Joint Action on Chronic Diseases and Promoting Healthy Ageing Across the Life Cycle

Good Practice in the Field of Health Promotion and Primary Prevention

Germany Country Review

Prepared by Bundeszentrale für gesundheitliche Aufklärung (BZgA)

CHRODIS
ADDRESSING CHRONIC DISEASES & HEALTHY AGEING ACROSS THE LIFE CYCLE

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This Country Review has been developed based on the questionnaire 'Good practice in the field of Health Promotion and Primary Prevention' developed by EuroHealthNet, as part of Work Package 5, Task 1 of JA-CHRODIS.

Background

JA-CHRODIS is a European collaborative initiative that brings together over 60 partners from 26 European Union Member States. The collaborative partners are from areas including the national and regional departments of health and research institutions. They work together to identify, validate, exchange and disseminate good practice approaches for chronic diseases across EU Member States, and facilitate the uptake of these approaches across local, regional and national borders. The focus of JA-CHRODIS is on health promotion and primary prevention, with an additional focus on the management of diabetes and multi-morbid chronic conditions. One of the key deliverables will be a 'Platform for Knowledge Exchange', which will include both an online help-desk for policy makers and an information portal which provides an up-to-date repository of best practices and the best knowledge on chronic care.

Work Package (WP) 5 focuses on these objectives in relation to the package's theme: *Good Practice in the Field of Health Promotion and Primary Prevention*. Furthermore, **the objectives of WP 5 are to promote the exchange, scaling up, and transfer of highly promising, cost-effective and innovative health promotion and primary prevention practices for older populations.** This will involve the identification, review, and validation of health promotion and primary prevention interventions for **cardiovascular diseases, stroke, and type 2 diabetes and their modifiable behavioural and social risk factors**. WP 5 will not only take into account lifestyles and health-related behaviours, but also the wider social and economic determinants that influence them.

The following **Country Review** provides an **overview of the health promotion and primary prevention situation and approaches for cardiovascular disease, stroke and type 2 diabetes in Germany**. This review outlines relevant policies; implementation mechanisms; good practices, and whether and how they have been identified; and forecasting and cost-effectiveness studies that have been undertaken on the topic in Germany. The authors of this report have also identified current gaps and needs of promotion and primary prevention of chronic diseases. The information in this report will contribute to subsequent WP tasks, namely the identification, exchange and transfer of promising practices to promote health and prevent strokes, cardiovascular disease and type 2 diabetes in Germany.

The Health Promotion and Chronic Disease Prevention Landscape

Policy design and implementation

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[1]; and non-governmental organisations, resulting in a multi-dimensional division of responsibilities between different organisations. Policies and health promotion and primary prevention implementation measures are initiated and developed at different levels and in two areas – within governmental organisations and self-administered bodies.

For example, the organisation and funding of pharmaceutical-focused primary prevention measures (such as vaccination and screening tests) is regulated through the code of social law, which is a federal law. The code of social law outlines that the statutory health insurance funds are responsible for primary prevention and health promotion; they are thus responsible for implementing primary prevention and health promotion measures which they then assign to service providers through negotiations and agreements.

Health policies are conceptualized on different levels and with the involvement of stakeholders from the government, self-administered bodies, the private sector (for profit and non-profit organizations) as well as civil society groups . Examples of policies initiated at some of the different levels include:

Federal government level (Bund): health promotion and prevention campaigns from the Federal Centre for Health Education (BZgA), an agency under the direct responsibility of the Federal Ministry of Health.

State government level (Länder): strategies and concepts developed by the State Associations for Health Promotion and Prevention[2]. These institutions aim to provide a

[1] A "self-administered body" (*koerperschaft)* in Germany is an organisation which is considered a legal entity by the state, but operates independently of the government, and does not receive funding from the government. Examples include the statutory health insurances and doctors chambers.

[2] In German: Landesvereinigungen/Landesarbeitsgemeinschaften/Landeszentralen für Gesundheitsförderung und Prävention

bridge between the policy sphere and the practical actors, to organise and coordinate the different stakeholders in prevention networks, joint actions, and projects.

Self-administered bodies: prevention guidelines that are developed and disseminated by the National Association of Statutory Health Insurance Funds. Another example is the development and dissemination of guidelines for practical and medical aspects of disease-specific prevention by the Association of the Scientific Medical Societies in Germany (AWMF).

All levels: the National Health Targets Process *health-targets.de* follows a participatory approach by uniting stakeholders from all areas towards commonly defined health targets in primary prevention.

Strategies and Programmes

Federal level

Coalition Agreement of the Federal Government of Germany

The 2013 coalition agreement provides key aspects of a legal draft for a federal law on prevention and health promotion to strengthen interventions in settings like schools, kindergartens, day care facilities, chronic care and nursing homes, and companies (Deutsche Bundesregierung, 2013, p. 82). In addition, the coalition agreement outlines that:

Existing regulations on the cooperation and coordination of stakeholders from the social health insurance funds, the states (Länder) and the communities will be improved.

Nation-wide health targets and standards in regards to quality management and evaluation will be considered. Screening measurements among children and activities for prevention and early diagnosis of disease in adults will be strengthened. Gender-related aspects will be emphasized in the development of medical guidelines.

National Health Target Process (Gesundheitsziele.de)

Structure[3]

Gesundheitsziele.de / *health-targets.de* started as a joint pilot project of the German Federal Ministry of Health and the GVG (Association for Social Security Policy and Research) in December 2000. Since 2007, *health-targets.de* has been a forum with more than 120 member organisations aiming to advance the development of the national health target process. Among them are: the federal government, the states (Länder), municipal associations, statutory and private health insurance funds, pension insurance funds, health care providers, self-help and welfare organisations and research institutes.

The organisational structure of *health-targets.de* comprises the steering committee, the board, the evaluation board and the working groups. The decision-making body includes the steering committee – for policy decisions concerning the overall process; and the board – for the operational level. The board sets up working groups for specific tasks, adopts the work results and makes recommendations to the relevant stakeholders in health politics. The evaluation board develops concepts for the health targets and the overall process.

Mission and Vision:

- Development of agreed-upon national health targets
- Networking and active participation of more than 100 stakeholders
- Discussion forum for future relevant health topics
- Steering instrument of health policy in Germany
- Framework for actions and recommendations in the implementation of prevention approaches
- Scientific evaluation

[3] Source: http://health-targets.de/cgi-bin/render.cgi?__cms_page=health_targets_in_germany
http://health-targets.de/cgi-bin/render.cgi?__cms_page=what_is_health-targets

Funding[4]

Health-targets.de is funded by a mix of stakeholders from the governmental, self-administered and the private spheres, in particular the Federal Ministry of Health (BMG), Health Ministries of the Länder (GMK), National Association of Statutory Health Insurance Physicians (KBV), German Hospital Federation (DKG), German Medical Association (BÄK), Association of Substitute Health Insurance Funds (vdek), Association of Local Health Insurance Funds (AOK), Guilds Health Insurance Funds (IKK), Company Health Insurance Funds (BKK), Association of Social Insurance in Agriculture (LSV), Association of Private Health Insurance (PKV), German Statutory Pension Insurance Scheme (DRV Bund), German Pension Insurance for Miners, Railway Workers and Seamen (DRV Knappschaft-Bahn-See), and Association for Social Security Policy and Research (GVG).

Health Targets:

1. Reduce the risk of developing type 2 diabetes, improve early diagnosis and treatment.
2. Reduce the mortality of breast cancer, increase the quality of life
3. Reduce tobacco consumption
4. Infant and child health: strengthen life competency, physical activity and nutrition
5. Strengthen health competence and patient sovereignty
6. Strengthen prevention, early diagnosis and sustainable treatment of depressive diseases
7. Healthy ageing
8. Patient safety

Stakeholders in the practical approach towards achieving these targets include institutions on the federal and state level, social health insurances and welfare bodies, private health insurances, health professionals as well as patients' representatives and self-help groups.

[4] Source: http://health-targets.de/cgi-bin/render.cgi?__cms_page=what_is_health-targets

Cooperation Network 'Equity in Health' (Kooperationsverbund gesundheitliche Chancengleichheit)[5]

The principal goals of the nationwide cooperation network are to improve equity in health and to support health promotion for socially disadvantaged populations in Germany. The cooperation network creates a professional framework and facilitates knowledge transfer as an interface between practice, science and decision-makers in politics.

Established in 2003 following an initiative by the Federal Centre for Health Education (BZgA), the activities of the Cooperation Network focus on four key fields of health promotion: in districts, for children, unemployed and older people.

The aims of the Cooperation Network are:

- To create transparency and make the diversity of practices more visible.

  All activities in the Network are presented on *www.gesundheitliche-chancengleichheit.de*. The website contains comprehensive information on social status-based health promotion, references to events, and interactive offers for professional exchange. One essential element of the Internet platform is the nationwide practice database, where more than 2,100 projects, programmes and networks can be searched online, sorted by good practice criteria.

- To disseminate good practice in Germany.

  The experience gained in good projects, programmes and networks offers valuable ideas for the further development of social status-based health promotion.

[5] http://www.gesundheitliche-chancengleichheit.de/english/

- To promote regional networking and the exchange of experience.

  With its Coordination Centres for Equity in Health, the Cooperation Network has an established structure in each state. The Centres support the transfer of information between the numerous players in the respective state, as well as collaboration between the federal and state level. Not least, they also advance quality development in social status-based health promotion.

A key outcome of the activities is a database for Good Practice interventions in the field of health promotion among socially disadvantaged groups.[6] The Good Practice criteria are developed out of quality criteria which have been identified through a structured evaluation process.

Based on („Cooperation Network ‚Equity in Health'", 2014), modified

Federal Centre for Health Promotion (BZgA)[7]

The Federal Centre for Health Education (BZgA) is the main governmental agency in the field of health promotion on the national level. It serves as a specialist authority under the direct

[6] http://www.gesundheitliche-chancengleichheit.de/praxisdatenbank/recherche/
[7] Source: http://www.bzga.de/home/bzga/tasks-and-goals/ ; edited

responsibility of the Federal Ministry of Health (BMG). BZgA was established by the Decree of 20.7.1967, according to which it has the following tasks, in particular:

- Elaboration of principles and guidelines relating to the content and methods of practical health education
- Vocational training and continuing education of persons working in the field of health education
- Coordination and intensification of health education in Germany
- International collaboration

BZgA's current work

1) The BZgA contributes to the development and implementation of national action plans and programmes

- For preventing infectious diseases, particularly HIV/AIDS and other sexually transmitted diseases
- For drug and addiction prevention (focusing on tobacco and alcohol prevention)
- For promoting child and youth health (healthy development; nutrition, exercise, mental health)

2) Performance of statutory tasks

- Sex education and family planning (basis: Pregnancy and Family Assistance Act)
- Education on the subject of organ and tissue donation (basis: Section 2, Transplantation Act)
- Education regarding blood and plasma donation (basis: Section 3 Para. 4, Transfusion Act)

3) Performance of national joint tasks with a population-wide impact that are necessary for implementing the key fields of education

- Evaluation and quality assurance
- Coordination and cooperation

Objective: Preventive Healthcare and Health Preservation

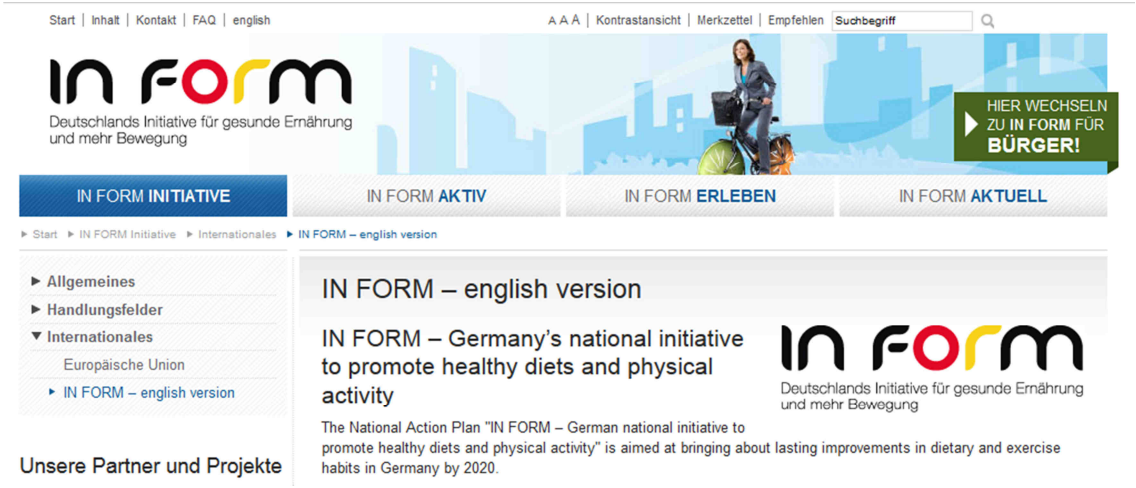
Preventive healthcare and health preservation are the two top-priority goals of the BZgA's work. Their measures and programmes contribute to reducing the incidence of new cases of disease in their key fields of education (primary prevention) and to improving the early detection of disease (secondary prevention), as well as to generally strengthening health-related potentials (health promotion). To this end, they strengthen people's knowledge,

attitudes and abilities, enabling them to behave healthily, recognise and avoid risks, and thus assume responsibility for their own health and that of others.

Effective and Efficient Prevention and Health Promotion

The fields of market observation, quality assurance and strategy development are of special importance with a view to effectiveness and efficiency. In addition, clear priorities have to be set, and the target groups and subject areas precisely defined. The aim is for the resources employed to achieve the greatest possible benefit in terms of health.

IN FORM – Germany's national initiative to promote healthy diets and physical activity



The National Action Plan "IN FORM – 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.

IN FORM aims to facilitate the "dialogue" between policy-makers, industry, the science community and civil society with regard for all questions concerning a healthy lifestyle and to encourage transparency, networking and co-operation. This, among other aspects, is reflected on the initiative's internet platform.

Objectives of the National Action Plan

With its National Action Plan, the German government aims to foster healthier environments for children to grow up in, to encourage adults to adopt healthier lifestyles and to see society as a whole enjoy a higher quality of life and physical fitness. The action

plan also intends to significantly reduce illnesses and diseases to which unhealthy lifestyles, unbalanced diets and lack of physical activity contribute.

To reach the aim of sustainably improving people's habits concerning diets and physical activity, the following actions shall be taken:

- Positive approaches towards healthy diets and sufficient physical activity shall be bundled and oriented towards the targets they have in common.
- Strategies and measures which include individual behaviours and take both the regional and national levels into consideration shall be developed.
- Structures shall be created which will enable people to lead health-sustaining lifestyles.
- Good practice projects shall be disseminated.

(IN FORM, 2014); shortened

National Strategy on Drug and Addiction Policy

The National Strategy on Drug and Addiction Policy was launched by the Federal Governmental Coalition in 2012.

The strategy takes recent developments in demography and society into account and addresses, for example, the growing challenge of addiction among older people. New trends and patterns in drug consumption were identified and taken into account.

New media and communication technology are recognized for their ambiguous role in drug and addiction prevention. On one side as a means for contemporary prevention approaches, and on the other side as a potential field of new addictive behaviour (e.g. internet addiction disorder and compulsive use of video games).

The national strategy addresses prevention methods to target groups through different approaches including early interventions, settings approaches (e.g. in schools and companies), and gender sensitive approaches.

The strategy entails plans for the organisation of addiction-related research, evaluation and counselling.

Specific goals and aims in the targeted areas are, for example:

<u>Alcohol</u>

- To strengthen parental competencies in regard to adolescents' and teenagers' alcohol consumption.

- To develop existing measures through the Federal Centre for Health Education (BZgA) that have showed to be successful, e.g. the campaign “Alcohol: Know your limits”.
- To strengthen early interventions in primary care.
- To foster occupational health projects for alcohol prevention.
- To promote situational abstinence in pregnancy.

Tobacco

- Development of counselling offers through health workers through wider availability of smoking cessation trainings.
- Evaluation of the medical treatment for smoking cessation in smokers with severe health conditions

Pharmacologic drug addiction

- Analysis of cognitive performance improvement drug abuse and mental wellbeing.

Gambling

- To strengthen the gamers’ protection and youth protection acts.
- To improve prevention of gambling addiction in the amendment of the gambling regulation.

Online addiction

- To improve the basis of data on compulsive and addictive use of the internet
- To strengthen media competency in adolescents and youth
- To strengthen support services for parents and teachers

Illicit drugs

- To strengthen prevention and health promotion in regards to newly emerged synthetic drugs as well as so-called “legal highs”.
- To strengthen targeted prevention offers in the young party cultures with a focus on risky mixed consumption (e.g. alcohol and synthetic drugs).

(Drogenbeauftragte der Bundesregierung, 2012), translated.

At the international level, Germany is an associated partner in the European Joint Action on Reducing Alcohol Related Harm (JA RARHA).

Tobacco

Tobacco use causes about 110,000 deaths per year in Germany. An additional 3,300 deaths are attributable to second hand smoke.

According to survey data from the Federal Statistical Office from 2009, about 14.7 million citizens over the age of 15 years smoke, equivalent to a share of 25.7%.

A gender difference exists in smokers: Among the male population about 30.5% are smokers, among the female population 21.2%. However, there is also a gender difference in the changes of smoking behaviour: While the share of smokers in the male population decreased by 5% since 1995, the share of smokers among the female population stagnated.

Tobacco policies

The reduction of tobacco consumption and a consequent protection from second hand smoke are urgent aims in health policy. The Federal Government of Germany tackles these challenges through comprehensive preventive, legal, and structural measures. This includes rising price policies, reduced access to cigarettes for children and adolescents, prevention campaigns, restrictions in public advertisement and non-smokers' protection in the workplace.

The Federal Government aims to reduce the share of smokers among youth to below 12% and among adults below 22%.

Campaigns

Several campaigns are addressing tobacco consumption. Examples on the national level are:

Smoke-free campaign ("Rauchfrei"-Kampagne)

- National campaign led by the Federal Centre for Health Promotion (BZgA) for the promotion of smoking cessation and smoke-free lifestyles among youth and adults.

- Class 2000 ("Klasse2000")
  A project for health promotion in primary schools to support the development of healthy lifestyles, including non-smoking.

- "Be smart – don't start" is a non-smoking contest targeted towards school classes with a special emphasis on the age group of 12 to 14 years. The programme is

supported by the Federal Centre for Health Education (BZgA), German Cancer Aid[8], German Heart Foundation[9] and other public and non-public institutions.
The participating classes agree through a "contract" to remain smoke-free for the following 6 months. Successful classes have a chance to win a range of prizes, up to a fully financed class trip. Since the start of the contests in 1997, more than 120,000 classes with over 3 million students have participated. About a third of the classes participate repeatedly in the contest. Low-threshold and scientifically evaluated materials are available for teachers.

- "Strengthening Children" ("Kinder stark machen") is a participatory initiative for the early prevention of addictive behaviours. The initiative targets children from age four on. The BZgA-run programme provides intermediaries like parents, sports clubs, schools and kindergartens with know-how and materials to strengthen early childhood development, resources and life competencies. The settings approach facilitates reaching marginalized and vulnerable groups.

Diabetes Care

The provision of care for diabetes patients is at the highest level in Germany. There have been many policy decisions that contributed to the excellent standard of care. These were both disease-unspecific and disease-specific actions. As for the latter, the introduction of Disease Management-Programmes for type 1 and type 2 diabetes mellitus was of particular significance.

Future activities are currently under discussion.

Environmental Health Action Programme

The Environmental Health Action Programme was launched in 1999 under the idea that health and environment are interdependent, and that environmental preservation is equivalent to sustainable health prevention.

The programme is a joint cooperation of three federal ministries (Ministry of the Environment, Nature Conservation, Building and Nuclear Safety, Ministry of Health, and Ministry of Food and Agriculture) and four governmental authorities (Federal Office for Radiation Protection, Federal Institute for Risk Assessment, Robert-Koch Institute, Federal Environment Agency). It links the policy areas of environment protection, health, and

[8] Deutsche Krebshilfe
[9] Deutsche Herzstiftung

consumers' protection on a high level. The action programme is embedded in the European Environment and Health Process (EHP).

Strategies, aims and measures include:

- Public Information on environmental-related health risks and healthy diets
- Research projects e.g. on pollutant load and pollutant sensitivity of children and adolescents, indoor chemical and biological contamination, environmental medicine, etc.
- Protection of children and adolescents from harmful environmental influences and pollutants
- Improvement of risk assessment and risk communication
- Implementation of environment and health pilot projects on the local level

State level

The 16 states (Länder) hold the legal responsibility for health and each of them follows its own approach for prevention and health promotion. Most of the states have implemented associations for health promotion and prevention (Landesvereinigung für Gesundheit) which include stakeholders from all spheres and multilateral funding of health promotion measures. These associations serve as state-funded coordination panels but allow shared models of funding from various stakeholders in the actual projects. They conceptualize and implement the policies for primary prevention and health promotion, often through a dedicated state working platform on prevention (Landesarbeitsgemeinschaft für Prävention/ Gesundheitsförderung) which includes stakeholders from different areas like social welfare bodies, science, politics, etc. The detailed structures and financing mechanisms differ in each of the 16 states.

Community level

Healthy Cities Network

The Healthy Cities Network in Germany emerged out of WHO's healthy city movement and in the wake of the 1986 Ottawa Charter on Health Promotion. The network is a voluntary association of 75 cities and communities that serves mainly as an action and learning platform to support the implementation of concepts on the local level.

Generally, the responsibilities for funding, conceptualizing and implementing primary prevention and health promotion are separately organised. While primary prevention is legally assigned to the responsibility of the statutory health insurances, health promotion at the federal level is carried out through the BZgA under the responsibility of the Federal

Ministry of Health. At the regional and local level, health promotion is implemented and sustained through a broad variety of stakeholders from public institutions, networks and civil society organisations (Hurrelmann, Klotz & Haisch, 2014, p. 380).

The Role of the BZgA in Health Promotion

The Federal Centre for Health Education works at the national level on the following topics:

- HIV and STI Prevention
- Sex Education and Family Planning
- Prevention of Child Abuse
- National Centre on Early Intervention
- Drug Prevention
- Prevention of Nutritional Diseases
- Organ and Tissue Donation
- Child and Youth Health
- Women's Health and Health Promotion
- Men's Health and Health Promotion
- Healthy Ageing
- Health Promotion for Migrant Populations
- Health Equity

Health-targets.de

The nation-wide process *health-targets.de* aims to provide a broader health policy by uniting stakeholders from health promotion and primary prevention.

Adressing risk factors for cardiovascular diseases and type 2 diabetes

The aforementioned policies for health promotion – *health-targets.de*, IN FORM and Cooperation Network 'Equity in Health' – address the common underlying risk factors for cardiovascular diseases and type 2 diabetes. Additionally, one of the eight health targets is dedicated to reducing the prevalence and improving early diagnosis of diabetes. In regards to primary prevention, separate policies for cardiovascular diseases and type 2 diabetes exist on the level of medical and pharmacological primary prevention.

Monitoring and evaluation

The national health target process includes an evaluation framework on two levels: one for the individual targets and one for the national health target process as a whole.

The Cooperation Network 'Equity in Health' does not evaluate itself but instead provides an evaluation framework and evaluation guidelines for the projects that are conducted by the network partners.

Focus on health inequalities and the socio-economic gradient

The Cooperation Network on 'Equity in Health' includes practices that aim to tackle the social gradient and primarily improve the health and health resources of socially disadvantaged groups.

Focus on older populations (65 and over)

Healthy and Active Ageing

BZgA runs two programmes to promote and support healthy ageing. One of the programmes ('Gesund und aktiv älter werden') primarily addresses the intermediaries in the field of healthy ageing. The measures of the programme aim to strengthen health promotion among older people especially through settings-based approaches. For this matter, the BZgA cooperates with relevant actors at the state and regional level and maintains an online knowledge hub to support health literacy.[10] Every year, a series of multiple regional conferences are held on health promotion in the context of healthy ageing to foster networking between stakeholders.

The second programme ('Altern in Balance') aims to support healthy ageing through primarily addressing people of both sexes in the target age group of 65 to 75 years. The programme aims to promote physical activity during everyday life and strengthen individual resources through effective individual health promotion and prevention, communicated through various means, e.g. print media, posters and online resources.

[10] www.gesund-aktiv-aelter-werden.de

Health-targets.de

One of the eight national health targets is dedicated specifically to healthy ageing.

Gender dimension

Gender and Health Promotion

BZgA operates two gender-targeted health promotion platforms for men and women addressing gender-specific topics.[11] The online platforms are complemented through annual gender health congresses and aim to improve networking of stakeholders in the different gender-related areas.

Health-targets.de

For the definition of a 'health target' in the context of the national health targets strategy, gender mainstreaming is one of three cross-sectional selection criteria (together with 'evidence base' and 'health equity').[12]

[11] http://www.frauengesundheitsportal.de/
http://www.maennergesundheitsportal.de

[12] http://gesundheitsziele.de/cgi-bin/render.cgi?__cms_page=was_ist_gz_de/arbeitsweise

Main Public Bodies and other Organisations

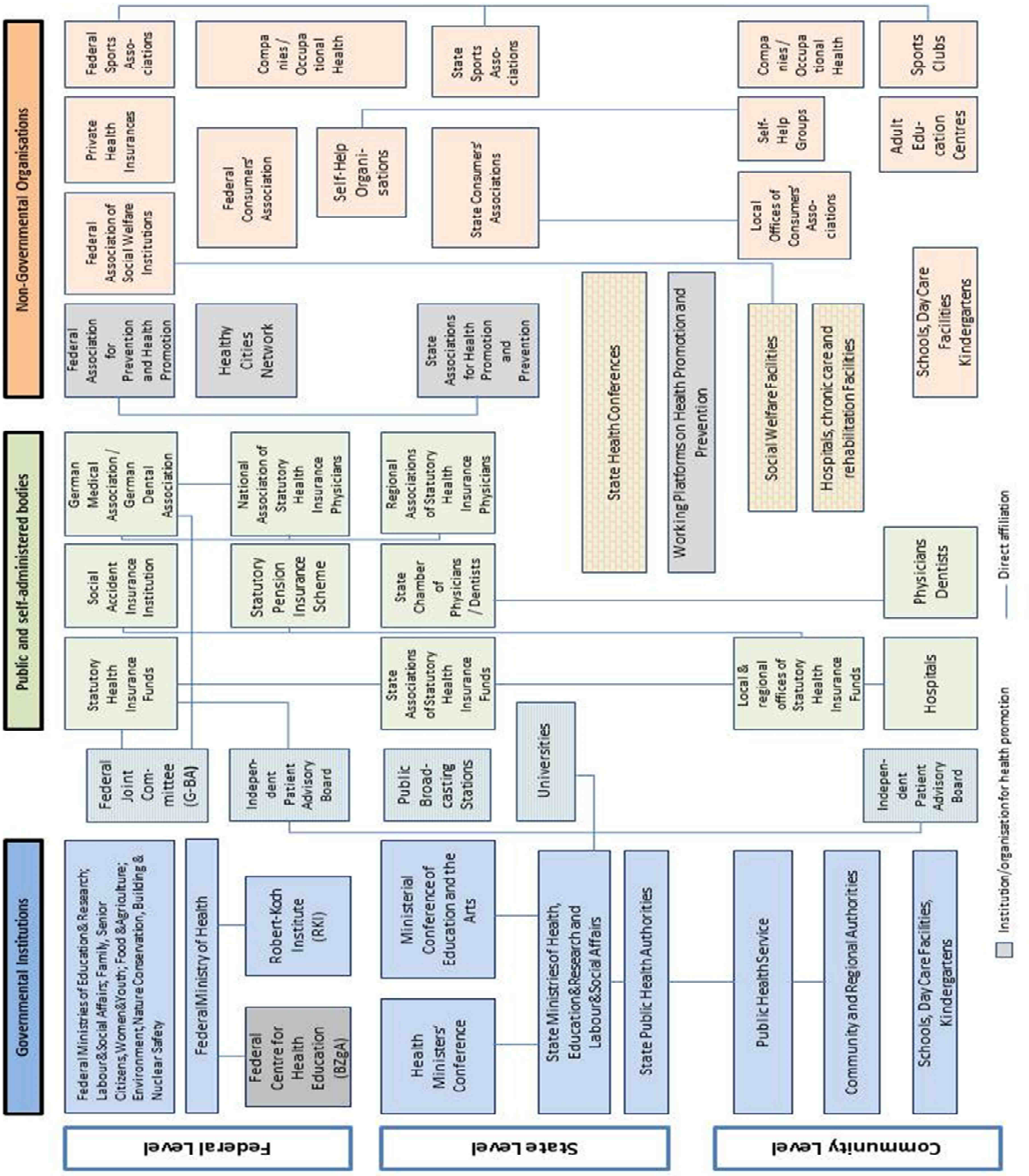


Chart based on (Blümel, 2011, S. 15); modified and translated

Financing

The key legal regulation for the financing of prevention (primary, secondary and tertiary) is the code of social law which is a federal law. The code of social law distributes the responsibilities for the financing of prevention (primary, secondary and tertiary) between different bodies and institutions from different spheres (public, self-administered, etc.). The basic principle is that the institution which carries the risk, if the prevention fails, is the one who finances the respective prevention methods (Hurrelmann et al., 2014, S. 412). But the allocation of the responsibility is not always clearly distinguishable between the different bodies, like the statutory health insurance funds, accident health insurance funds, statutory care funds, etc., and depends also on the target group(s). This results in different legislation and regulations at the federal and the state level.

The situation is even more complex when it comes to health promotion. The following table provides a simplified overview.

Table 1: Funding and financing of health promotion and primary prevention in Germany	**Governmental bodies**	**Public and self-administered bodies**	**Independent platforms and NGOs**	**Private sector**
National Level (Bund)	Budgetary funds of the Federal Ministries of Health, Family, Research, Interior, Nutrition, Labour and Social Affairs; Federal Centre for Health Education[13]	Financial resources of the statutory health insurance funds, statutory pension insurance fund, and statutory accident funds Financial resources from the physicians' self-administered bodies (National Medical Council)	Federal Association for Prevention and Health Promotion;[14] German Nutrition Society;[15] German Olympic Sports Confederation[16] Financial resources from foundations (e.g. Robert Bosch Foundation, Bertelsmann Foundation)	Major companies [according to the legal code on health and safety at work] Private health insurance funds[17]
State Level (*Länder*)	Budgetary funds of the state ministries of Health; Social Affairs; Interior; Culture; and Family State public health authorities;[18] State institutes for teacher education and school development[19]	State associations of the statutory health and accident insurance funds; State Medical Councils	State Associations for Health Promotion and Prevention;[20] Lottery Foundations[21]	Big companies; Donations and initiatives from private individuals
Regional and community level	Funding from community budgets; Local public health authorities; School, kindergarten and day care administrations	Financial resources of the statutory health and accident insurance funds	Health centres; local health initiatives; local foundations; sports clubs	Small- and medium companies; Donations from initiatives and private individuals

Table based on (Altgeld, 2010), modified and translated

[13] Bundeszentrale gesundheitliche Aufklärung
[14] Bundesvereinigung Prävention und Gesundheitsförderung (BVPG) e.V.
[15] Deutsche Gesellschaft für Ernährung
[16] Deutscher Olympischer Sportbund
[17] Private Krankenversicherung
[18] Landesgesundheitsämter
[19] Landesinstitute für Lehrerbildung (und Schulentwicklung)
[20] Landesvereinigungen/Landesarbeitsgemeinschaften/Landeszentralen für Gesundheitsförderung und Prävention
[21] Lotto Stiftungen

In 2012, the overall health costs in Germany were just above 300 billion Euros, from which 3.6% (10.9 billion Euros) were invested in prevention. This includes general health safety concerns like hygiene and disease surveillance, vaccinations, health counselling for HIV (2.3 billion Euros), health promotion (5.8 billion Euros) and screening/early diagnosis (10.9 billion Euros) (Statistisches Bundesamt, 2014).

Identifying Good Practices and Existing Databases

The multitude of existing methods and approaches to prevention and health promotion comes with an equivalently broad need for approaches for quality assessment. The BZgA, in cooperation with other stakeholders in the field of health promotion in Germany, has developed and transferred different tools and toolkits for the evaluation of interventions in various settings. The heterogeneity in this area led to the need for a structured overview on the existing methods of quality assurance in health promotion which, for example, is provided through the web portal www.evaluationstools.de.

Another step to tackle the need for a structured approach was the establishment of the Cooperation Project on Quality Assurance of Projects for Health Promotion in Settings.[22]

In 2004/2005 the BZgA-led nation-wide Cooperation Network 'Equity in Health' developed twelve criteria of good practice which are presented here:
http://www.gesundheitliche-chancengleichheit.de/english/

These criteria are the basis of a selection process which has, in the meantime, identified 118 examples of good practice. A detailed description of these examples, the background and their strategies for implementation are accessible through a good practice database:
www.gesundheitliche-chancengleichheit.de/praxisdatenbank

'Equity in Health' coordination offices were installed in all 16 states. They disseminate the twelve good practice criteria and use them in the activities of the state associations for health. Examples of good practice are described in a multi-step selection process. The process is based on documents developed by the projects with information on how they work, including interviews and visits to selected projects.[23]

[22] http://www.gesundheitliche-chancengleichheit.de/qualitaet-im-setting/
[23] Original information (in German) provided by Stefan Bräunling (Geschäftsstelle des Kooperationsverbundes "Gesundheitliche Chancengleichheit"); translated

In Germany, consistent standards or procedures currently do not exist for the assessment and systematic selection of health promotion projects with consecutive (long-term) funding.

According to the code of social law, the statutory health insurance funds are responsible for funding and implementing primary prevention measures. The National Association of Statutory Health Insurance Funds developed a guideline for the funding of primary prevention projects which uses the good practice criteria of the cooperation network 'Equity in Health' (GKV Spitzenverband, 2010). It additionally lists criteria to support interventions in settings like schools and neighbourhoods.

Case Example: Quality criteria for health promotion and primary prevention interventions tackling obesity in children and adolescents

Overweight and obesity in children and adolescents is a common finding in Germany and implies a high demand for interventions that build supportive environments and facilitate healthy lifestyles. The key question is how these interventions need to be designed to effectively reach out to the people in need and to contribute to a normal weight development in the long term.

Between 2008 and 2010 a working group moderated by the BZgA gathered the current knowledge on the quality of preventive measures for discussion in expert rounds and tests with practitioners. The following recommendations and criteria are based on quality assurance systems and complemented through scientific data and practical experiences from the field of obesity prevention.

Develop a common understanding

1. All stakeholders, including ideally the target group, develop and document a common understanding of health, its determinants and the different aspects of prevention.

2. a) The need for health promotion and an average weight development is evidence based and documented.

2. b) Existing health promotion measures and structures within the target setting or organisation are assessed.

Define target group and aims

3. The target group is defined on the basis of its need. Primary target groups may be:

- Pregnant women and their peer group(s)
- Children and their peer group(s)
- Adolescents and their peer group(s)
- Parents
- Intermediaries/ disseminators

4. The specific characteristics and strengths of the target group are recognized and documented.

5. The target group is involved in the planning and implementation of the measures (participation).

6. Primary aims and sub-goals of the intervention are defined. Possible areas of activity for which aims should be defined:

- Promoting healthy nutrition and breast feeding as well as building a supportive environment
- Promoting physical activity and building a supportive environment
- Strengthening of mental health and coping of stress. Building of a supportive environment.
- Reduction of inactivity especially in regards to screen time and building of a supportive environment
- Promoting tobacco cessation in pregnancy and building of a supportive environment

Conceptualization and implementation

7. A concept on how to reach main- and sub-goals as well as the target group is provided in a written form.

8. Avoidance of stigmatization and potentially unwanted side-effects is taken into account.

9. The intervention includes socio-structural activities.

10. a) Low-threshold approach

10. b) Access entry points and teaching methods are target-group oriented.

11. The strengthening and development of individual, familiar, and social capacities are key elements of the intervention.

12. a) Sufficient human resources for the implementation are provided

12. b) Accountability and responsibility of all stakeholders are clear and assigned.

12. c) Staff and other participants are sufficiently trained and qualified in regards to the target group, the aims and the setting as well as the content and teaching methods

13. The structural and organisational conditions facilitate the implementation and the achievement of the aims.

14. Funding of the intervention is secured.

Documentation and Evaluation

15. a) The content and the progress of the intervention is documented (process documentation).

15. b) How far the defined aims and goals are met is documented (result documentation).

15. c) Changes are documented (behaviour, structure, process, etc.).

Evaluation and Reflection

16. a) The expected and actual results are listed, critically assessed and evaluated

16. b) Processes are critically assessed and evaluated

16. c) Expenditures versus effects are critically assessed

Pursue and sustain successful interventions / optimize measures

17. Relations to and cooperation with other partners are maintained (networking)

18. Successful interventions are continued through the organisation and participants (continuity)

19. Contents and findings of the successful interventions are disseminated (transferability and transparency)

(Bundeszentrale für gesundheitliche Aufklärung (BZgA), 2010); translated

Database on Good Practice in health promotion for socially disadvantaged populations

The following twelve criteria (see diagram below) have been developed by an advisory committee within the Cooperation Network 'Equity in Health' on the basis of a discussion between stakeholders from science and practice.

Three key principles are taken into account for the criteria:

1. The criteria are aligned with the general aim of the project: The consideration of the needs, resources and burden of socially disadvantaged target groups should lead to a reduction in health inequities.
2. The criteria reflect WHO's holistic concept of health promotion, which aims to strengthen health resources of individuals on different levels. The purpose of health promotion is to enable individuals to gain control over the factors which are

determining their health. The settings approach plays a key role because it supports the strengthening of individual resources as well as an active influence on a healthy environment.

3. The criteria include the growing interest of donors and funding bodies, experts, and target groups in the quality of projects and in the legitimacy of how public money and donations are spent.

The Twelve Good Practice Criteria for Health Promotion for socially disadvantaged populations (Kooperationsverbund Gesundheitliche Chancengleichheit, 2013; translated)

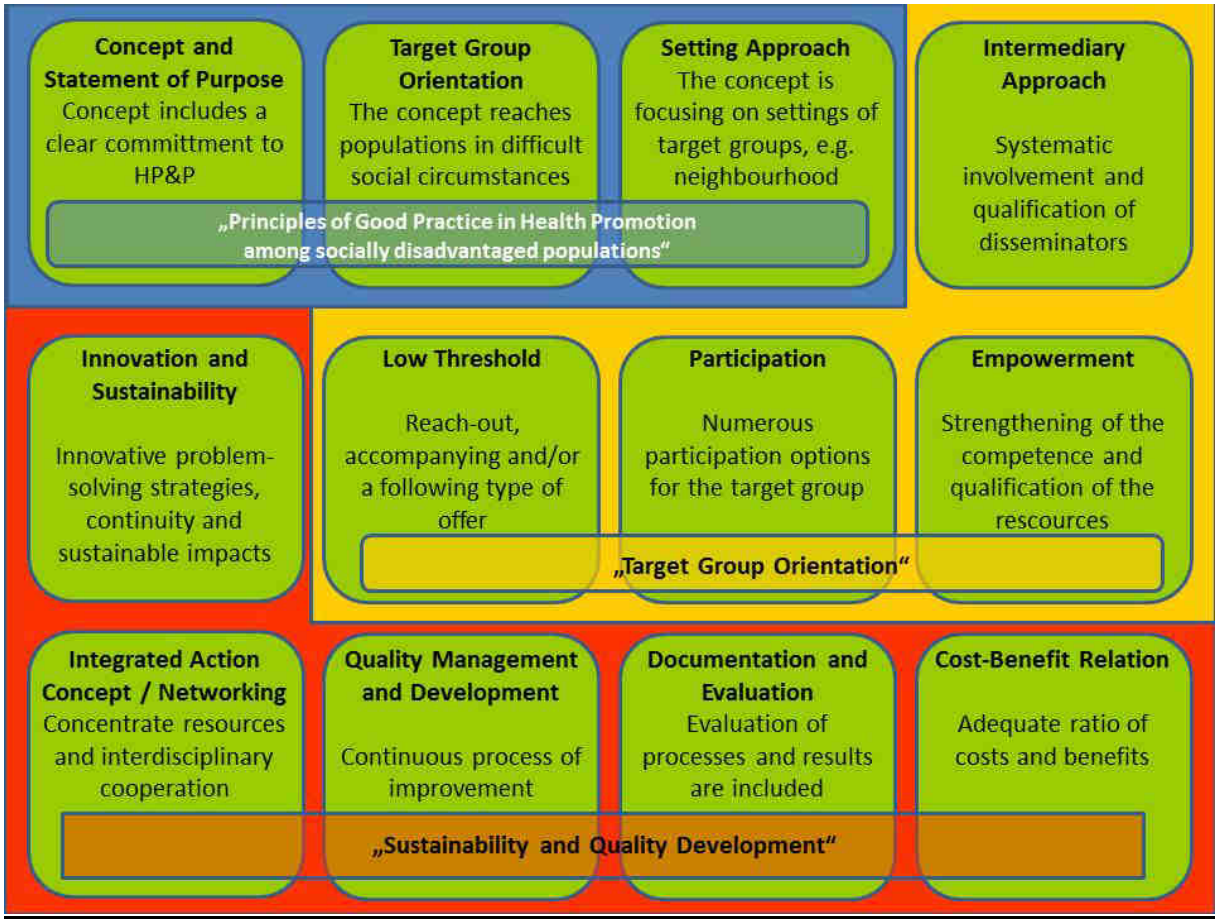


Diagram of criteria of good practice for health promotion for socially disadvantaged populations

A. Inclusion criteria

1. Concept and Statement of Purpose

The concept includes a clear commitment to health promotion and/or primary prevention with a respective target statement.

The written concept is given out to all colleagues. It includes a clear reference to the reduction of health inequalities related to the social status. The concept is used as a guideline and reference for the planning and evaluation of the daily work.

2. Target Group Orientation

The concept includes a precise definition of the target group which is supposed to belong to one or multiple socially disadvantaged groups.

Potential target groups are:

- All individuals within a setting, e.g. school, kindergarten, neighbourhood
- Individuals with a low social status, e.g.
  - low professional status (e.g. unskilled workers)
  - low income (e.g. welfare recipients)
  - low educational background (e.g. no qualified school degree)

Potential target individuals are:

- single parents
- asylum seekers and sans-papiers
- refugees with limited German language skills
- migrants with limited German language skills
- long-term unemployed persons
- individuals with disabilities
- pregnant women in difficult social circumstances
- detainees and ex-convicts
- individuals with drug addictions
- homeless individuals

The activities of health promotion are aimed towards the sustainable improvement of the health-related circumstances of the target group (settings approach). The project takes the special needs and resources of this group/ these groups into account. It reaches out specifically to this group / these groups (low-threshold).

B. Selection criteria

3. Innovation and Sustainability

The concept follows an innovative approach or contains innovative aspects and aims to maintain and continue successful components of the concept in a sustainable way.

Both aspects – the innovative character as well as the continuity – can be considered as relevant for "good practice". These two aspects might be contradictory in some circumstances as innovative aspects are more likely to be developed out of short-termed projects and continuity is more likely achieved within regular projects.

Both components need to be considered and it has to be assessed which aspects are crucial for the transfer into other projects.

Projects can be both fixed-term or continuous. Sustainability is a key aspect in this in regards to the structures of the project as well as the impact on the target group.

4. Intermediary Concept

The intermediary concept determines the way that selected communicators are involved in a project and how they are qualified for their tasks. Intermediaries and communicators are capable of informing about the project and enable access to the project's offers. They are also able to implement parts of the project themselves.

Communicators of health promotion projects are professionals (e.g. physicians, social workers, administrative staff) or selected and peer-accepted credible members of the target group. These persons, groups and/ or institutions are capable of effectively supporting a project through their professional network and/or professional activities by increasing the outreach of the project, by supporting its implementation or contributing to the building of new structures.

5. Low Threshold

Type 1: The concept of the project aims to reach out to the target group, and accompanies and blends into the target group's setting (settings approach). Low threshold projects approach the target group directly to enable a connection at the earliest possible time. A clear perception, precise understanding and sound knowledge about the everyday life and the living conditions of the target group are basic prerequisites in this approach.

Type 2: The low threshold work is characterized by a reflection on the hurdles and hindrances in the target group's access to the project offers with the aim to reduce and avoid these obstacles.

To increase the target group's access to the project's offers the following areas of potential hindrances are taken into consideration:

- Organisational circumstances, e.g. time, location, costs, bureaucracy
- Content of the offer, e.g. addressing of needs, target group adequacy and culturally appropriate conveyance of content
- Other factors, e.g. the knowledge of the existence of the project

This requires a precise perception, sound knowledge and understanding of the target group's living and social situation as well as a precise differentiation of the target group (target group defining conception).

6. Participation

The idea of participation in this context includes active engagement and competency in decision making processes in all regards of the management of life.

The target group should be empowered to define its own needs as well as wishes and ideas in the planning and implementation of the health promoting activities. Participation is a dynamic development process in which the target group continuously gains competencies for the active involvement in decision processes.

7. Empowerment

The intervention aims to support the target group(s) in an autonomy-developing process by the development of individual and collective action strategies.

This process connects to and develops the strengths and resources of the target group(s).

8. Settings Approach

The settings approach describes the path towards the creation of a "healthy living environment". For the implementation of a settings approach, three aspects are crucial:

- Strengthening of competencies and resources of the individuals living in the setting (individual level – 'behavioural prevention')
- Creation of a health promoting environment (structural level – 'structural prevention')
- Involvement of all individuals and/or groups within the setting

9. Integrated Action Concept and Networking

The connection to other actors in a local and professional environment contributes to an effective integration into the existing health promotion landscape.

Systematic networking efforts foster the exchange of information, mutual support and cooperation. Active involvement in continuously working local networks like neighbourhood fora or topic-related work groups contributes to the sustainability and transparency of the networking activity.

10. Quality Management

The aim of quality management and development is to align health promotion interventions with existing needs and to ensure that the conceptualization, implementation and further development are adequate for the target group. This is a continuous process of reflection and learning. Quality is not seen as a static entity but repeatedly evaluated, improved and developed. A target group-oriented perspective and the participation of affected people and individuals are important prerequisites for successful quality management and

development. The quality processes can be conducted internally through project workers or with external support.

The following areas have to be tested on a regular basis for potential improvements:

- Planning: Basics of the concepts, e.g. needs-analysis, definition of target group(s), definition of aims and goals
- Structures: Structural circumstances, e.g. rooms, required competencies of staff, finance and funding (including funding for quality processes itself)
- Processes: Work style, e.g. conflict management, participation of the target group, joint working efforts, low threshold approach
- Results: Impacts, especially in regards to the previously defined aims (documentation and evaluation), e.g. behavioural change within the target group, increased satisfaction with the offers, structural anchorage of the health promotion structures

11. Documentation and Evaluation

Evaluation and documentation support the development of quality in the project. They aim to structure and support work flows as well as to evaluate the defined targets during the project duration.

The documentation reflects the contents and results of the work processes to make it transparent to outsiders, e.g. by meeting minutes, event protocols, etc.

Evaluation builds on the documented information, to analyse and evaluate it on the background of the defined project targets. Evaluation types can be internal (self-evaluation) and external.

12. Cost-Benefit Ratio

The costs have to remain within an appropriate relation to the benefit. If feasible, a financial ratio can be applied.

Forecasting Studies

"Prediction models for incident type 2 diabetes mellitus in the older population: KORA S4/F4 cohort study" (Rathmann et al., 2010)

Summary

The aim was to derive Type 2 diabetes prediction models for the older population and to check to what degree addition of 2-h glucose measurements (oral glucose tolerance test)

and biomarkers improves the predictive power of risk scores which are based on non-biochemical as well as conventional clinical parameters.

Age, sex, BMI, parental diabetes, smoking and hypertension were selected for model 1. Model 2 additionally included fasting glucose, HbA1c and uric acid. The same variables plus 2-h glucose were selected for model 3. The area under the receiver operating characteristic curve significantly increased from 0.763 (model 1) to 0.844 (model 2) and 0.886 (model 3) ($P < 0.01$). Biomarkers such as adiponectin and insulin did not improve the predictive abilities of models 2 and 3. Cross-validation and bootstrap-corrected model performance indicated high internal validity.

This longitudinal study in an older population provides models to predict the future risk of Type 2 diabetes. The OGTT, but not biomarkers, improved discrimination of incident diabetes.

"An accurate risk score based on anthropometric, dietary, and lifestyle factors to predict the development of type 2 diabetes" (Schulze et al., 2007)

Summary

We aimed to develop a precise risk score for the screening of large populations for individuals at high risk of developing type 2 diabetes based on noninvasive measurements of major risk factors in German study populations.

Information on age, waist circumference, height, history of hypertension, physical activity, smoking, and consumption of red meat, whole-grain bread, coffee, and alcohol formed the German Diabetes Risk Score (mean 446 points [range 118–983]). The probability of developing diabetes within 5 years in the EPIC-Potsdam study increased from 0.3% for 300 to 23.2% for 750 score points. The area under the receiver-operator characteristic (ROC) curve was 0.84 in the EPIC-Potsdam and 0.82 in the EPIC-Heidelberg studies. Correlation coefficients between the German Diabetes Risk Score and insulin sensitivity in non-diabetic individuals were −0.56 in the TÜF and −0.45 in the MeSyBePo studies. ROC values for undiagnosed diabetes were 0.83 in the TÜF and 0.75 in the MeSyBePo studies.

The German Diabetes Risk Score (available at www.dife.de) is an accurate tool to identify individuals at high risk for or with undiagnosed type 2 diabetes.

Cost-Effectiveness Studies

"Should Health Insurers Target Prevention of Cardiovascular Disease?: A Cost-Effectiveness Analysis of an Individualised Programme in Germany Based on Routine Data" (Aljutaili et al., 2014)

Summary

Cardiovascular diseases are the main cause of death worldwide, making their prevention a major health care challenge. In 2006, a German statutory health insurance company presented a novel individualised prevention programme (KardioPro), which focused on coronary heart disease (CHD) screening, risk factor assessment, early detection and secondary prevention. This study evaluates KardioPro in CHD risk subgroups, and analyses the cost-effectiveness of different individualised prevention strategies.

The cost-effectiveness of KardioPro in the group at high risk of CHD was €20,901 per event-free year; in the medium-risk group, €52,323 per event-free year; in the low-risk group, €186,074 per event-free year; and in the group with known CHD, €26,456 per event-free year. KardioPro was associated with a significant health gain but also a significant cost increase. However, statistical significance could not be shown for all subgroups.

The cost-effectiveness of KardioPro differs substantially according to the group being targeted. Depending on the willingness-to-pay, it may be reasonable to only offer KardioPro to patients at high risk of further cardiovascular events. This high-risk group could be identified from routine statutory health insurance data. However, the long-term consequences of KardioPro still need to be evaluated.

"Economic Evaluation of Lifestyle Interventions for Preventing Diabetes and Cardiovascular Diseases" (Saha, Gerdtham & Johansson, 2010)

Summary

Lifestyle interventions (*i.e.*, diet and/or physical activity) are effective in delaying or preventing the onset of diabetes and cardiovascular disease. However, policymakers must know the cost-effectiveness of such interventions before implementing them at the large-scale population level. This review discusses various issues (e.g., characteristics, modelling, and long-term effectiveness) in the economic evaluation of lifestyle interventions for the primary and secondary prevention of diabetes and cardiovascular disease. The diverse nature of lifestyle interventions, *i.e.*, type of intervention, means of provision, target groups, setting, and methodology, are the main obstacles to comparing evaluation results. However, most lifestyle interventions are among the intervention options usually regarded as cost-effective. Diabetes prevention programmes, such as interventions starting with targeted or

universal screening, childhood obesity prevention, and community-based interventions, have reported favourable cost-effectiveness ratios.

"Health in Aging: Health Costs and Cost Effectiveness of Prevention"[24] (Brandes & Walter, 2007)

Summary

The objective of prevention is to avoid or to delay health impairments and diseases. For older people it is important to maintain their independence and to avoid and reduce the need for external help such as nursing care. Good starting points are the strategies for healthy life-style. Physical activity, smoking abstinence, and normal weight have proven to have their positive medical and economic effect on many chronic diseases such as type 2 diabetes mellitus, cardiovascular diseases, and certain types of dementia. The potential of prevention increases as those diseases affect one another. As for other health care, the cost-effectiveness of preventive measures must also be examined. There are few German studies addressing the cost-benefit of the non-medication prevention. Results from international studies can only partly be transferred to the German context. The cost-effectiveness for prevention for elderly people has been very rarely researched. Research in the field of prevention is so far not very well developed as for other health fields. There is a need for more specific research for methods, interventions and target groups. In health economics major challenges arise from different time schedules and various purchasers, as well as from the evaluation of human capital for the elderly.

"Physical Activity and Prevention of Cardiovascular Diseases" (Löllgen, Völker, Böckenhoff & Löllgen, 2006)

Summary

Physical inactivity is one of the major risk factors for cardiovascular diseases. Regular physical activity, conversely, is effective in reducing all-cause mortality, cardiovascular morbidity and mortality. Older and recent meta-analyses confirm the reduction of all-cause mortality and cardiovascular mortality by regular physical activity. So far, there is a dose-effect relationship especially from low to moderate training intensity; the steepness of this curve is more curvilinear with a decrease at higher categories of activity intensity. Regular physical activity even at low levels of intensity should be a part of daily life and lifestyles.

[24] In German: "Gesundheit im Alter: Krankheitskosten und Kosteneffektivität von Prävention"

The risks and side effects of physical activity can be neglected, pre-participation examination before training is strongly recommended. Counselling healthy persons and patients at any age for physical activity, and training prescription, should be an essential part of physicians' work in general practice.

"Cost-Effectiveness of Type 2 Diabetes Screening: Results from Recently Published Studies" (Icks et al., 2005)

Summary

Type 2 diabetes screening is recommended by various international diabetes associations. We conducted a literature research to identify and describe systematically recently published cost effectiveness analyses (CEA) for type 2 diabetes screening. Three analyses were included. One of them was conducted in Germany, based on the data of the KORA survey S4 (1999/2001). Two studies came from the US. The German as well as one of the US studies evaluated cost per detected diabetic case as main outcome. In contrast to the US study, the German study considered incomplete participation in the screening programmes as baseline case. HbA1 c testing combined with the oral glucose tolerance test (OGTT) was more expensive than OGTT or fasting glucose testing, but also most effective in detecting cases, due to high participation in this screening strategy. The second US study investigated the lifetime cost effectiveness of type 2 diabetes screening, based on a Markov model to calculate cost per quality-adjusted life year (QALY). Effectiveness data were derived from two large intervention studies in clinically diagnosed (not identified by screening) diabetic subjects. The authors conclude that type 2 diabetes screening is cost effective, in particular targeted screening in elderly hypertensive subjects. Diabetes screening may be cost effective.

However, the effectiveness of early detection and treatment of type 2 diabetes has not yet been shown, and data regarding the course of early detected diabetes are lacking so far. In the future, the most important question is whether type 2 diabetes screening and early treatment is effective with respect to clinical outcomes.

"Cost-Effectiveness of the Prevention of Coronary Heart Disease in Germany"[25] (Lauterbach, Gerber, Klever-Deichert & Stollenwerk, 2005)

Summary

[25] In German: "Kosteneffektivität der Prävention der koronaren Herzkrankheit in Deutschland"

It is generally accepted that the incidence of coronary heart disease can effectively be reduced by strengthening prevention. At the same time, it is still unclear how large the effects of life-style oriented preventive measurements such as diet and exercising are in everyday life. Furthermore, there is an ongoing debate on what measurements are effective. Thus, against the background of dwindling financial resources in health care, the input of health economic evaluation is explicated. General issues of health economic evaluation are presented. After that, an overview on the current findings of cost-effectiveness in primary prevention of coronary heart disease is given. Risk factors are separately discussed. It is demonstrated that preventive measurements dealing especially with hypertension and hypercholesterolemia can be cost-effective.

Gaps and Needs in the Field of NCDs

Obesity

There is a gap in Germany in the knowledge and systematic assessment of interventions on the policy and structural level for the prevention of obesity with combined approaches supporting healthy nutrition and physical activity, especially in regards to children and adolescents (Loss & Leitzmann, 2011).

Tobacco

The reduction of tobacco consumption is one of the eight national health targets, since 2003 (see the page National Health Target Process, Gesundheitsziele.de). Germany's current tobacco use prevalence is at 24% – an average position in international comparison. The number of tobacco users among adolescents and young adults decreased by 50% in the past decade through strategies that included health promotion interventions addressing behavioural and structural determinants. The number of adult male smokers decreased by 5% since 1995, but the smoking rates among adult women stagnated („Glossarbegriff - Rauchen", 2014; Pott, 2014).

The World Health Organization's "Report on the Global Tobacco Epidemic 2013" rates countries' tobacco control policies on the basis of a tool named MPOWER which makes classifications according to several categories (monitoring, smoke-free policies, cessation programmes, warnings, advertisement, etc.). National measurements are ranked in three compliance categories from high to low (World Health Organization, 2014).

Germany is ranked among the highest achieving countries in terms of monitoring of the prevalence of tobacco use (World Health Organization, 2013, S. 52). Medium compliance level is achieved in the categories "smoke-free policies", "cessation programmes", "warnings through mass media campaigns", "advertising bans", and "taxation". Challenges remain in the field of "health warnings", where Germany ranks in the lowest compliance category (World Health Organization, 2013, S. 114 – 115).

Alcohol

Abusive alcohol consumption is the main substance-related addiction in Germany. Risky alcohol consumption behaviours are found among 9.5 million people in Germany. About 1.8 million people are addicted to alcohol. The abusive consumption of alcohol is one of the main risk factors for various chronic diseases such as cancer, liver and cardiovascular diseases as well as alcohol-induced traumas. About 74,000 people die each year through alcohol-related causes (Bundesministerium für Gesundheit, 2014). The annual alcohol consumption per capita was 11 litres of pure alcohol, which is among some of the highest rates in OECD comparison (OECD, 2014).

Public perception of alcohol consumption is generally positive and not seen very critically by the broader population. Although the annual per capita consumption has shown mild decreases over the past years, the abusive consumption of alcohol in Germany remains a major public health and societal challenge.

Leadership/ Strategic Vision

After two previous attempts in 2005 and 2008, the third attempt to establish a national law on prevention and health promotion stalled in 2013. A new approach to a legal proposal has a high priority on the agenda of the government and is expected shortly.

Despite the lack of a nation-wide legal framework, joint cooperation projects like *health-targets.de* and the Cooperation Network 'Equity in Health' provide approaches that include a clear strategic vision, follow a life cycle approach and address health inequalities.

Financing

The resources allocated to prevention and health promotion within the German health system are relatively small in comparison to curative medicine (see section on financing above). However, measures of pharmaceutical-focused primary prevention as well as secondary and tertiary prevention receive reliable funding on a clear legal basis through the code of social law.

The situation is more complex in regards to non-medical prevention and health promotion, which currently lack a legal framework, resulting in a lower priority in public perception and a lack of sustainable funding (Rosenbrock & Gerlinger, 2014, S. 113).

Research

As the principles of evidence based medicine are likely to produce skewed results in favour of less complex interventions, standardized and systematic evaluation and quality assessment is seen as crucial in the scientific evaluation of prevention and health promotion interventions (Rosenbrock & Gerlinger, 2014, p. 111).

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