance Fund are also allocated to health promotion or disease prevention, though no sub-budget for this purpose has been distinguished[4] [18].

The importance of different public revenues for public health has changed in last years (see Figure 3 and Figure 4). Until 2012, the main public sources of funds for prevention and public health were tax revenues. This included expenditure by the central government (on public health programmes, vaccination and the functioning of National Public Health and Medical Officer Services) and to a lesser extent, spending by territorial governments (see Table II).[5] The latest data indicate however, that expenditure from social insurance outspends the

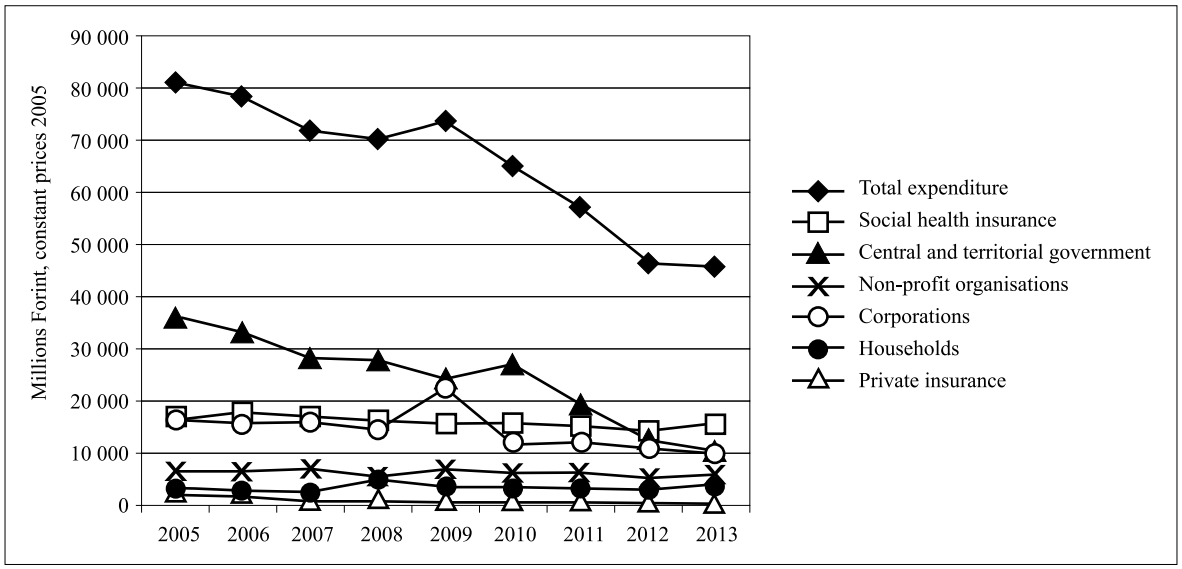

Figure 3. *Real expenditure on prevention and public health in Hungary, 2005–2013.*
Source: Based on OECD Health Statistics, http://stats.oecd.org/index.aspx?DataSetCode=HEALTH_STAT#; accessed: 18.06.2016.

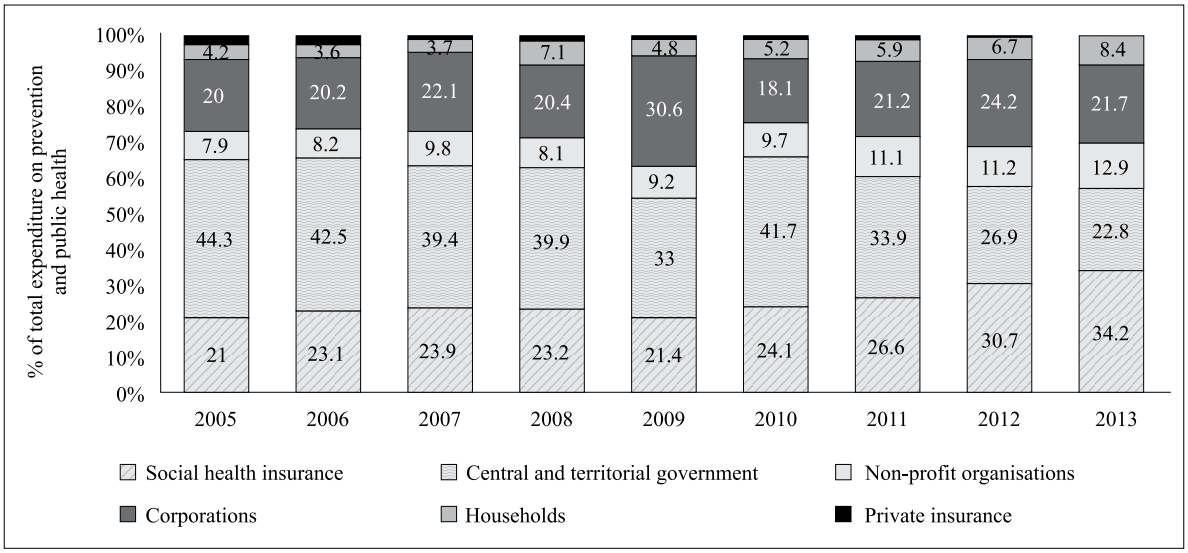

Figure 4. *The structure of prevention and public health expenditure by financing agent.*
Source: Based on OECD Health Statistics, http://stats.oecd.org/index.aspx?DataSetCode=HEALTH_STAT#; accessed: 18.06.2016.

expenditure of governments (i.e. in 2013, 34% of total expenditure on prevention and public health came from social insurance and 23% from tax revenues). This trend was due to a decline in the level of expenditure on prevention and public health by the central government (i.e. between 2005 and 2011, the share of the expenditure by the central government declined from 38% to 28%). It should be noted however, that since 2012 some of the expenditure of the central government on the activities of National Public Health and Medical Officer Services, classified earlier as expenditure on prevention, has been re-classified as administrative spending, which might explain the observed drop [19]. The expenditure of the Health Insurance Fund, on the other hand, has remained stable through the last decade (see Figure 3). This includes spending on prevention of communicable and non-communicable diseases; maternal and child health; family planning, and school health services [19].

The main source of private revenues for prevention and public health are corporations (more than 20% of total expenditure on prevention and public health) (Figure 3). These are resources related to occupational health. However, the level of expenditure by employers on prevention and public health is decreasing in favour

of expenditure on curative services (in 2005, expenditure on preventive services accounted for more than 40% of the total health expenditure of corporations, while 8 years later, in 2013, it was only 20%, see Table II).

The second largest source of private funds for prevention and public health are non-profit organisations. The expenditures of non-profit organisations account for approx. 13% of the total expenditure on public health and prevention and they are rather stable. Household out-of-pocket expenditure on prevention and public health services has been increasing, and in 2013 accounted for more than 8% of the total expenditure on these services. Resources from private insurance play minor and diminishing role in financing prevention services as preventive services or screenings no longer can be offered in private health insurance packages. Also, declining ratio of private insurance in financing prevention services is due to changes in legislation which promote the use of health savings accounts (egészségpénztárak), and this kind of spending appears as out-of-pocket expenditure.

5. Institutions involved in public health and health promotion and their programmes addressed to older people

Public health services are mainly the responsibility of the central government (the Ministry of Human Capacities[6]), which provides these services through the National Public Health and Medical Officer Service (NPHMOS). The NPHMOS was established in 1991 [20, 21] as a state agency to address the shortcoming of the traditional sanitary and epidemiological service, which failed to respond adequately to the challenges of non-communicable diseases. However, the NPHMOS was established on the basis of the State Supervisory Agency for Public Hygiene and Infectious Diseases, with limited professional capacity to become a modern public health institution [22]. This changed later in the 90s when public health professionals, trained at newly formed schools of public health, became available for employment by NPHMOS.[7] The administration of the NPHMOS was divided into three levels: national, headed by the Chief Public Health Officer, regional (seven regional offices, each covering the population of two to three counties) and sub-regional. Presently, territorial offices have been integrated into the government offices (kormányhivatalok). The NPHMOS has a broad range of responsibilities related to public health (environmental and settlement health, food and nutritional health, children and youth health, radiohygiene and chemical safety), epidemiology (monitoring epidemiological issues and changes in the population's health status), health protection, health education, health promotion, public health administration and occupational health (workplace hygiene, occupational medicine) as well as supervision of healthcare provision.[8]

The NPHMOS is supported by national institutes: the National Public Health Centre, the National Centre for Epidemiology, the Institute for Emergency Healthcare Supply Management, and the National Institute for Health Development. Among them, the National Institute for Health Development (*Nemzeti Egészségfejlesztési Intézet*, NEFI) is an important methodological background institution of the Ministry of Human Capacities with a mission of 'influencing the health behaviour of the population and providing health related information in the field of public health'.[9]

The territorial governments are key public stakeholders in health promotion for older people in Hungary. They are generally responsible for planning and providing local health services. However, they have limited financial capacity to spend on health (they have no earmarked funds for public health). Even the financing of capital cost, which territorial government are responsible for as the owners of health care facilities, requires subsidies from the central government [4]. Despite the financial barriers, some territorial governments have implemented health promotion programmes targeted at older people, usually with external EU financial aid, which are considered good practice (See **Box 4–6**).

Central and territorial self-governments fulfilling their responsibilities for health promotion among older people rely on the support of non-governmental partners, particularly NGOs. In the early 2000s, Hungary was considered a Central-Eastern European leader in legislation on NGO activities [23]. As of 2014, there were about 65,000 NGOs registered in Hungary[12] [25]. This number has increased since 2007 by approx. 3,000. Nevertheless, in that year only 4.7% of NGOs operated in the field of health and 9% in social services, 15.7% were active in education and 12.2% in sports and recreation.

A survey from 2000 indicated that about 20% of local self-governments had contracts with NGOs, delegating public services [25]. Public grants constitute a significant source of income for the NGO sector.[13] In 2007, 35% of the total sector income came from state or local grants [25]. These resources are distributed through calls for proposals and are funded from the National Civil Fund (i.e. a fund established by the Hungarian government in 2003, specifically in order to support NGOs). Yet, there are some critics on the over-politicisation and extensive bureaucracy of the state funding distribution to NGOs which threatens the sustainability of NGO's funding [23, 26].

An example of collaboration between the government and NGOs in the field of health promotion for the older population, is the 'Walking Club for Healthier Ageing' programme for pensioners over the age of 60. The programme promotes physical activity through club activities and supplements this with lectures on healthy ageing, culture, and other topics.[14] Another example – often indicated as a good practice – is 'Basic social services in rural settlements: Village and remote homestead community care-giving'. This programme functions within governmental policy addressed to excluded older people but it also involves civil society resources, and especially social networks. It is a multi-sectorial operation with a complex structure of activities which also has proven to be exemplary due to its low cost and high transferability [27]. Box 6 includes other examples of good practices by NGOs.

Target group: 60+ citizens of Ujbuda

Ujbuda is one of the largest districts in Budapest.[10] In 2008, to develop social and healthcare strategy for the elderly, the self-government of Ujbuda started a complex programme. This programme is in line with the principles of the Elderly People's Charter, adapting them to and putting them into practice at the local level.

The main objective of the project is increasing quality of life with the instruments of the self-government and achieving results in: fighting loneliness, eliminating the generation gap, ensuring and providing life-long learning, maintaining health and an active lifestyle, ensuring a safe environment and maintaining the independence, activity and dignity of elderly people as long as possible. This project is complex, providing more than two hundred programmes and services monthly that improve the quality of life of the target group and help maintain their activities.

The major elements and results of the Programme are as follows:[11]

- Building communities (organised and run by trained volunteers on different subjects, e.g. shopping, teaching English, German, Esperanto, dermatology courses).
- Ujbuda 60+CARD, which entitles the elderly to take part in centrally organised programmes and courses at a low cost or free of charge.
- "Communication – in time", specifically for elderly people (the district newspaper, an internet webpage and newsletters inform about the events and programmes). Information is provided in the Ujbuda 60+ Programme Centre in person and on the phone every working day. Moreover, the Media Workshop Group is one of the volunteer communities where trained journalists deliver news for the elderly about the elderly.
- Culture – several dozens of programmes from hand crafts to playing musical instruments.
- Senior Academy Ujbuda – lectures and courses.
- Health and sports – courses and competitions.
- Crime prevention sub-programme – to make people to feel safer.
- Telephone for elderly people – a device specifically for the elderly.

Ujbuda 60+ is a voluntary programme. Its tasks are financed by the Ujbuda Self-Government, but they are seeking funds from EU tenders (Q-Aging and Senior Capital Project).
In 2009 and 2013 Ujbuda won the prize of the Elderly – for a Friendly Municipality. Currently the Ujbuda60+ is the largest and most well-known programme in Hungary in the issue of active ageing.

Box 4. *Municipality of Ujbuda's Programme for Elderly People 60+.*

Source: On the basis of information and materials presented by Ilona Gyorffyne Molnar (the Head of Citizen's Services Directorate of the Local Government & the Municipality of District 11 of Budapest) during the European Congress of Regional and Local Governments in Krakow, 5 April 2016.

Target group: 60+ senior citizens

In Zugló (the 14th district of Budapest), in the framework of the Silver City pilot project, the Zugló Age Centre was created. This centre helps in solving the problems of the elderly, making the most of their activity potential, processing their suggestions related to community life, and communicating those to the local government authority or government organisations.
The Zugló Age Centre offers complex activities dedicated to older people: Infopoint, volunteering, andragogy (a series of scientific lectures in the form of a free university) and a community building. One of the crucial services offered for the elderly is the ability to gain information about the initiatives/activities of district offices, civil or church organisations. The Infopoint ensures the accessibility of the offered programmes, their connections and the rules of participation in the programmes. They also collect feedback (suggestions/questions) regarding the programmes.
One of the main conditions of the Age Centre is that participants feel involved in the issues of the elderly of Zugló.

Box 5. *Zugló Age Centre (the 14th district of the Capital City, Budapest).*

Source: http://budapesttimes.hu/2014/09/19/in-the-silver-city-communities-there-are-more-opportunities; accessed: 15.04.2016.

Target Group: Older people (60+)

The Budapest Cultural Centre (BCC) is a professional service institution of the community cultural institutions, civil organisations and communities in the 11th District of Budapest. In 2006, the BCC implemented a computer learning programme for older people by developing and sponsoring the *Click on it Grandma programme*, which helps senior citizens and retired people overcome the main obstacles of computer and Internet usage. The practice-oriented training courses offered by the BCC are specially developed for and targeted at meeting the special needs of older people. The BCC is an educational methodology centre targeted at meeting the needs of senior citizens and has also established good relations with all local cultural and community centres nationwide. Since 2006 the BCC has extended the programme beyond Budapest and set up a nationwide educational network to launch courses franchised, administrated and supervised by the BCC. Now this is the largest programme of its kind in Hungary and is run in 12 cities.
In 2013 the BCC implemented the intergenerational Project: "Granny – Student IT Study Circle." Older and younger people meet regularly in the BCC. During the meetings older people acquire new IT skills and thanks to the length of the meetings they have a chance to put the newly acquired knowledge into practice. The BCC encourages the elderly to start learning or volunteering.
According to BCC analysis, the senior education structure in Hungary needs to be further developed and improved. The central and local health promotion initiatives need to be further supported. Participation in such activities stimulates personal development, builds self-esteem, allows for better communication and reduces social exclusion.

Box 6. *Budapest Cultural Centre (BCC) Budapest, XI. District Etele út 55.*

Source: https://joinup.ec.europa.eu/community/epractice/case/click-it-grandma; accessed: 13.04.2016.

- 'Learning through Volunteering in Senior Age' – a project that focuses on enhancing lifelong learning by knowledge exchange and inter-generational dialogue. The side goal of this initiative is to combat national prejudices.[15]
- The activities of the non-profit company TMSZK (*Társadalomfejlesztési Módszertani és Szolgáltató Központ Nonprofit Kft.*) that is a professional-methodology centre providing 'aid to its collaborative partners to reduce the negative social, economic and cultural effects triggered mainly by ageing as a process'. It offers professional and methodological assistance primarily to elderly and senior citizens, employers, state organisations and institutes, local governments and civil organisations covering certain areas.[16]
- 'Seniors Club' – Retired Teachers' Association together with other institutions organised IT training, museums visits, community meetings and various other joint programmes for the elderly.[17]

Box 7. *Health promotion for older people – good practices by NGOs.*

Source: EuroHealthNet, Healthy and Active Ageing (Report), Bundeszentrale für gesundheitliche Aufklärung, Brussels 2012, http://www.healthyageing.eu/sites/www.healthyageing.eu/files/resources/Healthy%20and%20Active%20Ageing.pdf; OEFI, 'Országos Egészségfejlesztési Intézet'; accessed: 15.05.2016 [28].

Conclusions and recommendations

The results of our review indicate that health promotion is a neglected area in the Hungarian health care system. Hungary belongs to the group of countries with the lowest expenditure on prevention and public health and the level of this expenditure is decreasing. There is no separate fund for public health which does not allow the securing of sufficient financial resources for health promotion programmes. Moreover, the lack of legislation specifically dedicated to public health diminishes the importance of this area of the health system. However, given the poor status of the Hungarian population, which can largely be attributed to an unhealthy lifestyle, greater policy attention to health promotion is highly warranted.

The important target group for health promotion activities should be the elderly population, which will be increasing in size in the coming decades. As evidence indicates, this group is characterised with very low health status. The need for paying greater attention to older people has been already recognised by the Hungarian government, which developed a National Ageing Strategy. Still, programmes focused on health promotion are lacking.

There are various barriers to the implementation of health programmes in Hungary. Along with the earlier mentioned resource constraints, a lack of political commitment to pursue health programmes, especially if inherited from political predecessors, might be also a hindering factor. Although non-public institutions such as NGOs, can be valuable partners in health ageing policies for the government and territorial self-governments, more commitment and support is needed to ensure a greater prevalence and sustainability of health promotion initiatives targeted at older people.

Notes

[1] The ratio between the number of persons aged 65 and over (the age when they are generally economically inactive) and the number of persons aged between 15 and 64. The value is expressed per 100 persons of working age (15–64) (Eurostat).

[2] The list of compulsory and discretionary screening programmes is included in Decree No. 51/1997 (XII.18.) NM of the Minister of Welfare on Preventive and Early Diagnostic Services that Can be Utilised in the Frame of the Social Health Insurance System and on the Certification of Participation in Screening Programmes. Decree No. 18/1998 (VI.3) NM of Minister of Welfare on the Prevention and Control of Infectious Diseases and Epidemics regulates the operation of surveillance systems for communicable diseases, immunisation against communicable diseases and the procedures of infectious disease control.

[3] It should be noted that the data on expenditure for prevention and public health include various expenditures and their comparability across countries is limited [16].

[4] The HIF is divided into more than 30 sub-budgets according to the type of service.

[5] This expenditure also includes resources from external sources (EU grants) for funding health promotion, which have been increasing in last decade.

[6] The Ministry of National Resources was created in 2010 by merging five ministries responsible for social, family and youth affairs; health care; education; culture; and sport. These ministers are now represented by State Secretariats (including the State Secretariat for Healthcare), led by a Minister of State [4].

[7] The first School of Public Health was established at the University of Debrecen in the framework of the 'Health Services and Management Programme' (1993–2000) [9].

[8] https://www.antsz.hu/en/about_us; accessed: 15.06.2016.

[9] http://www.oefi.hu/missio_en.htm; accessed: 15.06.2016. According to the plans of the government, this institute together with some other institutes, is going to be integrated into the National Healthcare Service Centre at the beginning of 2017 (see: Feller A., Gaal P., Velkey Z., Major reorganization among the background institutions of the Ministry of National Resources, http://www.hspm.org/countries/hungary25062012/livinghit.aspx?Section=2.3%20Organization&Type=Section; accessed: 3.01.2017).

[10] 142,000 citizens, 42,000 of whom who have reached the age of 60.

[11] http://www.ujbuda.hu/ujbuda/sokan-voltak-a-60-gyalog-lo-program-elso-setajan; accessed: 15.04.2016.

[12] NGOs in Hungarian are usually referred to as "civil organisations" (civilszervezet). They can have the legal form of an association (egyesület) or a foundation (alapítvány). There are also non-profit companies (general partnerships, limited partnerships, limited liability companies, or shareholder companies). These three categories can be qualified as Public Benefit Organisations (PBO). Hungarian law introduced two tiers of PBO status: 'basic' and 'prominent.' The latter enables

participation in local self-government responsibilities. PBOs can receive public grants and subsidies and citizens can donate them 1% of their income tax. In 2012, 53% of NGOs had PBO status; and approx. 8% of NGOs had the status of 'prominent' PBOs.

[13] Financing of NGOs in Hungary comes from several sources. This includes individual and corporate donations, including the '1% of tax' and members' contributions, but also grants from governmental institutions and foreign organisations.

[14] http://www.ofi.hu/; accessed: 15.04.2016.

[15] http://www.onkentes.hu/; accessed: 15.04.2016.

[16] http://www.tmszk.hu/en/introduction/; accessed: 15.04.2016.

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Political will against funds deficiency: Health Promotion for Older People in Bulgaria

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Authors contribution

MP and SG designed the concept, MP carried out the data collection and analysis, and drafted the paper, EA, AS, IK and AD commented on the paper and provided additional data, EM, WG and SG reviewed the draft and provided comments for the final version. All authors read and approved the final version submitted.

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Abstract

In Bulgaria, health promotion and health education have received less attention in comparison to other public health areas, which has resulted in a small health promotion budget and consequently, in limited health promotion initiatives. This country report draws upon several national reports focused on the Bulgarian health system, and other country specific sources in order to outline the major institutional and financing challenges for health promotion in Bulgaria, and specifically for health promotion for older adults. As evident from this review, the programs and activities oriented toward health promotion for older adults are inconsistent and incomprehensive. The existing programs are mostly in the form of isolated small-scale projects aimed at enabling older workers to reach the statutory retirement, or supporting retired citizens to maintain their health and well-being. Effective strategic vision, coordination and stable funding in the area of health promotion for older adults is indispensable for helping Bulgarian seniors to live longer and healthier.

Key words: **public health, health promotion, older adults, health policy, Bulgaria**

Introduction

Similar to many Eastern European countries, Bulgaria struggles with adverse demographic trends, population health indicators below the EU averages, shortage of public resources, and inefficient health system. Guided by the ambition to improve the population health status, the government recently adopted the Bulgarian National Health Strategy, which attempts to shift the policy focus to the prevention of socially important diseases, raising public awareness on healthy lifestyles and improving the public health networks. This paper provides an overview of the development of the public health legislation in Bulgaria, and outlines the current institutional and financing challenges for health promotion, specifically for health promotion among older adults. The information is gathered through a reviews of key national reports focused on the Bulgarian health system and other country-specific sources. The paper has a policy orientation and targets decision-makers in the region, who could learn from the public health processes in Bulgaria.

1. Legislation on public health and health promotion generally and for older population

The first Act on Public Health was adopted in Bulgaria in 1903 and was renewed in 1929. It defined sanitary and anti-epidemic standards as well as activities for combating social diseases [1]. During the communist period, specifically in 1973, a new Public Health Act was adopted, which emphasized environmental protection, behavioral factors, demographic issues and the involvement of the community. This act remained in force until 2005 when the Health Act became effective [2] and is still applied. Among other issues, the act regulates the health protection and health promotion activities, as well as patients' rights. It demonstrates the policy goal to improve the population health and to reach the average European health indicators. Nevertheless, the public health legislation in Bulgaria is continuously undergoing changes, which leads to some gaps and confusions about public health responsibilities [1].

With regard to occupational health, the first policy attention was observed during the communist period when several initiatives focused on the workers' health were implemented within the public enterprises. In 1997, the Law on Health and Safety at Work came into force, which regulates the occupational health services and obliges the employers to assure such services for their employees to minimize work-related health risks [3]. Occupational health services range from surveillance of working environment, evaluation and monitoring of employees' health status to counselling and guidance about health risks and their prevention [1]. However, there are no national-level initiatives on the occupational health of older persons.

Health promotion and health education have received less attentions in comparison to other public health areas. Traditionally, policy priorities have been focused on medical care and treatments. This has not only resulted in a very small health promotion budget but also in limited initiatives in the field of health promotion as well as in the lack of integration between public health programs and other health policy measures [4]. Thus, despite the international collaboration and research projects in Bulgaria, the modern public health and health promotions tools remain largely underutilized [5].

The health promotion interventions mainly focus on healthy behavior as well as on health information, education and communication, training for health professionals, and health surveys among the population and medical staff [1]. There are no major health promotion initiatives specifically focused on older adults.

2. Health system indicators

Prior to 1989, Bulgaria had a strongly centralized health system funded primarily by public resources. At present, the health system is transformed into an insurance-based system funded by health insurance contributions, general tax revenue allocated by the government, and a high level of out-of-pocket payments. The limited public resources for health are coupled with major problems in the health and demographic status of the population, as well as with inefficient health system management and poor service provision [6]. While public health services, specifically prevention and health promotion, are declared to be a policy priority [1], their share in the health expenditure is only about 3–4% (see **Table I**). In this regard, the Ministry of Health expenditure on prevention and health promotion services is just over 1% of the total health expenditure. The public health resources are mostly allocated to vaccines and immunizations. Prevention of non-communicable diseases and health promotion account for only about 9% of the total expenditure on public health services [7].

Overall indicators: Total health expenditure per capita: 453.89 Euro Total health expenditure as % of GDP: 7.87%
Selected function as % of total health expenditure: Curative care: 47.13% Pharmaceuticals and other medical non-durable goods: 42.39% Rehabilitative care: 1.62% Preventive care: 2.73% Healthy condition monitoring programs: 1.70% Information, education and counseling programs: 0.32% Immunization programs: 0.23% Early disease detection programs: 0.49%

Table I. *Health system indicators – Bulgaria (data for 2013). Source: Based on the Eurostat database.*

3. Population aging indicators

Bulgaria experiences adverse demographic trends due to a low birthrate, high mortality rates and migration to other countries. The population size, which had a pick in 1989 (about 9 million), has been steadily declining and in 2012, the population size was just 7.33 million [8]. This suggests a drop by 18% which is the highest observed in the EU. The life expectancy at birth is overall low com-

pared to other EU member states: 71.1 years for males and 78.0 for females (see **Table II**). As a result of these demographic changes, a rapid aging of the population is observed and this trend is expected to continue to grow. The share of the population 65+ is foreseen to grow from about 20% in 2014/2015 to 31.8% in 2060 and the share of the population 80+ is foreseen to grow to 12.1% in 2060. Given this unfavorable trend, the old age dependency ratio (30.2% at present) is projected to increase reaching 58.7% in 2060.

Life expectancy: Life expectancy at birth: 74.5 years Life expectancy at birth males/females: 71.1/78.0 Life expectancy at 65: 16.0 years Life expectancy at 65 males/females: 14.1/17.6
Healthy life years: Healthy life years at 65 males: 8.7 years Healthy life years at 65 females: 9.6 years
Share of older population: Proportion of population aged 65+: 20.0% of total population Proportion of population aged 80+: 4.6% of total population Old age dependency ratio 65+: 30.2%

Table II. *Population ageing indicators – Bulgaria (data for 2014/2015).*

Source: Based on the Eurostat database.

4. Health status of older population

The main health indicators in Bulgaria are below the EU averages. The most striking indicator is the comparatively high mortality rate among those aged 40–59 years. The major and overwhelming mortality causes among the older population are cardiovascular diseases constituting 65% of deaths in 65+ males (SDR equal 4787.97) and 75% of deaths in 65+ females (SDR equal 3670.8). Cancers account to 16% of deaths in older men (SDR equal to 1143.89) and 10% in older women (SDR equal to 564.39). This indicates a substantial scope for health system interventions, particularly in relation to public health and lifestyle changes, especially important in the prevention of cardiovascular diseases. Important concerns are the risk factors related to smoking, alcohol abuse and unhealthy nutrition [1]. Such unhealthy lifestyle trends are observed among older adults as well.

As shown in **Table III**, a relatively low share of elderly persons in Bulgaria perceives to have long-standing illness and limitations in usual activities due to health problems (about 30-50% in the age groups below 85 years), but at the same time the mortality rates are high compared to those in other countries. This explains the low healthy life years at the age of 65 years (8.7 years for males and 9.6 years for females) compared to other EU member states.

Prevalence of long-standing illness: Age group 65–74 males/females: 38.3%/44.4% Age group 75–84 males/females: 49.9%/52.3% Age group 85+ males/females: 67.3%/68.3%
Self-perceived long-standing limitations in usual activities due to health problems: Age group 65–74 males/females: 29.6%/34.3% Age group 75–84 males/females: 47.6%/52.5% Age group 85+ males/females: 63.4%/73.6%

Table III. *Health status of older population – Bulgaria (data for 2014).*

Source: Based on the Eurostat and EU-SILC databases.

5. Potential sources of funding public health and health promotion activities

Public health services in Bulgaria are mainly funded and provided by the state (see **Table IV**). This includes all health promotion activities, such as those for elderly persons, but also some prevention services, e.g. services related to health check-ups, check-ups for non-communicable diseases, vaccinations and immunization programs [7]. The Ministry of Health allocates a special annual budget for these promotion, prevention and public health control services. In fact, the branches of the ministry responsible for public health services, so called Regional Health Inspections (RHIs), receive global budgets from the Ministry of Health, calculated based on historical data. This means that the budget of a RHI allocated previous year, is adjusted for inflation and budget growth. However, some services provided by the RHIs are paid directly by the user through user fees (for example, for laboratory tests). There are also public health programs funded and implement by the municipalities.

The following is a list of key public health promotion and education programs implemented at the national level and funded through the state budget allocated to public health [1]:

- National Program for the Limitation of Smoking;
- National Program for the Prevention of Alcohol Abuse;
- National Anti-Drug Strategy;
- National Action Plan for Food and Nutrition;
- National Program for the Prevention and Control of HIV/AIDS and STDs
- National Program for the Prevention and Control of Tuberculosis.

The National Health Insurance Fund (NHIF) finances public health services provided by general practitioners (GPs). The latter services include for example immunization as well as primary prevention and early detection of diseases [9]. The list below shows the basic public health services covered by the NHIF, which are often called prophylaxis services:

- Basic prophylactic examinations and medical tests for determining the health condition of each insured person and for the early diagnosis and detection of diseases;

Source of funding	Beneficiary	Additional Comments
Taxes *Including* – general taxes	The general public or specific target group who uses the public health services.	The general tax revenue allocated to public health is channeled through the branches of the Ministry of Health or the municipalities.
Health insurance premiums *Including* – social insurance – private insurance	Socially insured patients who use public health services provided by GPs or specialists. Mostly foreigners or adults who wish extra insurance.	In addition to insurance premiums, socially insured patients also pay co-payments for each visit to GP or medical specialist. The role of private insurance is minor.
Other public institutions	Beneficiaries of public health services provided by other ministries	e.g. the Ministry of Environment and Water, the Ministry of Labor and Social Policy
Other sources		
Funds from the employers	Employees	Company projects or initiatives
Households	Users of services covered by the social insurance or at the private sector	Co-payments or full fees in the private sector
Foreign	International research projects and EU funds beneficiaries	International research projects
Others	Roma communities and patients with chronic diseases.	Provided by NGOs, including Roma community organizations and associations of patients with chronic diseases.

Table IV. *Sources of public health funding in Bulgaria.*
Source: Based on own review of literature.

- Additional examinations and tests in relation to the most common diseases typical of a certain age and gender;
- Compulsory periodic medical examinations and tests under the Law on Occupational Health and Safety, defined in Ordinance No 3 of the Ministry of Labor and Social Policy and Ordinance No 14 of the Ministry of Health.

Public health services utilized under the NHIF require co-payments by the patients. Until 2012, the official fee for each outpatient visit to a GP and medical specialist (after a referral) was equal to 1% of the minimum monthly salary for the country. For hospitalization, the fee amounted to 2% of the minimum monthly salary per day for the first 10 days of the hospital stay paid once a year. However, in order to reduce the financial burden for the insured people, in 2012, the Council of Ministers replaced the user charges set as a percentage of the minimum monthly salary by fixed co-payments. Elderly patients who use services under the NHIF pay the same co-payments as all other patients, unless they fall in one of the exemption categories, e.g. suffering from specific diseases, being disabled, having low-income, etc. There is no exemption for elderly persons only [10]. It should be also mentioned that the public health services (e.g. health check-ups) are underutilized in Bulgaria even when such services are covered by the NHIF.

Nongovernmental organizations (NGOs) such as the Red Cross, various Roma community organizations and associations of patients with chronic diseases also collaborate with the public health institutions in Bulgaria [1]. The NGOs are active in the field of health promotion as well.

Although private health insurance is not well developed in Bulgaria, there are private insurance companies offering health promotion and prevention packages. However, such insurance is mostly purchased by those without health insurance, such as foreigners, or those who wish extra insurance.

6. Institutional analysis (sectors, organizations and their functions)

The Ministry of Health is the main decision-makers in the public health area in Bulgaria and is directly accountable for the public health policy in the country. In addition to national health protection programs and state sanitary control, the ministry is also responsible for data collection and preparation of annual health status reports [1]. The national health strategies are integrated into the local level action plans of the regional authorities, and are implemented at the municipal level. The funding for health promotion and disease prevention at the local level is also directly related to these action plans. The implementation approach is individual and context-specific depending on the capacity and resources available at the regional level. Thus, the local-level ministry institutions have the obligation to fulfil the objectives of the national health policies [7].

Various health programs are implemented at the regional level by the 28 RHIs, which are decentralized branches of the Ministry of Health [5]. The RHIs are the most active local stakeholders in the public health area. The work of the RHIs is supervised and coordinated by the Principal State Health Inspector appointed by the Prime Minister at the proposal of the Minister of Health. The inspector also supervises the provision of

public health services outside the health care system, for example in sectors such as defense, transport, internal affairs and justice [1]. Overall, the following public health functions are carried out with the involvement of regional and local authorities: health screening, disease prevention, health information, health education, enabling social engagement and self-support, sport and recreation activities.

In addition to this, there are several national centers active in the area of public health protection and promotion, such the National Centre of Radiobiology and Radiation Protection, the National Centre of Infectious and Parasitic Diseases, the National Centre of Drug Addictions, the National Centre for Public Health and Analyses. Regional and municipal bodies are also responsible for disease prevention and social protection. Other actors in the health promotion area include the NHIF, Bulgarian Red Cross, NGOs and private insurers. The role of the latter two is however minor.

Overall, the public health activities in Bulgaria are intersectoral and multilevel as the Ministry of Health, RHIs and national centers collaborate with institutions belonging to the Ministry of Environment and Water, the Ministry of Labor and Social Policy, the Ministry of Education, Youth and Science, the Ministry of Agriculture and Foods, the State Agency for Child Protection, as well as with the municipal councils [1]. The general supervision and coordination of health promotion activities is done by the Department of Public Health at the Ministry of Health with regards to national-level programs, and by the Departments of Health Promotion at the RHIs with regards to local-level programs. The National Centre of Public Health and Analyses is also responsible for several national health promotion and education programs [1].

Other organizations that implement health promotion and disease prevention programs, including programs that target modifiable behavioral and social risk factors among older adults (65+ years), include public health associations, patient organizations and organizations for the protection of patients' rights [7].

7. HP4OP – Health Promotion for Older People (examples of good practices)

In Bulgaria, there are no special, nationwide health programs aimed at people aged 50+ [8]. Direct financial incentives programs related to health promotion that target the group of elderly persons are also absent. However, some activities in the field of "active aging" could be found in the frame of international projects carried out under programs funded by supranational agencies, municipalities or private companies [7]. Overall these activities are relatively few, scattered and lack sustainability, and their evaluation is only done internally for the purpose of the given activity applying quantitative indicators predominantly.

The following cases describe good practices of occupation-based active aging projects in Bulgaria carried out by employers and municipalities [3, 11]:

- Project "SISC – Senior Intergenerational Social Capital" was carried out in Bulgaria in 2008–2011 by the project partner iCENTRES under the coordination of E.Ri.Fo, Italy. The funding was provided through the Lifelong Learning Programme – Gruntdvig. The objective was to equipped senior citizens with skills necessary for coping with changes in order to help them to remain active community members, and to increase their involvement in teaching others (i.e. transferring competence and know-how to younger persons). The project provided e-learning tools for the intergenerational transfer of knowledge, namely skills analysis, identification of strengths and weaknesses, and selection of appropriate trainings to perform the role of a mentor. This helped to strengthen the self-esteem of the participating seniors. The project was equally effective in the other partner countries. It is recognized however, that the universal character of the e-learning tools developed in this project might not fit all settings.
- Project "Age Management in the Company" was carried out in 2004 in Bulgaria by the Bulgarian Telecommunication Company AD, which also provided the project funding. With the participation of trade unions operating in the company, collective bargaining agreement was signed under which the project was launched. The project was addressed to people who worked in the company for at least 10 years and opted for the employment contract termination. Some of the participants were 50+ years old. The project offered short-term entrepreneurship training organized by the Regional Chambers of Industry and Commerce as well as assistance in business plans preparation and subsidized support for selected entrepreneurial plans. Although the project significantly increased the chances of maintaining the professional activity of the elderly persons, there is no information whether the companies established by workers aged 50+ were sustainable. It is however evident from this project that older people are willing to use the possibilities of prolonging their professional activity.
- Project "Skills Development and Employment Growth of People at the Age Over 50" was carried out in 2009–2011 in the municipality of Kardzhali, Bulgaria. The project was managed by the Business Consult and received funding from the European Social Fund. The main objective was to improve the prospects of employability among unemployed older citizens through skills development. The project consisted of needs analysis, training of participants and internships. As a result of the project, the majority of the participants took up employment within 2 years after the project completion. Thus, the project significantly improved the chances of employment among older citizens. Unlike many other projects that aim at standardized trainings focused on computer skills and basic foreign language skills, the beneficiaries of this project were offered training to undertake a specific occupation. Transferability of such practices is quite high in case the new projects are able to identify the needs of the local labor market.

It is also necessary to mention the "Back to Work" program, which allows seniors to look after their grandchildren and receive an reimbursement from public funds [8], as well as the Program "Care", which is a recreation subsidized-tourism program offered by hotels in the inactive season to pensioners who are in need of optimizing their physical regime, changing the atmosphere and communication [12]. Also, the Bulgarian municipality of Belogradets participated in the project "Glob@l Libraries" where village libraries were set up or transformed into training centers for health educations. This initiative is especially relevant for elderly persons in Bulgaria as many of them live in the rural areas.

Another example of a good practice project focused on elderly persons is the project "Telecare Network for Support of Elderly People" [13]. It addresses the needs of older people with disabilities and stimulates NGOs to support this group of elderly persons to deal with risks and maintain social participation through telecare services. The project is located in the Sofia municipality and has received funding under the Bulgarian-Swiss Cooperation Program, Thematic Fund (TF) "Reform Fund Linked to Civil Society Participation" (CSP). The project is implemented by the Institute for Community-Based Social Services Foundation (ICSS). Also the project "Silver City" in the Burgas municipality addressed the needs of older citizens. The project was funded under the Southeast Europe 2007–2013 Network and was a part of the local action plan on active aging.

In the framework of the Operational Program Human Capital 2007–2013, funded by resources form the European Social Fund, there are also various initiatives for improving the quality of care for older and disabled persons. Examples of such initiatives are "Home Care for Independent and Decent Life", "Social Assistant", "Home Help", "Personal Assistant", "Alternatives" and others, with the participation of municipalities, NGOs (e.g. the Red Cross), care providers and the Agency for Social Support [14].

8. National health promotion policy generally and addressed at the older people

In Bulgaria, the health policy priorities are defined by the Ministry of Health and are stipulated in the National Health Strategy [1]. The most recent National Health Strategy 2014–2020 has just come into force. The main objectives of the strategy are a healthy nation as well as sustainable, efficient, accessible and high-quality health services [15]. Among other issues, the strategy outlines the need of implementing the "Health in All Policies" approach as well as pro-active, efficient and effective promotional, preventative and rehabilitation programs. The strategy is innovative for the Bulgarian context because it distinguishes age groups with different needs, which should be targeted separately to effectively improve their health status and well-being, and secure their dignity.

A strong centralization is observed with regard to the development and implementation of health promotion and primary prevention-related policies. The main decision-maker in this area is the Ministry of Health. The role of the ministry is to develop and approve all health promotion and disease prevention programs in the country. However, the subsequent execution of these programs is a task of the local level ministry institutions. For this purpose, local level action plans are developed and implemented.

1. The needs of the older population (65+ years) in Bulgaria are specifically addressed by the National Strategy for Demographic Development (2012–2030). A key element in this strategy is the promotion of active ageing, namely retaining and developing the labor potential of older persons; encouraging lifelong learning and professional training; promotion of flexible employment for older workers; counteracting the negative attitudes of employers to older workers; encouraging voluntary involvement of older people in society [8].
2. The National Demographic Strategy was complemented by the National Concept for Active Ageing adopted in 2012. It is however solely focused on maintaining the activity of people aged 50+. The promotion of healthy lifestyles, health improvement and diversification of social services are not sufficiently emphasized [8].
3. In addition to this, in 2012, Bulgaria adopted the National Plan to Promote Active Aging among Elderly in Bulgaria (2012–2030). This was done through a protocol of the Council of Ministers [7]. The plan has the objectives to assure appropriate conditions and equal living opportunities for people 50+ years old. The plan also aims to promote active aging among the elderly persons in Bulgaria.
4. With the objective to develop the long-term care for elderly persons and to improve their quality of life, in the beginning of 2014, the National Strategy on Long-Term Care was approved. It focuses on setting up a system of home-based long-term care to assure the social inclusion of older persons, as well as the health and care services they need [16].

The Operational Program Human Capital also stipulates measures for older workers aged 55–64. The objective here is to involve older workers as mentors of newly employed people to those jobs. The program also regulates the possibilities for part-time work, flexible working hours, also for older persons. Such options could facilitate the 'transition' of an older employee to retirement through part-time work. A voucher system for financing training in digital technologies and learning languages for people aged 50+ is also defined in this program [8, 17].

The concept of lifelong learning is also integrated in the Vocational Training Strategy and in the Employment Strategy. These programs together with the Operational Program Human Capital mentioned above comprise the National Lifelong Learning Strategy. The overall objective is to upgrade the individual skills and qualifications through training programs offered by universities, private

training companies and non-profit organizations. The strategy does not target solely people of older working age group but also younger persons [8].

The National Strategy for Reducing Poverty and Promoting Social Inclusion 2020 is relevant for older persons living under the poverty limit. Among other objectives, the strategy also aims to assure the equal access to health services, including public health services, for the poor elderly individuals in Bulgaria [18]. The strategy is related to the new Operational Program Human Capital 2014–2020, which among other things, focuses on the improvement of the employability of older persons.

Conclusions and recommendations

Public health in Bulgaria shows major gaps due to its past focus on treatment and secondary prevention. It is therefore vital to effectively shift public health activities to health promotion and disease prevention. Health promotion should become an explicit objective not only in policy documents but also in the public health practice. To realize this, the Ministry of Health has the responsibility to assure predictable, stable and adequate funding for health promotion and disease prevention, as well as the implementation of good practices when developing policies on health promotion and disease prevention. Given the expertise gained at the academic level through international cooperation and research, it will be important to involve university staff and research institutes in the evaluation of health promotion and disease prevention programs [7].

The problems in the Bulgarian public health sector outlined in this review, explain the unfavorable health indicators in the country, which are way below the European averages. This suggests even greater challenges for the future public health policy in Bulgaria. As a response to these challenges, the Bulgarian National Health Strategy outlines a number of national targets focusing on the prevention of socially important diseases; raising public awareness on healthy lifestyles; and improving the public health networks. However, this will require systematic monitoring and registration of population health status, which is still problematic in Bulgaria [1]. There is a need for more close collaboration between national, regional and municipal stakeholders in the public health area. The local capacity in the health promotion area needs to be constantly strengthened and supported by the government.

Specifically with regard to older persons, as evident from the above review, the policy and practice oriented toward health promotion targeting this group is inconsistent and incomprehensive. This is not surprising as its legal framework is still being formed and the public health resources are overall limited. The existing programs that can be related to health promotion interventions for older adults are mostly in the form of isolated small-scale projects and mostly aimed at enabling older workers to reach the statutory retirement, or supporting groups of retired citizens in maintaining their health and well-being [8]. Clearly there is a need of coordinated health promotion interventions for older adults with a broader scope taking into account the variety of health determinants. An effective strategic vision and implementation plans, as well as better cross-sectoral coordination and stable funding in the area of health promotion will be vital for helping Bulgarian seniors to live longer and healthier.

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Health Promotion for Older People in Lithuania: Between bureaucratic and financial constraints

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Authors contribution

MP and EM designed the concept, MP carried out the data collection and analysis, and drafted the paper, LM, AS, IK and AD commented on the paper and provided additional data, EM and WG reviewed the draft and provided comments for the final version. All authors read and approved the final version submitted.

Abstract

The health system in Lithuania has a strong focus on hospital treatment. Overall, there is a lack of sufficient funds explicitly devoted to public health. This country report draws upon several national reports focused on the Lithuanian health system and other country-specific sources in order to outline the major institutional and financing challenges for health promotion in Lithuania, specifically for older adults. As suggested in our review, the key problems in public health services in Lithuania, including health promotion for older persons, are the bureaucratic and financial constraints, a lack of intersectoral cooperation, staff shortages and capacity problems. The implementations of public health initiatives greatly depend on the political will and the government's ability to implement policies, which are still weak in Lithuania. Moreover, the public health legislation lacks clarity and fails to provide an adequate base for local-level evidence-based interventions. Concrete action plans, as those recently developed in the area of healthy aging and health inequalities, are needed to provide guidance for health promotion among older adults.

Key words: **public health, health promotion, older adults, health policy, Lithuania**

Introduction

The concept of public health first appeared in Lithuania in the 1990s. In 1991, the Supreme Council approved the National Health Concept of Lithuania, which outlined the need of public health reforms as well as a stronger focus on health promotion and disease prevention [1]. The document provided a starting point for the development of public health training programs as well as legislation and regulations related to public health activities in the country. This paper reviews key national reports focused on the Lithuanian health system and other country-specific sources in order to outline the major institutional and financing challenges for health promotion in Lithuania, specifically for health promotion focused on older adults. The paper has a policy orientation and provides an overview of the topic for decision-makers in Lithuania, as well as for those in other countries in the region who could learn from the Lithuanian experience.

1. Legislation on public health and health promotion

The principal guidelines for the provision of public health services in Lithuania were first outlined in the Health System Law of 1994. In this period, the Public Health Surveillance Service was also established within the Ministry of Health, which replaced the Soviet-era sanitary-epidemiological services. The concept of public health was also introduced in the Lithuanian Health Program of 1998, which covered the period 1998–2010. Based on this program, in 2002, the Public Health Law and the Public Health Monitoring Law were adopted by the Lithuanian Parliament and later also the National Public Health Strategy 2006–2013 [2–4].

Other laws and regulations that guide the public health sector activities in Lithuania include the Law on Consumer Protection (1994), the Law on Prevention and Prophylaxis of Communicable Diseases (1996), the Law on Alcohol Control (1995), the Law on Tobacco Control (1995), the Law on Product Safety (1999), the Law on Food (2000), the Law on Dangerous Substances Control (2001) and the Occupational Health and Safety Law (2003) [3, 4].

In 2011, the Lithuania's Health System Development Dimensions 2011–2020 was adopted, which stipulates the directions for the development of the Lithuanian health system. The main objective of this document is to consolidate the efforts of different health care stakeholders for the creation of more efficient and competitive health services. The key areas covered by this document are health improvements and self-responsibility for health, expansion of the health care market and creation of fair competition mechanisms, increasing transparency, cost–effectiveness and rational use of resources, as well as evidence-based care and access to safe and quality services. The Alcohol and Drug Control Program was also adopted in 2011 [4].

The legislative and regulative base of the public health activities in Lithuania continue to develop also at present. In the period 2012–2014, the Lithuanian government approved the National Progress Program for 2014–2020, the state progress strategy Lithuanian 2030, the Lithuania Health Strategy 2014–2025, as well as the horizontal inter-institutional action plan "Health for All" as part of the Lithuanian 2030 Strategy [4]. The improvement of population health is seen in the latter document as a horizontal priority, which is key for the achievement of the three vertical priorities, namely smart economy, smart society and smart governance [2]. In 2015, the new Public Health Development program for 2016–2023 was approved. The legislation implementation is outlined further on in this paper.

2. Health system indicators

Before 1990, Lithuania had a health care system organized according to the Semashko model like all other Soviet Union republics. The system was hierarchical and strongly centralized with regard to planning, funding and service provision. The health care reforms during the transition period, resulted in the creation of a decentralized insurance-based health system predominantly funded by the National Health Insurance Fund (NHIF) based on compulsory insurance contributions. However, there are also high out-of-pocket payments, which are a cause for concern as they threaten the access to health care for vulnerable groups [3, 5]. With the decentralization of the health system in the 1990s, the provision of primary and social care, and public health activities at the local level became the responsibility of the municipalities. It was expected that the municipalities can better meet the needs of the communities. This became difficult to achieve in the recent years because public health spending was reduced as a result of the economic crisis [3]. In 2013, the total expenditure on preventive services was only 1.34% of the total expenditure on health (see **Table I**). Recently however, there were significant investments in the network of local health bureaus and central public health organizations.

Overall indicators:
Total health expenditure per capita: 725.74 Euro
Total health expenditure as % of GDP: 6.14%
Selected function as % of total health expenditure:
Curative care: 49.83%
Pharmaceuticals and other medical non-durable goods: 28.17%
Rehabilitative care: 3.12%
Preventive care: 1.34%
Information, education and counseling programs: 0.44%
Immunization programs: 0.13%
Early disease detection programs: 0.41%
Healthy conditions monitoring programs: 0.18%
Long-term care (health): 7.61%

Table I. *Health system indicators – Lithuania (data for 2013). Source: Based on the Eurostat database.*

3. Population aging indicators

An important demographic feature in Lithuania, is the considerable gender gap in life expectancy at birth, which is the highest among the EU member states [3]. In 2013, men were expected to live 68.5 years compared with 79.6 years for women (**Table II**). Besides, similar to most Central and Eastern European countries, a reduction in the population size was experienced in Lithuania due to the low fertility rate and substantial migration during the transition period as well as during the recent economic crisis [6]. At the same time, life expectancy has increased. The intensity of these demographic changes characterizes Lithuania as one of the fastest ageing countries in Europe [7]. Hence, there are concerns that the working-age population will decline dramatically in the coming years, which will bring a number of economic, labor market and social challenges, and could make it difficult to sustain the economic growth and improvements in living standards [6].

Life expectancy: Life expectancy at birth: 74.7 years Life expectancy at birth males/females: 69.2/80.1 Life expectancy at 65: 17.4 years Life expectancy at 65 males/females: 14.3/19.5
Healthy life years: Healthy life years at 65 males: 6.1 years Healthy life years at 65 females: 6.1 years
Share of older population: Proportion of population aged 65+: 18.7% of total population Proportion of population aged 80+: 5.1% of total population Old age dependency ratio 65+: 28.1%

Table II. *Population ageing indicators – Lithuania (data for 2014/2015).*

Source: Based on own review of literature.

4. Health status of older population

Like most Central and Eastern European countries, Lithuania scores below EU average on most of the main health indicators. Most importantly, over the past decades, mortality due to preventable causes, such as unhealthy lifestyle, was higher in Lithuania than in Western European countries [8]. Important concerns are the risk factors such as smoking, overweight and obesity, unhealthy nutrition habits, as well as physical inactivity [9]. To a great extent, this is attributed to the lack of inter-sectoral public health interventions, particularly in relation to public health and lifestyle changes [3]. Such unhealthy lifestyle trends are observed among older adults as well. Gender differences related to the health status of older persons in Lithuania, are also found. In particular, long-standing illnesses and limitations in usual activities due to health problems, are more prevalent among older women than among older men (**Table III**). These gender differences, to a certain extent, are attributable to the worse social position for elderly women as a result of lower level of socialization, education and social networks [10], and also to their longer life expectancy. Prevalent mental health problems among elderly include: anxiety, sleeping and eating disorders, depression, mania, Dementia (Alzheimer and Pick disease). An increased level of suicides among elderly is observed.

Prevalence of long-standing illness: Age group 65–74 males/females: 58.4%/64.7% Age group 75–84 males/females: 71.1%/81.5% Age group 85+ males/females: 89.0%/89.9%
Self-perceived long-standing limitations in usual activities due to health problems: Age group 65–74 males/females: 49.2%/57.3% Age group 75–84 males/females: 64.2%/77.1% Age group 85+ males/females: 83.0%/87.1%

Table III. *Health status of older population – Lithuania (data for 2014).*

Source: Based on the Eurostat and EU-SILC databases.

5. Potential sources of funding public health and health promotion activities

The health system in Lithuania has historically focused on hospital services and hospital treatment [4]. Overall, there is a lack of sufficient funding explicitly devoted to public health, which is also indicated by the low overall spending on preventive care compared with the spending on curative care, pharmaceuticals and other medical non-durable goods (see **Table IV**). Potential sources of funding for public health activities, including health promotion activities, comprise: state and municipalities' budgets; the NHIF budget, EU funds and other international funds, the health promoters' own funds, and other funding sources [4].

The funding of public health institutions is the responsibility of either the government or the municipality. National public health institutions, such as specialized public health institutions of the Ministry of Health, as well as the State Food and Veterinary Service, the State Labor Inspectorate, and the Drug, Tobacco and Alcohol Control Department, are financed through the state budget. Municipal public health bureaus are financed by both budgets allocated by the Ministry of Health and local budgets [4]. The Ministry of Defense and the Ministry of Interior in Lithuania also run health facilities.

Public health services provided by health care providers are financed through the NHIF budget, which comprises the citizens' compulsory insurance contributions and additional budget allocations by the Ministry of Finance to the Ministry of Health (as contributions for those insured by the state and as subsidies to cover the treatment of those no insured). At the primary health system level, some basic public health functions, such as health promotion, primary prevention and immunization, are carried out by GPs who are reimbursed by the NHIF. Also, GPs, medical specialists and dentists are involved in the service provision within the national screening programs financed by the NHIF. Among other things,

Source of funding	Beneficiary	Additional Comments
Taxes Including – general taxes	The general public or specific target group who use services provided by state public health institutions or municipal public health bureaus.	The general tax revenue allocated to public health is channeled form the Ministry of Finance to the Ministry of Health, and then used or redistributed by the Ministry of Health for public health services provision.
Health insurance premiums Including – social insurance – private insurance	Socially insured patients who use public health services provided by the NHIF.	Compulsory insurance premiums for the NHIF, which also cover some basic public health services provided by GPs, specialists or dentists. No role in public health for private insurance.
Other public institutions	Beneficiaries of public health services provided by other ministries.	e.g. the Ministry of Justice and the Ministry of Interior.
Other sources		
Funds from the employers	Employees.	Company projects or initiatives.
Households	Users of public health services covered by the NHIF or at the private sector.	Co-payments for some services under the NHIF or full fees in the private sector.
Foreign	International research projects and EU funds beneficiaries.	International research projects and programs funded by through the EU structural funds.
Others	Patients with chronic diseases.	Provided by NGOs and associations of patients with chronic diseases.

Table IV. *Sources of public health funding in Lithuania.*
Source: Based on own review of literature.

NHIF covers the provision of information on the issues of disease prophylaxis, and preventive health check-ups of persons eligible for the compulsory health insurance, as prescribed by the Ministry of Health [11].

There are also user charges for services provided under the NHIF, including public health and health promotion services (e.g. check-ups). There is no exemption for older persons from such charges. A small charge is required to register with a GP but if a patient chooses to change physician within six months after registration, there is a further administrative charge [11]. However, there are also quasi-formal (unregulated) charges set by the different providers as well as payments for services not included in the list of personal health care services financed by the NHIF [12].

The Ministry of Economy and Ministry of Finance also participate in decisions about investments in the health sector, including investments in the area of public health. Such investments can take place within the state investment programs or programs funded from the EU structural funds [4]. Thus, a substantial part of the public health interventions is carried out through national and international programs, as well as international projects. For example, substantial funding has been obtained for strengthening the capacities of the Lithuanian public health system to meet the standards of the EU regulations [4]. In 2013, there were about 50 projects in the field of public health, financed from the EU structural funds or other international funding mechanisms (the EU Health Program, WHO). These projects focused on the development of health impact assessment, professional training, communicable disease prevention, monitoring injuries, reducing health inequalities, strengthening preparedness for emergencies, improving radiation protection, expanding public health laboratory functions and improving mental health [3].

Nongovernmental organizations (NGOs) and associations of patients with chronic diseases are also active in the health promotion area but mostly in discussions, lobbying and dissemination of information [4]. There is a recent program for funding NGOs. Since 2016, NGOs are competing for grants from the State Health Strengthening Fund. Major priorities are prevention of alcohol consumption, mental health improvements and healthy lifestyle.

Private health insurance is not well developed in Lithuania. Such insurance mostly covers risks during a travel and stay abroad, as well as premium payments and payouts. No public health or health promotion activities are mentioned in the private health insurance packages offered.

6. Institutional analysis (sectors, organizations and their functions)

The main responsibility for the regulation and supervision of the health system in Lithuania, including public health activities such as health promotion and primary prevention, lies with the Ministry of Health. The ministry develops health policies and national health programs, coordinates the implementation of these policies and programs, and monitors the implementation outcomes. It also drafts legal acts and issues regulations related to the health sector. Moreover, the Ministry of Health and national public health agencies (e.g. Heath Education

and Diseases Prevention Centre) provide manuals and guidelines as well as training for professionals based on current empirical evidences. The Ministry of Health also runs 15 health care facilities and national public health institutions, and develops health care infrastructure. Major investments in the health sector are joint decisions of the Ministry of Health and the Ministry of Finance [4].

Due to recent reforms, there is a National Public Health Center with 10 regional departments subordinated to the Ministry of Health, which together with the Radiation Protection Center and the Health Emergencies Situations Center are responsible for public health safety, dealing with health emergencies, consumer rights protection, environmental safety, as well as prevention and control of communicable diseases.

There are also several public health bodies which function under the Ministry of Health, such as the Centre for Health Education and Disease Prevention, the Institute of Hygiene, the State Mental Health Centre, the National Public Health Surveillance Laboratory, Forensic agencies, Addiction Diseases Centers, and the Centre for Communicable Diseases and AIDS. Specifically, the Centre for Health Education and Disease Prevention carries out interventions in the area of non-communicable diseases and injury prevention, health promotion, physical activity and nutrition, environmental health and health specialist training. The interventions carried out by the Institute of Hygiene relate to the monitoring of population health and its determinants, measuring health inequalities and work environmental effect on health, health technology assessment in public health and occupational health, developing and testing innovative interventions in public health. The State Mental Health Centre implements mental health policy and public mental health measures to monitor and strengthen the population mental health [3, 4].

In addition, the National Health Board, which is subordinate to the Parliament, plays an important role in health policy implementation. The members of the board represent the municipalities, universities, NGOs and public health professionals. They coordinate the public health policy implementation carried out by the municipalities at the local level [4]. Furthermore, the Drug, Tobacco and Alcohol Control Department, which reports to the government, is the main institution responsible for tobacco and alcohol control.

Municipalities are responsible for setting up and implementing local health programs and public health activities. For this purpose, the municipalities have established Public Health Bureaus, which offer health promotion, public health monitoring, communicable disease prevention, prevention of non-communicable diseases and injuries, implementation and evaluation of public health programs [13]. At present, there are 45 bureaus in the country. Municipalities that do not have such bureaus, purchase public health services from other municipalities. The activities of a municipal public health bureau are monitored by the municipality board and the municipal director of administration. The board approves the health activity programs and sets their budget, and the director of administration monitors the implementation of the programs [3, 4].

The NHIF coordinates, supervises and audits the activities of the territorial health insurance branches, including the budget planning and control, and other financial decisions. The territorial health insurance branches are responsible for signing contracts with health care providers and pharmacies, reimbursing these providers, disseminating information about health insurance provisions, controlling the local service provision and financing municipal public health programs. The territorial health insurance branches have supervisory boards consisting of representatives from the Ministry of Health, the NHIF and the municipalities [4]. Screening programs including screening programs for disease prevention (such as cardiovascular disease prevention targeting population 40–55 year old males and 50–65 year old females) are funded through the NHIF.

Other stakeholders in the Lithuanian public health sector include voluntary organizations (NGOs such as the Red Cross Society and the Caritas Federation) and associations of patients with chronic diseases (the Diabetes Association, the Association of the Blind, the National Tobacco and Alcohol Control Coalition, the Lithuanian Heart Association). They are involved in the public debates and some of them are active in providing assistance, disseminating information and promoting proper treatment and prevention, as well as lobbying the interests of certain patient groups [4]. The Diabetes Association provides assistance to diabetic patients, promotes the study, the spread of knowledge and the proper treatment of diabetes, attempts to remove limitations of diabetics discrimination related to labor, studies and insurance. The Lithuanian Heart Association helps those who are suffering from heart disease, and those who want to avoid it, and it assists in improving physicians' professional skills related to heart diseases [4]. These stakeholders communicate with the state public health institutions described above, at both national and regional/municipal level.

7. HP4OP – Health Promotion for Older People (examples of good practices)

In Lithuania, there are various nationwide programs that have a direct or indirect relation to health promotion and prevention among people aged 50+. These programs are implemented by applying a complex approach contributing to solving the age-related problems [14]. However, direct financial-incentive programs related to health promotion that target the group of elderly are absent. Some activities in the field of "active aging" could be found in the frame of international projects. Overall, these activities are relatively few, scattered and lack sustainability.

The following cases describe good practice programs and projects in Lithuania that have a relation to the maintenance of the health and social activities of older persons:

- The National Screening Programs financed by the NHIF. Women up to 60 years are offered cervical cancer screening every three years, and those aged 50–69 years are offered breast cancer screening every two years. Men aged 50–75 years (and over 45 for those at risk) are eligible for prostate cancer checks every two years. In addition, biannual colorectal cancer screening is available for adults aged 50–75 years; annual screening for those with high cardiovascular risk is available to men aged 40–55 years and women aged 50–65 years [4].
- The National Anti-Discrimination Programs. These programs aim to foster the respect for human beings, including elderly persons, to support the implementation of the principle of non-discrimination and equal opportunities within the Lithuanian legislation, to raise social awareness and understanding of tolerance based on age, gender, race, nationality, language, origin, social status, religion, convictions or beliefs, sexual orientation, disability etc. The programs provide a platform for organizing various educational events and NGO supportive activities aimed at reducing discrimination. The initiatives of the Office of the Equal Opportunities Ombudsperson are some examples of such programs [14]. These programs can be especially beneficial for the elderly population because discrimination based on age (including the discrimination of elderly patients within the health system) has been observed in the country [7].
- Cross-border initiatives to support the employability of older people. These initiatives are funded by the European Social Fund. Examples of such initiatives in Lithuania are the EQUAL Network "Elderly 45+" and Older Workers Learning Net. The EQUAL Network "Elderly 45+", among other things, offers a toolbox "Ageing in the Professional Life", which includes instruments against age discrimination and promotion of the employment of older workers. This toolbox is designed with the participation of various European countries, including Lithuania. In addition, the Older Workers Learning Net includes educational institutions from Lithuania and other EU member states that cooperate in the development of e-learning programs for older workers. These e-learning programs are developed by taking into account the individual learning pace and living habits of the elderly individuals. Another goal of the network is to promote the benefit from business training of older workers among the employers [15].
- Being Healthy and Fit in Later Life (HEFILL) was a Grundtvig Learning Partnership Project provided by two seniors citizens associations from Lithuania and Austria, and two sport associations from Germany and Italy (2010–2012). This project aimed to: exchange experience and good practice in the field of sports and physical activities in the later life and to make proposals on how to increase the level of physical activity among inactive older people. The qualified trainers and adult learners attended workshops, where services, activities and exercises targeting seniors, were demonstrated. These physical activities and exercises were filmed and will be made available in a DVD format for further implementation into practice in project's countries [16].
- From Isolation to Inclusion (i2i-project) was an international project focused on the identification and improvement of measures that enable population groups at a multi-dimensional risk of social exclusion, to actively and fully participate in the community life. The project was implemented in cooperation between local authority and external experts. The target group was older people at the risk of isolation and poverty, with disabilities or chronic disease. The project aim was to strengthen initiatives by older people for older people and establish the supporting networks for these initiatives. The aim was also to facilitate and encourage social and political changes focused on the improvement of the life conditions of the target group [17].
- Cultural and artistic projects for older persons. The Lithuanian government provides annual funding for cultural and artistic projects, which aim to encourage the citizens, including elderly people, to participate in creative activities and cultural initiatives. As a result, many elderly are members of cultural institutions, such as cultural centers that offer amateur artistic activities, as well as public libraries that promote public access. There are also public libraries for disabled and elderly people supported at home. These libraries bring prints by bus to the homes of such persons, and set up out-patient items in remote rural areas, disabled communities, and society centers. To a certain extent, these projects help older people in dealing with social exclusion, employment, education and lifelong learning issues and enable them to foster their social connections [18].

8. National health promotion policy generally and addressed at the older people

As mentioned earlier, the concept of public health appeared in Lithuanian policy documents only in the 1990's. The Lithuanian Health Program was launched in 1998 and the Law on Public Health was adopted in 2002. This law is the key policy document that defines the public health principles in the country as well as the overall approach to the implementation of these principles. However, the law is criticized for its lack of clarity on how health-related lifestyle interventions have to be designed and delivered, and how to collaborate with other sectors in such interventions. In the terms of this law, the health sector is solely responsible for the poor population health. The amendments in the law in 2007 defined the public health functions at national and local levels, and provided a legal base for municipalities to establish the Public Health Bureaus [3]. In addition, the State Program for Developing Public Health Care at Local Level (2007–2010) made it possible to develop the services of these bureaus. Evidence suggests that the public health

bureaus have been effective in providing timely information about the population health status and increasing health awareness of the population [3].

In addition to the decentralization of public health service provision, a shift in the government health policy is also observed. While before the policy focus was on improving service quality and efficiency within the health care organizations, currently, the government emphasizes the issue of accessibility to health care and the role of public health in health policy. It is expected that by strengthening primary care, including public health services, more disease can be prevented and more patients can be treated at the primary level, which can help to increase the overall efficiency of the health system. However, the government has not yet undertaken any structural reforms in the health sector to realize this ambition [19]. Furthermore, the public health programs that are currently offered at the primary care level (such as screening programs), are opportunistic rather than population based even though they are describes as efficient [3, 20].

The lack of political will and the inability to implement policies can explain to a certain extent why Lithuania compares poorly with its neighbors in terms of health policy performance despite its well-trained public health workforce [21]. Also, a lack of institutional capacity in relation to the volume of responsibilities in the public health area has been observed. This problem has been partly resolved by the creation of the municipal public health bureaus, which have the responsibility to provide public health services to municipality residents [4].

One positive aspect of the municipal public health bureaus is their broad mission, goals and priorities to promote not only health but in general also the well-being of the community. They rely on local experience, community consultations and evaluations in planning their activities. This facilitates a partnership between the local governments, service providers, other stakeholders and the local community in the implementation of public health services and programs [3, 22]. However, the municipal public health bureaus face various challenges such as the lack of public health specialists, shortage of funds and lack of regulations on the cooperation between medical and public health specialists [3].

In 2009, the Lithuanian government approved the National Strategy for Health and Safety at Work (2009–2012) and the action plan for its implementation. The Ministry for Social Security and Labor, the Ministry of Health, the Ministry of Education and Science, and the Ministry of Agriculture collaborate in the implementation process. This collaboration extends to research institutions, universities, trade unions, associations, enterprises, organizations, and employers' organizations. Importantly, the strategy prioritizes the need of strengthening the occupational health and safety policy through the development of trainings, dissemination of information and economic incentives. This priority corresponds to the EU requirement for progressive and constructive regulatory framework [15]. The strategy also emphasizes the need to improve the education systems and information concerning health and safety for employers and employees, fostering the health prevention services for employees, improving the safety of workers who perform hazardous activities, e.g. through training projects. The strategy also recognizes that depression caused by health problems may lead to the incapacity to work. Therefore, the promotion of mental health in the workplace is an important policy objective [15].

The social and economic consequences of population aging are also national priorities in Lithuania. The main policy document in this area is the National Strategy of Overcoming the Consequences of Ageing, which promotes the principles of active ageing. It creates the conditions to maximize older people's quality of life, recognize their experience and skills and adequately ensure their future [14]. The document is praised for its holistic approach towards population ageing and for encompassing various aspects, such as the demographic situation, income and income guarantees for older people, employment, health and social services, opportunities for promoting well-being of older people, access to cultural life, transport facilities, personal security, participation in the activities of non-governmental organizations and promotion of a positive image of ageing [14]. The focus is on the implementation of cross-sectoral strategies and programs to address the population ageing issues. Various policy documents have emerged as a result of this focus: the National Demographic (Population) Policy Strategy, the National Anti-Discrimination Programs, the National Program on Equal Opportunities for Women and Men, the Programs for Reduction of Regional, Social and Economic Disparities, and the Rural Development Strategy for 2007–2013.

In 2014, the Action Plan for Healthy Ageing Protection in Lithuania 2014–2023 was approved by a ministerial order. This action plan aims to encourage older persons to take care of their health. The plan focuses not only on the prevention of the most prevalent health problems, such as cardiovascular disease, stroke, and diabetes, but also on the promotion of a healthy life-style, for example, physical activity. One shortcoming of this plan is that the group of older people is not explicitly defined, which brings questions about its implementation [4].

Another action plan approved by a ministerial order in 2014, is the Action Plan for Reducing Health Inequalities in Lithuania 2014–2023. This plan focuses of the socio-economic dimension of health. It aims to reduce the heath inequalities in certain Lithuanian regions and among different social groups, including older persons. It also covers actions related to inequalities in access to health care, disease prevention, and health promotion programs [4].

Conclusions and recommendations

The Lithuanian government has recognized the importance of public health and has placed a priority on this area. However, there are still many obstacles to be removed before the positive health effects of this new health policy orientation can be observed.

The key problems in public health services in Lithuania, including health promotion for older persons, relate to bureaucratic and financial constraints, lack of intersectoral cooperation, staffing problems and qualifications of the personnel responsible for implementing public health functions. The establishment, funding and activities of local public health greatly depend on the government's will and ability to implement public health policy, which are still week in Lithuania [3, 21]. According to the recent literature [23], there are certain failures in the functioning of the health care system in Lithuania. This is due to the absence of new national public health strategy as well as due to shortcomings on the local level [23]. Moreover, the public health legislation lacks clarity and fails to provide an adequate base for local-level evidence-based interventions. The assessment of local needs and the allocation of resources to public health measures depend on the knowledge and capacity of the municipalities. In Lithuania, a lack of institutional capacity in the area of responsibilities has been recognized at the local level. Concrete action plans, as those recently developed in the area of healthy aging and health inequalities, are needed to provide guidance on the public health policy implementation.

Overall, medical, cultural and social services for older people, as well as health promotion services, are underdeveloped in Lithuania and require the government's attention. Adequate access to such services is important for maintaining the health and well-being of older persons, and for providing them with an opportunity for an independent living [14].

There is also a need of a more comprehensive approach to the development of public health programs, and specifically in the area of health promotion. In particular, the focus should be on the evaluation of health promotion programs and the integration of this evidence in the development of subsequent programs. The evaluation should not only cover the program outcomes but also the implementation process to better understand how health promotion interventions can be best implemented in Lithuania. This also applies to future health promotion programs for older persons. Currently, there are only few good practices described in the public health area. Overall, multi-disciplinary research on primary prevention or health promotion is lacking. Cooperation between the health and non-health sectors is also absent [4]. Generation of empirical evidence on public health interventions and their dissemination among stakeholders that are directly or indirectly related to the public health sector, seem imperative for the improvement of population health in Lithuania.

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