HEALTH PROMOTION AND PRIMARY PREVENTION IN 14 EUROPEAN COUNTRIES:

A COMPARATIVE OVERVIEW OF KEY POLICIES, APPROACHES, GAPS AND NEEDS

CHRODIS

ADDRESSING CHRONIC DISEASES & HEALTHY AGEING ACROSS THE LIFE CYCLE

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The following people contributed to this report: Barbara Battel Kirk; Ingrid Stegeman, Cristina Chiotan, Caroline Costongs (EuroHealthNet);Thomas Kunkel (Federal Centre for Health Promotion and Education, BZgA) and representatives of the following organisations that developed country reviews outlining health promotion and disease prevention in their countries:

Associated Partners - The National Center of Public Health and Analyses (Bulgaria); National Institute for Health Development (Estonia); Federal Centre for Health Education (Germany); Regional Health Authority of Attica (Greece); The Directorate of Health (Iceland); Health Service Executive, Institute of Public Health, European Institute of Women's Health (Ireland); Ministry of Health, Istituto Superiore di Sanita (Italy); Ministry of Health, Center For Health Education and Disease Prevention (Lituania); Directorate of Health (Norway); National Health Institute Dr. Ricardo Jorge, Directorate-General of Health, (Portugal); Ministry of Health, Social Services and Equality, Institute of Health Carlos III, Autonomous Communities and Public Health Authorities (Spain); National Institute for Public Health and Environment (Netherlands)

Collaborating Partners - Ministry of Health (Cyprus); The Platform for Better Oral Health in Europe (United Kingdom)

JA-CHRODIS is a European collaboration (Jan 2014 – March 2017) that brings together over 60 associated and collaborating partners from e.g. national and regional departments of health and research institutions, from 26 Member States. These partners work together to identify, validate, exchange and disseminate good practice on chronic diseases across EU Member States and to facilitate its uptake across local, regional and national borders. The focus is health promotion and primary prevention as well as the care of patients with diabetes or with more than one chronic condition (multimorbidity).

For more information, please visit the website www.CHRODIS.eu

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This summary report presents an overview of the information presented in fourteen country reports developed by representatives of organisations participating in the EU Joint Action on Addressing Chronic Diseases and Healthy Ageing Across the Life Cycle (JA-CHRODIS) in the area of Health Promotion and Primary Prevention.

JA-CHRODIS is a European collaboration that brings together over 60 partners from national and regional departments of health and research institutions, from 25 EU Member States and Norway. These partners, and the European Commission, through it's Health Programme[1], are investing almost 10 million Euros in this initiative to identify the best appraoches to reduce the burden of chronic diseases in Europe. This involves the identification, validation, exchange and dissemination of good practice on chronic diseases across EU Member States and facilitating its uptake across local, regional and national borders. JA-CHRODIS focuses on the topics of health promotion and primary prevention as well as the care of patients with diabetes and with more than one chronic disease (multi-morbid conditions).

Twenty-five JA-CHRODIS partners from 15 European countries are involved in JA-CHRODIS work on health promotion and primary prevention. It is commonly acknowledged that most chronic diseases can be prevented, or their onset delayed, and that investing in health promotion and disease prevention can increase the cost-efficiency of health care spending while improving the quality of citizens' lives. To establish a baseline understanding of what European countries are doing in this field, Partner organisations from Bulgaria, Estonia, Germany, Greece, Iceland, Ireland, Italy, Lithuania, Norway, Portugal, Spain, the Netherlands (Associated partners) as well as Cyprus and the UK (Collaborating partners) responded to in-depth questionnaires relating on this topic. In their responses, partners outlined the health promotion and primary prevention 'landscapes' and contexts, gave examples of good practice and identified what they felt were gaps and needs in their countries to develop and maintain ethical, effective and efficient policy, programmes and practice in this area. The responses were then edited and shaped into Country Reports.

This summary report presents an analysis of the key findings in the individual Partner Country reports, including:

- There is a diversity of systems and structures in relation to health promotion and prevention policies, programmes and practice, ranging from centralised in a majority of countries to differing levels of decentralisation and devolution in other Partner Countries.
- Levels of development in relation to health promotion and prevention capacity also vary.
- All Partner Countries have National Health Plans and there is also reference to other health and health related policies and programmes in all reports.
- A national ministry/department of health is responsible for the initiation and development of national health policy in the majority of Partner Countries.
- Implementation of such policies is most frequently undertaken at regional or at local level.
- Examples of evaluation and monitoring of policy and programme implementation are described in the reports. However, there are frequent references to the need for agreed criteria, more

1 http://ec.europa.eu/health/programme/policy/index_en.htm

coordinated and structural approaches to monitoring and evaluation and dedicated funding for evaluation and better dissemination and use of findings.

- There are differences across Partner Countries in relation to the models of health which underpin health promotion and primary prevention polices and practice. A majority of countries make reference to the social determinants of health while the remainder focus more on disease/risk approaches.
- The majority of Partner Countries indicate that a partnership approach is used in relation to health promotion and prevention, including the involvement of ministries other than health (with some referring to Health in All Policies) and of nongovernmental organisations. However, some countries report that there is a need for more structured and coordinated approaches in order to develop and maintain effective partnerships.
- In the majority of Partner Countries health promotion and disease prevention activities are funded from national taxation systems. In one country (Iceland), some funds are sourced from a tax on alcohol and tobacco. There are few references to funding from the private sector but many to accessing funding from the European Structural Funds and other EU sources.
- Most Partner Countries highlight the fact that funding for health promotion and disease prevention is inadequate and forms a very small proportion of overall health budgets. In a number of Partner Countries, the recent economic crisis is noted as having had a negative impact on funding for health in general, and on funding for promotion and prevention in particular.
- The need to develop and sustain workforce capacity for health promotion and disease prevention, in relation to increasing both numbers and levels of competence, is referred to in the reports from the majority of Partner Countries.
- A small number of Partner Countries indicated that they have a database of examples of good practice and have developed frameworks for identifying and selecting such examples.
- Examples of good practice across a range of policies, programmes and practice were identified by some Partner Countries.
- The gaps and needs in relation to health promotion and primary prevention identified across Partner Countries can be summarised under the following headings:
  - Monitoring/evaluation and research
  - Capacity/capacity development/knowledge development
  - Partnerships/Participation/HiAP
  - Funding/other resources
  - Approaches/social determinants/settings
  - Communication and coordination
  - Leadership and strategic vision
  - Reorientation of health services
  - Quality assurance and competence

SUMMARY CONCLUSIONS

The country reports provide a useful insight into approaches used, levels of capacity and crucial gaps and needs in relation to health promotion and primary prevention policy and practice. There are clear differences across the Partner Countries in relation to health promotion and primary prevention systems and structures, in levels and sources of funding and in levels of capacity. Despite these differences, common themes emerge in the gaps and needs identified in the individual reports in relation to health promotion and disease prevention. These offer an excellent basis for reorientation, innovation, improvement, redevelopment and capacity development in health promotion and prevention, both within their respective countries and as a shared venture. The reports also demonstrate that there is a wealth of experience, knowledge and examples of good practice in Partner Countries that can form the basis for addressing gaps and needs and to promote the exchange, the necessary scaling up, and transfer of highly promising, cost-effective and innovative health promotion and primary prevention practices.

The prevalence of NCDs across EU Member States is high, and public health budgets are constrained. Investing in health promotion and primary prevention has been shown to be cost effective, yet, as this report confirms, only a very small percentage of health expenditures are allocated to this. There is huge potential in strengthening health promotion and primary prevention policies and practices and in delaying the onset of chronic diseases in Europe and reducing their burden by investing more, and more inventively in this area. The differences that exist across Partner countries highlight the need to find a shared terminology and understanding of core health promotion concepts and ethical frameworks, based on already well defined and agreed frameworks such as the Ottawa Charter for Health Promotion (15) and successive WHO delcarations and charters (16-22).

In addition, existing concepts and approaches outlined in this report need to be complemented with innovative thinking and emerging opportunities or 'markets' for health promotion, like e-health, m-health and cooperation with third sector or business organisations. Stronger linkages should also be sought between health promotion and other sectors that are closely related to and affect health, such as sustainable development, employment and social affairs.

The findings of this baseline report reflect that while much is being done across Europe, their remains an urgent need to invest more in health promotion and primary prevention, to fully unlock its potential to help reduce the burden of chronic diseases in Europe. Advances can be made if EU Member States work more closely together on the basis of common priorities, goals and approaches and share new information so that they can reinforce and strengthen each other's efforts. JA-CHRODIS partners working on this theme will build on the knowledge established in this report by e.g. exchanging good practice, engaging in study visits and issuing their final recommendations on how best to strengthen health promotion and primary prevention across Europe.

INTRODUCTION

JA-CHRODIS

Chronic disease represent the major share of the burden of disease in Europe and are responsible for 86% of all deaths. They affect more than 80% of people aged over 65 and represent a major challenge for health and social systems. An estimated 700 billion Euros, or 70-80% of health budgets are spent on chronic diseases in Europe each year.[1]

The Joint Action on Chronic Diseases and Healthy Ageing across the Life Cycle (JA-CHRODIS, 2014-2017) is a European collaborative initiative that was jointly designed and is being jointly implemented by the European Commission and 60 Partners to address the common challenge of chronic diseases. Partners include national and regional departments of health and research institutions from 26 European Union Member States. These Partners are working 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, on the prevention and management of diabetes and on the care and treatment of patients with more than one chronic disease (multimorbid chronic conditions). One of the key deliverables is a 'Platform for Knowledge Exchange', which includes 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 the prevention and care of chronic diseases.

The specific focus of the work of JA-CHRODIS in the area of health promotion and primary preventions[2] is 'to promote the exchange, scaling up, and transfer of highly promising, cost-effective and innovative health promotion and primary prevention practices for older populations'.

Strengthening investments in health promotion and primary prevention is key to reducing the burden of chronic diseases in Europe, for reasons outlined by a recent paper by the European Commission DG Economic and Financial Affairs (ECFIN). The paper states that "it is universally acknowledged that lifestyle factors, such as tobacco smoking, obesity, wrong diet and lack of physical activity have a significant impact on health outcomes, increasing demand for health services. Major chronic diseases can often be prevented through lifestyle changes … Moving resources from treatment to prevention of cardiovascular diseases or diabetes will increase the cost-effectiveness of spending, while relying on treatment alone will be suboptimal".[3] Increasing life-expectancies and population ageing mean that many people will have to work beyond the current statutory retirement ages.[4] Yet in most European Member States, these statutory

1 The Final Report on the EU's Reflection Process on Chronic Diseases, 2013
http://ec.europa.eu/health/major_chronic_diseases/docs/reflection_process_cd_final_report_en.pdf
The 2014 EU Summit on Chronic Diseases, Conference Conclusions
http://ec.europa.eu/health/major_chronic_diseases/docs/ev_20140403_mi_en.pdf

2 JA-CHRODIS applies the Ottawa Charter definition of health promotion: "the process of enabling people to increase control over, and to improve their health (Ottawa Charter for Health Promotion. WHO, Geneva,1986).
Primary prevention is directed towards preventing the initial occurrence of a disorder. We use primary prevention methods before the person gets the disease (WHO Health Promotion Glossary, 1998)

3 Efficiency estimates of health care systems. European Economy. Economic Papers 549: http://ec.europa.eu/economy_finance/publications/economic_paper/2015/ecp549_en.htm

4 European Commission. The 2015 Ageing Report: Underlying Assumptions and Projection Methodologies, European Union, 2014. http://ec.europa.eu/economy_finance/publications/european_economy/2014/pdf/ee8_en.pdf

retirement ages are higher than healthy life years (HLY). It is therefore crucial to prevent, for as long as possible, poor health status amongst the older population, to ensure that as many as possible of the additional life years being gained are enjoyed in good health, so that they can remain a vital part of society.

The JA-CHRODIS partners from 15 European countries involved in work on health promotion and disease prevention have defined good practice criteria in this field and will select good practice that meet criteria, and exchange learning through e.g. a conference and study visits. This process should be based on an understanding of similarities and differences that exist between countries in relation to their policies and approaches in this area and their perceived gaps and needs. To establish this, JA-CHRODIS partners involved in this work responded to a questionnaire relating to the structure and delivery of health promotion in their countries. In many Partner Countries, these responses were formulated through a collaborative process, involving different relevant organizations and actors who provided input and reached consensus. EuroHeathNet then coordinated the process of shaping the responses into country reports.

This report provides a comparative overview of the information included in the 14 country reports. This information can provide insight into further steps that EU Member States can undertake to support one another and strengthen their health promotion and primary prevention policies and practices, and thereby address the "urgent need …", as stated by the Final Report on the Reflection Process on Chronic Diseases "… to change the imbalance between prevention and health care budgets, and to invest in prevention to help avoid paying for healthcare in the future."[5]

SCOPE OF SUMMARY REPORT

Given the wealth and complexity of information provided in the individual Partner Country reports, this Summary can only attempt to highlight key areas and issues.

The conclusions drawn in the summary report are based on the information provided by Partner Countries and on comparisons of findings from individual reports undertaken by some of the participating countries. The Summary outlines and discusses the commonalities and differences across Partner Countries reports (1-14) in relation to:

- Health systems with particular reference to health promotion and prevention
- Relevant policies - their development, planning, implementation, evaluation and monitoring
- Funding
- Examples of good practices
- Current gaps and needs in relation to health promotion and primary prevention of chronic diseases

5 Council of the European Union. Reflection Process: Innovative Approaches for Public Health and Health Care Systems – *Discussion. Brussels, 23 September, 2013.* http://ec.europa.eu/health/major_chronic_diseases/docs/reflection_process_cd_final_report_en.pdf

It should be noted that the length of the individual reports and the depth to which issues were explored in relation to health promotion and primary prevention varied across the Partner Countries.

Comparisons between Partner Countries in relation to levels of capacity, funding and levels of activity in health promotion and primary prevention presented in this summary are based on the information provided in the individual reports and are made to assist future planning and information and knowledge exchange. No criticism is intended or implied on any aspect of health promotion and primary prevention activity in any country by any comments contained in the Summary report. Where examples of policies/processes/good practice, etc. are related to specific countries this is for illustrative purposes only and does not imply that other countries may not have the same or similar policies or undertake similar activities.

For the sake of brevity much of the summarised information is presented in tables and only references for key sources are provided. Readers are referred to the individual Partner Country reports for more detailed information and references on sources, which can be found on the JA-CHRODIS website: http://www.chrodis.eu/our-work/05-health-promotion/wp05-activities/country-reports/

HEALTH PROMOTION AND PRIMARY PREVENTION LANDSCAPES

POLICY CONTEXTS AND CAPACITY IN RELATION TO HEALTH PROMOTION AND PREVENTION

The current health promotion and primary prevention landscapes, as described in the individual country reports, provide the context for the discussion of the development, funding, implementation, monitoring and evaluation of health promotion and prevention policy, programmes and practice in Partner Countries.

From the information provided in the reports there appears to be a diversity of political and policy systems relating to health ranging from mainly centralised (e.g. Cyprus, Greece, Lithuania) to complex devolved systems (e.g. Spain and the UK). Given the varying level of detail included in the reports it is not possible to undertake a complete analysis of all systems and structures or make definitive links between these and levels of capacity for health promotion and primary prevention across Partner Countries.

All Partner Countries reported that they have a National Health Plan and other health specific laws and policies were identified in most countries. Some countries (e.g. Ireland, UK, and the Netherlands) noted that they used the social model of health and that the social determinants of health approach forms the basis for the majority of their health policies. In other countries (e.g. Bulgaria, Greece, Lithuania) the emphasis appeared to focus more on the epidemiological/disease model.

A minority of Partner Country reports specifically referred to evidence based policy development (e.g. Italy, the UK, the Netherlands and Ireland). While a majority of countries made implicit reference to ethical dimensions in their reports (e.g. in relation to equity) only one country (Norway) indicated that there was an explicit formal ethical basis for health promotion and primary prevention activity.

An overview of National Health Plans and related laws and policies as detailed in the individual reports is provided in Table 1.

Table 1 Overview of National Health and related policies and/or national strategies

COUNTRY	NATIONAL HEALTH POLICY/ STRATEGIES	OTHER HEALTH POLICIES/ STRATEGIES	OTHER RELEVANT POLICIES/OTHER STRATEGIES
Bulgaria	National Health Strategy 2014-2020	National Programme for Prevention of Chronic NCDs 2014-2020 Total Ban on Smoking 2012 National Strategy for the Fight Against Drugs 2009-2013; 2014 - 2018 Strategic Policy Health Framework on Improving the Nation's Health 2014-2020 Health Care Concept Active Aging among the Elderly	National Strategies for Poverty Reduction and Social Inclusion Promotion Physical Educations and Sports Development; Roma Integration; Health Strategy for Disadvantaged Ethnic Minorities 2011-2015 National Programme for Cervical cancer Primary Prevention 2012 -2016
Cyprus	Heath Strategy 2014-2018	Strategic Paper on Diabetes 2004	
Estonia	National Health Plan 2009-2020	Public Health Act (under revision) Regulation on health protection for catering facilities in preschool institutions and schools 2008 Alcohol Policy Green paper 2014 Tobacco Act (under revision)	Strategic Plan for Sport for All; Plan for Primary Care 2009-2015
Germany	National Health Target Process (Gesundheitsziele.de)	The National Strategy on Drug and Addiction Policy 2012. The Environmental Health Action Programme 1999	The National Action Plan 'IN FORM' "to promote healthy diets and physical activity".
Greece	National Strategy Action Plan for Health 2011-2013 (not fully implemented) Heath in Action 2012	Smoke free legislation 2010 Protection of minors from tobacco and alcohol consumption 2008 Occupational health and Safety 2010	National Action Plan for Diabetes 2015; Cancer 2011-2015
Iceland	National Health Policy 2020	Medical Director of Health and Public Health Act 2007 Health Service and Primary care acts/regulations Policy on alcohol and drug prevention 2020Policy on tobacco control Cancer Policy (draft) Action plan to reduce obesity (2011)	Welfare Watch recommendations National Curricula Guidelines 2011 (health and well-being now one of six pillars of education) Laws on Immigration Matters 2012 National Transport Policy Environmental Impact Assessment Food Labelling Legislative Act on Sport 1998 Media Act 2011 Regulation on maximum levels for trans fatty acids in Food Regulation on the use of keyhole labelling in the marketing of foodstuffs

COUNTRY	NATIONAL HEALTH POLICY/ STRATEGIES	OTHER HEALTH POLICIES/ STRATEGIES	OTHER RELEVANT POLICIES/OTHER STRATEGIES
Ireland	Healthy Ireland – A Framework for Improved Health and Wellbeing (2013) National Health Service Plan	Tackling Chronic Disease Framework Changing Cardiovascular Health Diabetes: Prevention and Model for primary care 2005 Health Promotion Strategic Framework National Health Promotion Strategy	Framework for Reform of the Health Service 2012-2015 Positive Aging Starts Now 2013 Tobacco Free Ireland 2013 National Strategies on: Substance misuse strategy; Drugs; Children and Young people; National Men's Health Strategy Framework for Action on Obesity Health Eating Guidelines Population Health Strategy Chronic Illness Framework 2008 Strategies for Cancer Control; Intercultural Health ; Traveller Health
Italy	National Health Service (Servizio Sanitario Nazionale, or NHS) (1978) NHS health services moved from the central to the regional level government (2001). National Centre for Disease Prevention and Control (CCM) established by the Ministry of Health (2004) National Prevention Plan (2005) National Programme Gaining Health: "making healthy choices easy" (2007) ("Health in All Policies") National Prevention Plans2005-2009 and 2010-2013 National Prevention Plan 2014 – 2018 approved 13th November 2014	National Training Plan on Cardiovascular Risk (2005) Interdisciplinary Working Group for Reduction of Salt (2007) National Monitoring Surveillance Systems (2008) National Diabetes Plan (2012) Technical Document to reduce the disease burden of cancer(2011-2013), extended to 2016 (30th October 2014)	"Health service chart": strategy for quality assurance (1995) National Plan for Clinical Guidelines (2004) National Health Plan 1998–2000 (community home care scheme was included to better integrate health and social care services) Laws e.g. Smoking Laws (2003) National Health Plan 2006–2008 National Solidarity Fund to reduce inequalities between northern and southern regions (2007)
Lithuania	National Public Health Strategy (2006-2013)	Public health care/monitoring Laws on Tobacco; Alcohol Control; Food.	Health System Law 1994 Health Programme 2008-2010 Action Plan Lithuanian Health System Development Dimensions 2011-2020 Action Plans: Reducing Health inequalities; healthy aging protection Procedure for the health promotion of Cardiovascular disease risk individuals Control and prevention programmmes: Cancer; Stroke
Norway	National Health Strategy	Public Health Act 2011 Health and Care Services Act 2012 Equal heath and care services National Strategy for Immigrant Health 2013-2017 NCD Strategy 2013-2017	Coordination Reform 2008-2009 Public Health Report: Good Health Shared Responsibility 2012-2013 Strategy to reduce Social Inequalities in Health 2007 Elderly over 65 in Norway – fact sheet

COUNTRY	NATIONAL HEALTH POLICY/ STRATEGIES	OTHER HEALTH POLICIES/ STRATEGIES	OTHER RELEVANT POLICIES/OTHER STRATEGIES
Portugal	National Health Plan 2004-2010 National Health Plan 2012-2016		National Programmes on Cardio/ Cerebrovascular Disease, Diabetes, HIV/AIDs, Mental Health, Smoking Prevention and Tobacco control, Oncological Disease, Promotion of Healthy Eating, Respiratory Disease Prevention, Control of Infections and Antimicrobial Resistance
Spain		Cohesion and Quality at the NHS Act Public Health Act Tobacco production, selling and consumption National Strategies on: Chronicity; Ischemic Health Disease; Diabetes; Stroke; Health promotion and prevention; Nutrition and prevention of obesity	Physical Activity and Sports Policies and programmes in each region covering health promotion, prevention and chronicity
The Netherlands	National Policy Document on Health 2011	Public Health Act Youth Act 2013 Exception Medical Expenses Act Social Support Act Health Insurance Act	National Prevention Programme National Diabetes Action programme Public Health Status / Forecasting Report Partnership Overweight Netherlands Programme Committee on Socioeconomic Health Differences Ageing and Employment Policies LGBT and Gender Equality Policy Plan
UK			England National Health Check Programme

The reports from Partner Countries also indicated diversity in levels of capacity and funding in relation to health promotion and primary prevention. It would appear that some Partner Countries have more developed health promotion and prevention capacity and capabilities (e.g. Estonia, the Netherlands, Germany) than others (e.g. Bulgaria, Greece, Cyprus, Lithuania) based on criteria used in the Questionnaire (Table 2).

Table 2 Overview of Partner countries with good practice databases and examples

COUNTRY	NATIONAL HEALTH POLICY	GOOD PRACTICE	
		Database	Examples
Bulgaria	X		
Cyprus	X		
Estonia	X	X	X
Germany	X	X	X
Greece	X		X
Iceland	X		X
Ireland	X		X
Italy	X	X	X
Lithuania	X		
Norway	X	X	X
Portugal	X		X
Spain	X	X	X
The Netherlands	X	X	X
UK	X	X	X

Stakeholders, partnership and participation

The involvement of Departments/Ministries other than Health in developing and implementing health promotion and primary prevention policies and programmes is highlighted in a number of Partner Country reports. Specific mention is made to 'Health in all Policies' (HiAP)[6] as the basis for such involvement in some reports (e.g. Norway, Ireland, Iceland, Italy, Cyprus and Portugal). An example of high level commitment to HiAP is given in the Icelandic report which describes a ministerial committee on public health which is chaired by the Prime Minister, with the Ministers of Health, Education and Culture and Social Affairs and Housing as core members and other ministers participating as required. In Italy, a cross-sectoral approach in line with HiAP involves several stakeholders such as Ministries, Regions, Public Health Services, the Food Industry, Consumer Associations, Trade Unions. In Lithuania, it is reported that while HiAP is included in the National Health Programme (2014-2023) and is implemented in some contexts, it could be more widely used. The Ministries /Departments, other than Health, identified as having health promotion/ primary prevention roles/input are presented in Table 3.

These partnerships demonstrate a real potential for health promotion and disease prevention to innovate and develop new approaches in cooperation with other sectors and organisations. Other stakeholders bring new perspectives and solutions that can be used to promote health and prevent disease.

Table 3 Ministries/Departments/Agencies involved in National Policy Development (in addition to Health)

MINISTRIES/DEPARTMENTS	OTHER AGENCIES
Office of the Prime Minister	Food and Veterinary Authority
Public expenditure and Reform	Occupational Health and Safety
Health, Social Services and Equality	Transport Authority
Social Protection	National Planning Agency
Transport, Tourism and Sport	Environment Agency/Department
Environment Community and Local Government	Commissioner of Policies
Jobs enterprise and innovation/ Social Welfare and Employment /Labour and Social Policy	Local Authorities/Regional Governments
Justice and equity	Country ministries (e.g.UK)
Migrant populations	National health Insurance Fund
Youth and Sport	Regional health Insurance Fund
Education, Science and Culture	Centres of Healthy Living
Ministry of education and Science /Education and Skills	Environmental Protection Agency
Agriculture Food and Medicine	Health and Safety Authority Welfare
Children and Youth Affairs	Primary Health Service/Groups of Primary Care centres
Communication Energy and National Resources	Municipalities
Economic Affairs	Public Health Units/Directorates at different level
	Service for Interventions on Addictive behaviours
	Organisation for Health Research and Development
	Health Promotion Institutes
	Boards of Health Supervisor/Health Inspectorates
	National Organisation for Health Care
	Central Statistics office

6 http://www.euro.who.int/en/health-topics/health-determinants/social-determinants/policy/entry-points-for-addressing-socially-determined-health-inequities/health-in-all-policies-hiap

In a majority of the Partner Countries an institution (or institutions) at national and/or devolved levels was identified which had specific public health roles (including informing and influencing public health policy, programmes and practice and undertaking specific public health tasks, notably research). These bodies vary in relation to focus, level of authority and input and influence as demonstrated in Table 4.

Table 4 Institutions with public health roles which inform, influence public health or undertake related tasks[7]

COUNTRY	ORGANISATION	MAIN ROLE
Bulgaria	**National Centre for Public Health and Analysis**	*Protecting public health and preventing diseases, providing information for health care management*
	Regional Health Inspectorates	*Effective implementation of the Health Policy across the country aiming to improve the quality of medical services and to make prevention a compulsory element at all levels.*
Estonia	**National Institute for Health Development**	*Public health/health promotion research and development of programmes and activities*
Germany	**The Federal Centre for Health Education (BZgA)**	*Elaboration of principles and guidelines on practical health education, vocational training and continuing education, coordination of health education and International collaboration*
	Robert-Koch Institute (RKI)	*Disease surveillance and public health reporting*
Greece	**National Council of Public Health**	*Scientific, coordinating and opinion issuing duties in the field of public health*
	Centre for Control and Prevention of Disease	*Control of NCDs and AIDs*
	Organisation against Drugs	*Planning and implementation of policies for perverting and combating drug addiction*
	National Centre for Diabetes mellitus	*Monitoring, prevention and treatment of diabetes*
	National School of Public Health	*Postgraduate/ further education, research in public health, health promotion and prevention*
	Institute of Preventive Medicine and Occupational Health	*Implementation of research and educational projects and promotion of knowledge on preventative medicine, health promotion and research methodology.*
Iceland	**Directorate of Health**	*Among other things is responsible for various health promotion and preventative tasks, including monitoring health status and determinants of health, publishing national guidelines, managing health promoting schools and communities and the health promotion fund*
Ireland	**Royal College of Physicians in Ireland**	*Post graduate training, clinical leadership*
	Institute of Public Health in Ireland	*Cooperation for public health between Northern Ireland and the Republic of Ireland through supporting the development of public policy to improve population health and reduce health inequalities*
Italy	**Istituto Superiore di Sanita**	*Research , clinical trials, control and training in public health and acting as a clearing house for technical and scientific information on public health issues*
	National Health Council	*Support for national health planning, hygiene, public health, etc.*
	Agency for Regional Health Services	*Conducting comparative effectiveness analysis*
	National Centre for Disease Prevention and Control	*Creation of synergies between different regional initiatives through identification of best practice, to promote sharing objectives and tools across regions*
Lithuania	**Centre for Health Educational Disease Prevention**	*NCDs/ injury prevention, child health, health promotion, environmental health and health specialist training*
	Institute of Hygiene	*Monitoring of health and its factors, research on health inequalities, developing and testing innovative intervention in public health, evaluation of health strategies and measure of programmes.*

7 Other institutes were also identified by some Partner Countries but for the sake of brevity only those which appear to be directly focused on public health/health promotion/prevention are included in this table.

Table 4 Institutions with public health roles which inform, influence public health or undertake related tasks[8] (continued)

COUNTRY	ORGANISATION	MAIN ROLE
Norway	**The Norwegian Directorate of Health**	*A specialised agency responsible for the compilation of various ordinances, national guidelines and campaigns? It also advises the ministries concerned on health policy and legislation, manages grants for service projects and research and it executes diverse projects designed to promote public health and improve living conditions in general.*
	The Norwegian Institute of Public Health (NIPH).	*The main source of medical information and advice*
Portugal	**National Institute of Health**	*Aims to increase gains in the public health sector*
	Directorate General of Health	*Aims to guide and develop programmes of: public health; improved healthcare; total clinical and organizational quality management and to prepare and assure the execution of the National Health Plan*
The Netherlands	**Health Promotion Institutes**	*Action on specific themes (e.g. nutrition/physical activity/ migrant health/mental health)*
	National Institute of Public Health and the Environment	*Health, disease and care surveillance and public health reporting*
	Centre for Healthy Living	*Promotes the use of appropriate lifestyle interventions based on evidence.*
UK (England)	**Public Health England**	*Brings together public health specialists from more than 70 organisations into a single public health service.*

The importance of the active participation of nongovernmental organisations (NGOs) in all aspects of health promotion and primary prevention was highlighted across all Partner Countries. The main types of NGO's and networks identified in the reports are listed in Table 5.

Table 5 Types of Nongovernmental Organisations (NGOs) and networks identified in Reports

Patients Organisations/Patientsrights	*Cancer Societies; Heart/Cardiology Associations; Asthma Association; Thoracic Society; Association of Tubercular and Chest Patients; Diabetic Associations; Society of Stroke Patients*
Stages of Life focused groups	*Centre for Ageing Research and Development; Age and Opportunity; Age Action; National Support Network for the Elderly; Federation of Elderly Citizens; Youth Associations*
Risk factor/lifestyle focused Groups	*Alcohol Action; Action on Smoking and Health; Tobacco Control Coalition; Sports Associations; Centre of Addiction Medicine*
Public Health Associations and Professional Groups	*Rehabilitation Association; Society of Diabetology; Cardiology Foundation; National Institute Of Preventative Cardiology ;UK Royal Society for Public Health; Public Health Associations; Trade Unions; Associations of General Practitioners; Association of Health Visitors; Association of Family Physician; Medical Associations; Association of Health Promotion Practitioners*
Networks (including international networks)	*Healthy Cities; Elderly Friendly Cities; Health Promoting Schools/Kindergartens; EuroHealthNet; European Workplace Health Promotion*
Other	*Ethnic Minority Communities/Groups; Social enterprise to promote the health of the population; Industry e.g. Food Industry.*

There are, however, differences in the approaches taken in Partner Countries in relation to partnerships involving NGOs and other non-statutory stakeholders. Some countries (e.g. Estonia, Cyprus, Iceland, the UK) indicated that they have clear and systematic structures for such activities, other countries reported that a partnership approach is used but on a less organised and structured basis (e.g. Ireland, the Netherlands) and the remainder reported that there is little or no emphasis on or implementation of partnership approaches.

8 Other institutes were also identified by some Partner Countries but for the sake of brevity only those which appear to be directly focused on public health/health promotion/prevention are included in this table.

For example, in Lithuania it is noted that voluntary organisations are active in lobbying for the interests of certain patient groups but that limited partnerships between different sectors and nongovernmental organisations leads to less effective use of resources and efficient programme implementation.

Examples of how stakeholder input into policy development and planning for health promotion and primary prevention is managed are outlined in Table 6.

Table 6 Examples of how stakeholder input is managed

Cyprus	National workshop through which stakeholders inform policy development.
Portugal	Advisory and Monitoring Council supports the planning and monitoring of community participation, ensures inter-ministerial involvement and collaboration in the implementation of the Health Plan.
Germany	Forum with more than 120 member organisations aims to advance the development of the national health target process, which includes 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.

IMPLEMENTATION AND EVALUATION/MONITORING

Whatever the level of initiation and development of health promotion and primary prevention policies, their implementation is most frequently reported as being at regional/local level (e.g. The Netherlands, Spain). In some cases the implementation stage is managed through formal agreements between the national health department and the regional/local administrations. In other countries national policy appears to inform and/or forms the basis for local policy development and implementation.

In some of the Partner Countries there is a defined monitoring/evaluation strategy which is managed at national level and which is linked to agreed national health promotion and prevention strategies (e.g. Portugal, Germany, and Ireland). In other Partner Countries evaluation of policy implementation is reported as occurring at other levels, if at all. An overall finding from the reports is that monitoring and evaluation are areas that are not well developed and that where they do exist, they are not well coordinated or implemented at structural level.

There is reference in the country reports to the need to develop robust and shared criteria as the basis for monitoring and evaluation of health promotion and primary prevention policies, programmes and practice. Reference is also made to the fact that there is limited sharing of findings from evaluation and monitoring and of resulting examples of good practice. The need to develop mechanisms to improve dissemination of findings and their application to improve health promotion and prevention policy and practice is clearly identified across all reports.

FUNDING

While the country reports provide different levels of detail of how funding systems operate, the funding mechanism for health promotion and primary prevention most frequently reported by Partner Countries is through national government budgets. There are variations across Partner Countries in relation to how the national health budgets are sourced, operated and managed with most indicating that funding comes from taxation. For example, in Portugal it is reported that 90% of funding is from taxation while public and private health insurance systems make up the remainder.[9]

There was consensus across all Partner Countries that the emphasis within health budgets is on curative interventions and that there is a significant lack of funding for health promotion and primary prevention. For example, the UK estimates that the amount spent on prevention is 4% of the total health spending, Bulgaria that 8.87% of the total health policy expenditure in 2012 was spent on promotion, prevention and public health control and in Norway in 2009, 3.3% of health expenditure was spent on prevention and administration. In 2012, the overall health costs in Germany were just above 300 billion Euros, of which 3.6% (10.9billion Euros) were invested in prevention. In Ireland, the limitations of funding was highlighted in the context of the fiscal challenges posed by the recession which meant that health policies are developed as 'cost neutral', with an emphasis on best use of existing resources.

There were also examples of national and statutory health insurance funds (e.g. Lithuania, Estonia, and Germany). In Italy the private health insurance is reported as playing a limited role in funding the health system, accounting for approximately 1% of total health spending in 2009. There was limited reference in the reports to private sector funding, for example, to small amounts of funding from commercial parties such as the food industry and public-private partnerships in the Netherlands. Some funding from private organisations/NGOs such as the Gulbenkian and Aga Khan Foundations was reported in Portugal. Other sources of funding for health promotion and prevention that were identified in the reports include a lottery fund and a public health fund financed with a 1% of the taxes on alcohol and 0.9% of the taxes on the wholesale of tobacco which is active in Iceland.

In some Partner Countries funding for health promotion and primary prevention was also noted as coming from other stakeholders such as NGOs, municipalities and regional governments. Such funding is described as usually being specific to action on health promotion and prevention in given geographic areas, and / or to population groups, activities (such as sport) or named diseases /risks related to the funder's area of interest. Other sources of funding reported in a number of the Partner Countries included the EU through the European Development Fund and European Social Funds and funding for specific programmes and projects.

While there was evidence of different levels of funding for health promotion and prevention across Partner Countries there was, as noted, reference in all reports to an overall lack of funding and to the need for consistent, dedicated funding to support sustainable and effective health promotion and primary prevention.

9 It is only possible to provide a short overview of the main points on funding for health promotion and prevention in the Partner Countries, as the individual reports give different levels of detail on the systems operating in their respective countries. Readers are referred to the individual reports (see:http://www.chrodis.eu/our-work/05-health-promotion/wp05-activities/country-reports/) or other published sources for more specific and detailed information on health promotion and primary prevention funding.

The impact of the recent worldwide financial crisis was recognised as having had a negative impact on health promotion/primary prevention within Partner Countries (e.g. Iceland and Greece). However, it is interesting that the Icelandic report indicated that the economic collapse of 2008 had actually shifted political and professional focus more towards health, wellbeing and equity and the use of the social determinants of health as the basis for policy development.

EXAMPLES OF GOOD PRACTICE

In considering examples of good practice in health promotion and disease prevention that can be shared by Partner Countries and beyond, it is important to note that, in addition to the examples explicitly identified as good practice (see Table 7), other elements of policy, programmes and practice that were described in the reports are also useful exemplars. For example, sharing how stakeholder involvement is managed in different countries (e.g. Cyprus, Germany, Portugal) and how 'Health in All Policies' is implemented (e.g. in Iceland and Italy) could prove useful to other countries. Other similar examples gleaned from the reports include:

- The coordination of multidisciplinary public health by Public Health England, an organisation that brings together public health specialists (from medical public health and other public health related professionals, including those from Environmental and Mental Health and Community Development) into a single multidisciplinary service.
- An evidence based programme developed by the Royal Society for Public Health in the UK which targets marginalised groups through health trainers focusing on supporting behaviour change.
- The Italian Ministry of Health has created and maintained a constant and constructive dialogue with the food industry which has resulted in some food and distribution companies volunteering to improve the nutritional quality of some of their products, reducing serving sizes and decreasing the amount of less healthy products from the school settings.
- An explicit ethical framework that is the basis for the Public Health Act in Norway.
- Implementation of HiAP in Norway which was recognised by other Partner Countries as an example of good practice.

These examples of wider process and contextual practice and policy development are useful as examples of good practice in themselves. They also serve as reminders that the context within which more risk/disease oriented interventions are developed and delivered is key to ethical, evidence based and effective health promotion and primary prevention.

In addition, there is a wealth of experience that can be shared by those countries with greater experience in and capacity for health promotion and prevention in advocating for, developing and sharing agreed models of health and health promotion which focus on social determinants and health equity with other countries with less well developed capacity and experience.

In considering the specific examples of good practice offered by Partner Countries, the need to establish robust and agreed criteria for what in fact constitutes 'good practice' is evident. Examples of established procedures to identify good practice used in Partner Countries include:

- Procedures from the National Health Service in Spain which use agreed explicit criteria for inclusion and evaluation are applied to the field of health promotion and prevention.
- The BZgA, in Germany, in cooperation with other stakeholders in the field of health promotion, has developed tools and toolkits for the evaluation of interventions in various settings. A structured overview on the existing methods of quality assurance in health promotion is provided through a web portal[10]. In 2004/2005 the BZgA-led nation-wide Cooperation Network 'Equity in Health' which developed twelve criteria of good practice.
- Systems and procedure for identifying best practice in health promotion developed in the Netherlands entitled the 'Dutch Recognition System'[11], which assess practices included in its Centres for Healthy Living and supports the delivery of efficient and effective local health promotion.

Other frameworks for identifying and selecting examples of good practice identified in the country reports included existing procedures and criteria used to select and fund health promotion and prevention interventions (e.g. in Iceland, Portugal, Italy). Each fund, however, appears to have a slightly different emphasis in the criteria used.

There is also reference in the reports to Partner Countries' contribution to, and use of, guidance and recommendations published by bodies such as the World Health Organisation (WHO), the European Union, the Nordic Council of Ministers, etc. For example, the Centre for Health Services Research in Greece is reported as using, and advocating for the use of, the European Quality Instrument for Health Promotion (EQUIHP)[12]. There is also a reference to health promotion practice competencies and standards developed by the CompHP Project[13] which, while focused on individual practitioner competencies, can also be useful in exploring criteria for overall good practice.

In relation to the specific request to supply examples of good practice, there were differences across Partner Countries in the number and type of examples identified. Half of the participating countries indicated that they had well populated databases of good practice. Most of the Partner Countries did supply some examples and, in addition, there is also reference in many of the reports to national instructions and guidelines for all those working in the field of public health and to specific clinical guidelines.

There were differences in the focus, type and methodologies of the varying examples of good practice which were supplied by Partner Countries. In some cases these are examples of actual practice activities and processes (e.g. Italy, the Netherlands). Other countries refer more to outcomes/outputs of policies and programmes or the data collected in national surveys and epidemiological studies (e.g. Iceland and the UK). All of these examples are useful – but it is important for countries to explore what they consider to be 'good practice', and to consider the development of agreed criteria and mechanisms for sharing information on process and qualitative as well as quantitative and formal research. This debate will be influenced by different perspectives on what constitutes evidence in health promotion and by which model of health underpins health promotion and prevention practice.

10 www.evaluationstools.de

11 http://www.loketgezondleven.nl/algemeen/english/centre-for-healthy-living

12 http://ec.europa.eu/health/ph_projects/2003/action1/docs/2003_1_15_a10_en.pdf

13 http://www.iuhpe.org/index.php/en/comphp

Those espousing the medical model will likely emphasis measurements based on changing individual behaviour and on risk/disease specific measurements while those endorsing the social model will focus on 'upstream' changes that impact on the determinants of health. In this context, there is an interesting reference in the Irish report to the need to avoid 'lifestyle drift' – described as the situation where policy starts off by recognising the need for 'upstream' work on health determinants only to drift 'downstream' and focus on individual lifestyle and disease in the implementation and evaluation stages. This warning should be noted when exploring what constitutes evidence of good practice in health promotion and prevention at all stages of planning, implementation and evaluation.

Examples of frameworks for the systematic appraisal, identification and selection of examples of good practice have, as discussed, been developed in some of the Partner Countries. These have formed the basis for wider discussion and the development of agreed pan European criteria as to what constitutes 'good practice' in the area of health promotion and primary prevention in the context of JA-CHRODIS. Differences in systems, structures and the model of health underpinning policy and practice will impact on future cooperation between the Partner Countries and there is a need for shared understanding of what is meant by specific terms and the concepts to facilitate effective cross- country exchange of information and support.

The specific examples of good practice identified in Partner Country reports are outlined in Table 7. More information on examples of good practice, databases and agreed criteria frameworks described in the country reports is presented in Table 9 (Appendix 1). Further information on pan-European criteria, drawn from the county reports and agreed by European experts in field is available on the JA-CHRODIS website.[14] Since the field of health promotion and primary prevention is constantly developing, Partner Countries will also be asked to identify innovative good practice approaches, beyond those outlined in Table 7, that e.g. apply m-health or e-health technologies or that involve strong cross-sectoral policies, processes and practices.

14 See: http://www.chrodis.eu/our-work/05-health-promotion/wp05-activities/criteria/

Table 7 Examples of good practice

COUNTRY	DATABASE	PROCEDURES TO IDENTIFY/ SELECT BEST PRACTICE	OTHER
Estonia	Electronic database for health promotion activities. Recommendations on interventions on Type 2 Diabetes, low income groups, chronic diseases, the elderly, community , obesity, addiction, mental health, school based interventions etc		
Germany	Methods of quality assurance in health promotion www. evaluationstools.de. 118 examples of good practice: www.gesundheitliche-chancengleichheit.de/ praxisdatenbank	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/	
Greece			• Health Promoting Hospitals International Network • Healthy Cities International Network • Healthy food at schools • Smoking cessation clinics • National action plans and campaigns for smoking, obesity, physical activity and healthy diet
Iceland			• Guidelines for the creation of clinical practice • Clinical guidelines(e.g. risk assessment and prevention of cardiovascular disease, Type 2 Diabetes, blood pressure monitoring) • Health promoting schools (pre-primary and upper secondary) and community • National health register • Survey Health and wellbeing of Icelanders • The Reykjavik Study and Risk Calculator for CHD • Health history of Icelanders • The resident assessment instrument
Ireland			• Healthy Ireland Framework draws on evidence and good practice from around the work. • Review of approaches used for prevention by NGOs • Report from Group on Obesity • National Clinical programmes • Social marketing quit campaign • Smoking cessation services and training • Health Prompting Health Services • Health Cities • Evaluation of National Smokers Inline 2008-2011 • Weight management Treatment Algorithms • Obesity Campaigns • National Guidelines on Physical Activity • Health Promoting Schools

COUNTRY	DATABASE	PROCEDURES TO IDENTIFY/ SELECT BEST PRACTICE	OTHER
Italy	• FORMEZ Best Practice – supports local communities to identify, select, strengthen and disseminate best practice on healthy lifestyles • PRO.sa – health promotion projects grounded in theories of evidence and best practice. Aims to support evidence informed decision making processes. • Regional good practice at EU level in the context of Innovative Partnerships on Active and Healthy Aging.	Established procedure and framework to identify good practice at national level http://www.dors.it http://www.retepromozionesalute.it/bd2_ipertesto.php?idcriterio=1	• Monitoring Systems • CUORE- estimating the impact of cardiovascular risk • National Training Plan on Cardiovascular Risk • Mattone Project – aims to increase the role of regional health systems and policies in Europe by strengthening their ability to investigate opportunities offered by the EU and other international organisations
Norway	Norwegian Electronic Health Library provides free access to point-of-care tools, guidelines, systematic reviews, scientific journals, and a wide variety of other full-text resources for health-care professionals and students.		• Guidelines on Primary Care Prevention of Cardiac Disease (2009), Diabetes (2011) and Stroke (2010 • Public Health Profile for municipalities which can be used to identify and measure areas for health improvement in each community. • Healthy Life Centres which offer effective, knowledge based programmes and methods to help people who need support in health behaviour change • Guide on setting up and managing Healthy Life centres • The Hunt Study – a unique database of family and personal studies which indicate changes in health and vital status.
Spain	Good practices of the Spanish National Health System available at: http://www.mssi.gob.es/organizacion/sns/plancalidadSNS/BBPP.htm	Established procedure to identify good practice across the National health Service	
The Netherlands	Database – Lifestyle interventions (1900 interventions)	Procedures to identify and select best practice (the Dutch Recognition System)	• Guideline for Cardiovascular Risk Management • Guidelines for Healthy Food • Guidelines to Quit Smoking • Standard of Diabetes Care (including prevention) • Health Promoting Schools (health mark) • Online manuals for local policy for healthy municipalities (alcohol, smoking, overweight and physical activity) • Implementation of EPODE in vulnerable parts of the Dutch municipalities • Doetichem Cohort Study which monitors the health and lifestyles of four generations every 5 years
UK	NICE guidelines on best practice including; Lifestyle and wellbeing; Diabetes and other endocrinal, nutritional and metabolic; conditions; Cardiovascular conditions; Health Inequality; Cardiovascular assessment and modification of blood lipids	NICE criteria	Raising healthcare workers and the public's awareness of the link between Atrial Fibrillation and Stroke and preventing Stroke from this cause.

GAPS AND NEEDS

When considering the gaps and needs identified in the Partner Country reports it is important that these are reviewed in the context of the existing assets which support ethical, effective and efficient health promotion and prevention action. These include dedicated workforces, academic and professional knowledge bases and NGO/Community capacity.

While specific examples of good practice are identified as part of the individual reports, there are also examples of potential assets/examples of good practice described in other sections of the reports as already discussed (page 19).

The gaps and needs in relation to health promotion and prevention identified in the individual reports were analysed to identify common themes. It is interesting to note that, while there was a wide range of diversity across the health promotion and primary prevention landscapes in Partner Countries (e.g. structures, levels and types of policy development, implementation and monitoring/evaluation), the themes emerging in relation to gaps and needs were very similar. However, the degree of emphasis on and priority level of gaps/needs would appear to vary across the participating countries.

The main themes emerging from the analysis of gaps and needs identified in the Partner Country reports are listed below (Table 8) with further details under each heading elaborated in Table 10 (Appendix2).

Table 8 Key Gaps and needs - Themes by Country

THEMES	**Evaluation/ monitoring/Research** *including priority setting/funding/other capacity/dissemination and implementation of findings*	**Capacity/capacity development/ knowledge development** *including workforce numbers/competence/ organisational competence/knowledge base /education and training*	**Partnership/ participation/HiAP work** *including methods and approaches, advocacy for, multidisiplinarity.*	**Funding** *including inadequate funding/ lack of consistency/ dedicated funding.*	**Leadership/strategic vision** *including political commitment, shifting priority/focus to prevention, leaders.*
COUNTRY	Bulgaria	Bulgaria	Bulgaria	Bulgaria	Bulgaria
	Cyprus	Cyprus	Cyprus	Estonia	Greece
	Germany	Estonia	Greece	Germany	Iceland
	Greece	Greece	Ireland	Greece	Ireland
	Estonia	Ireland	Italy	Iceland	Portugal
	Iceland	Lithuania	Lithuania	Ireland	The Netherlands
	Ireland	Norway	Portugal	Italy	UK
	Italy	Portugal	Spain	Lithuania	
	Lithuania	Spain	The Netherlands	Norway	
	Portugal	The Netherlands		Portugal	
	Spain			The Netherlands	
	The Netherlands			UK	
	Spain				

THEMES	**Approaches/social determinants/ settings** *including focusing on social determinants, health equity, vulnerable groups, settings approach and education and training*	**Communication / Coordination** *including sharing of information/ good practice/evidence at and across all levels/ countries etc and mechanisms to do so. Avoiding duplication/ best use of resources*	**Reorient Health Services** *including Integrating health promotion and disease prevention into health care practice/reorienting from a curative to a health promoting/ preventative model*	**Quality Assurance / competence** *including standards, competencies, organisational standards guidelines on implementation of effective methods*	**Other** Lack of policy framework No tradition of preparing public health reports Health impact assessment tools not used
COUNTRY	Cyprus	Bulgaria	Greece	Norway	
	Estonia	Greece	Iceland	The Netherlands	
	Greece	Lithuania	Lithuania	UK	
	Ireland	Portugal	Spain		
	Italy	Spain			
	Lithuania				

DISCUSSION AND CONCLUSIONS

The reports developed by the Partner Countries provide a useful insight into current health promotion and primary prevention landscapes, and contexts and capacity in their respective countries. More specifically, they outline the policies, processes of policy development, funding systems, gaps and needs and examples of good practice in relation to health promotion and primary prevention in the participating countries.

There are differences across the Partner Countries in terms of health systems and structures and in levels of capacity and funding for health promotion and primary prevention and in the models of health and health promotion underpinning their systems, structures and policies. Some countries noted that they used the social model of health and emphasised social determinants as the basis for many of their policies. In other countries the emphasis seemed to be more on the epidemiological/disease model. These differences are reflected in what were offered as examples of good practice (i.e. process vs. outcomes/data).

Models of policy initiation development, implementation, monitoring and evaluation differ across the Partner Countries. However, the initiation and development stages are most often centralised at national level, the implementation stages devolved to regional and local levels and monitoring and evaluation stages are the least well defined and developed at any level.

The participation of stakeholders in all stages of policy development, implementation and evaluation also differs across Partner Countries, ranging from little or none to active and structured engagement using recognised partnership approaches. Gaps and needs in relation to stakeholder participation and the use of partnership approaches are identified in some countries while examples of good practice to support these approaches are offered in others. The types of NGO that are involved in health promotion and disease prevention across most of the Partner Countries show a strong degree of commonality, however, differences are evident in the range of Ministries and use of Health in All Policy guidelines in policy development and implementation.

All Partner Countries made reference to a lack of consistent funding at levels adequate to deal with the health promotion/primary prevention gaps and needs identified. There was reference to 'evidence based approaches' in a few of the reports and these examples may provide a useful basis for developing shared approaches to advocating for dedicated and sustained funding streams.

The ethical dimensions of health promotion and primary prevention were explicitly noted in only one report but many others referred to equity as the basis for their policies and programmes. Exploration of shared ethical principles, drawing on agreed international definitions and standards, and how these are, and can be, applied in policy and practice terms should form a basis for all future exchanges of knowledge and examples of good practice.

While there were significant differences in systems and structures across Partner Countries there were many commonalities in the key themes emerging from the gaps and needs identified in relation to health promotion and primary prevention. The areas of evaluation, monitoring and research were most frequently identified as both gaps and needs by Partner Countries.

Capacity and capacity development was the second most common theme emerging from the gaps and needs identified in the individual reports, including reference to limited workforce numbers and lack of specific competence, leadership, knowledge base and of education and training on health promotion and primary prevention. Issues relating to partnership work, funding, the reorientation of health services and the use of specific approaches and models (e.g. social determinants of health/settings approach) were also identified as gaps and needs to be addressed by Partner Countries. The themes of quality assurance and competence and of communication/coordination, while specifically identified by fewer countries, are pivotal to ensuring effective, efficient and ethical health promotion and prevention and need future attention.

The needs and gaps identified by the Partner Countries offer a useful / valuable basis for reorientation, improvement and capacity development in health promotion and prevention, both within their respective countries and as a shared venture. Given the multiple references to capacity and capacity development in the reports, exchange of knowledge and experience between the Partner Countries could usefully focus on this area using established Europe wide frameworks such as the CompHP Health Promotion Core Competencies and Standards[15]. Other points of reference that can support further analysis and planning on capacity development include the Review of Public Health Capacity in the EU, published in 2013[16] and Strengthening Public Health Capacities and Services in Europe: a Framework for action, published by the World Health Organization in 2011.[17] Exploration of the availability of existing online education and training programmes and /or of developing such programmes, endorsed by the Agency for Public Health Education Accreditation (APHEA)[18], could also be the basis for future shared work.

It is important to note the differences in the focus, type and methodologies of the varying examples of good practice which were supplied by Partner Countries. In some cases these are examples of actual practice and process while other countries refer more to outcomes/outputs of policies and programmes (or the data collected). All of these examples are relevant – but it is useful for countries to explore what they consider 'good practice', to explore the development agreed criteria and for sharing on process and qualitative reporting on practice as well as quantitative and formal research. Examples of frameworks for systematic appraisal, identification and selection of examples of good practice have been developed in some of the Partner Countries, and have provided a basis for wider discussion and the development of pan European criteria as to what constitutes 'good practice' in the context of JA-CHRODIS's work in the area of health promotion and primary prevention. This can contribute to a shared understanding of what is meant by specific terms and the concepts and competencies underpinning aspects of practice that can be shared, as differences will impact on future sharing between the Partner Countries.

This variation in examples also reflects differences noted across the reports in relation to models and approaches to health (i.e. between social models and medical models) and these differences impact on what is accepted as 'evidence' for all aspects of health promotion and primary prevention. These differences

15 http://www.iuhpe.org/index.php/en/comphp

16 http://ec.europa.eu/health/social_determinants/docs/report_ph_capacity_2013_en.pdf

17 http://www.euro.who.int/__data/assets/pdf_file/0008/147914/wd10E_StrengtheningPublicHealth_111348.pdf

18 www.aphea.net

highlight the need to find a shared terminology and understanding of core health promotion concepts and ethical frameworks, in particular those based on already well defined and agreed frameworks such as the Ottawa Charter for Health Promotion (15) and successive WHO declarations and charters (16-22).

The explicit assets identified as examples of good practice should be combined with evidence of good practice, information and knowledge that are 'implicit' in the reports (i.e. not formally identified as examples of good practice) and used as the basis for 'asset based' capacity development for all. A wealth of examples of good practice, models of capacity development and experience across all aspects of policy, programmes and practice is demonstrated in the individual reports which can form a solid foundation for shared effects to improve and develop strong, ethical and effective health promotion and prevention across Partner Countries and beyond.

CONCLUSIONS

While socio-economic developments, advances in the treatment of diseases, and progress in technology, medical practice and patient care have led to a generally increasing life expectancy, this has not been matched by a corresponding increase in healthy life years. A key approach to improving quality of life in Europe, ensuring that older people remain a vital force in society for longer and containing rising health-care costs, is therefore to invest more in effective health promotion and primary prevention strategies to delay the onset of chronic disease across the life-cycle. The findings of this overview report reflect that while much is being done across Europe, there remains an urgent need to increase investment in health promotion and disease prevention, as reflected in the low levels of expenditure in this area, and to identify the most effective approaches to promoting health and addressing risk factors. Advances in reducing the burden of chronic diseases could be made if EU Member States are pro-active / take the lead / take initiative and work together on the basis of shared goals, concepts, innovation and information so that they can reinforce and strengthen each other's' efforts in this area.

While there are significant differences between Partner Countries in relation to systems and structures there is clear evidence of commonalities in relation to the needs and gaps in health promotion and primary prevention. There are also useful examples of new and good practice in relation to policy, programme and practice available within the Partner Countries and of others developed at European and international levels. There is, in addition to the specific examples of good practice offered in the reports, a wealth of experience and knowledge across the Partner Countries that can be shared on issues such as advocacy for health promotion and disease prevention, Health in All Policies implementation, using the determinants of health as the basis for health policy, linking with new technological developments, partnership working with nongovernmental organisations and ethical approaches to policy and programme development, implementation and evaluation. Mechanisms for sharing information, examples of good practice and support for capacity development should be based on common terminologies and concepts and on a shared ethical dimension of health promotion and primary prevention. JA-CHRODIS Partners will build on the findings of this baseline report and apply the opportunities that the Joint Action provides to share and develop new learning and encourage stronger investments in health promotion and primary prevention, to reduce the burden of chronic disease and improve quality of life across Europe.

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APPENDICES

APPENDIX 1

Table 9 - Overview of good practice selection processes and criteria

COUNTRY	SPAIN	ITALY	GERMANY	THE NETHERLANDS	PORTUGAL	UK, ICELAND	ESTONIA	BULGARIA, IRELAND, GREECE, CYPRUS, LITHUANIA
Type of Criteria/ Approach	National Procedure for the identification of good practices across the NHS (full concept	Pro Sa (full concept + database) http://www.retepromozionesalute.it	Cooperation Network, Equity in Health (full concept)	Full concept + database	Funding criteria	Clinical guideline approach	Electronic database for health promotion activities	No information provided
Criteria	Evaluation	Composition of the Working group (multidisciplinary, multi-sectoral, target group included)	Concept and Statement of Purpose	Inclusion criteria: Manual of intervention available Process evaluation Material for the next 2 years available Contact person	Project area facing health strategies and objectives (Relevance)		"Like" – option No criteria	
	Sustainability	Equity	Target Group Orientation		Quality of methods			
	Alignment (with national strategy)	Empowerment	Innovation and sustainability	Two-way assessment: Description of the project/'well described' Theoretical basis of the project	Process evaluation			
	Quality	Involvement/Participation	Intermediary Concept		Sustainability			
	Transferability	Setting approach	Low Threshold		Transferability			
	Participative Approach	Theoretical models of behavior change	Participation	Transferability ('Feasibility')	Participation			
	Multi-Stakeholder Approach	Evidence of effectiveness and good practice examples	Empowerment	Effectiveness – Ranked by Strong indications Good indications First indications	Cost-effectiveness			
	Appropriate Budget	Context analysis	Setting Approach					
	Adequacy (alignment)	Determinants analysis	Integrated Action Concept and Networking					
	Relevance (Target group orientation	Resources, time and limits	Quality Management					
	Evidence based	Partnerships and alliances	Documentation and Evaluation					
	Evaluation possible (registry system in place)	objectives	Cost-Benefit Ratio					
	Sustainability	Process evaluation						
	Comprehensiveness	Intervention/activities description						
	Ethical considerations	Output and outcome evaluation						
	Efficiency	Sustainability						
	Equity	Communication						
		Documentation						

APPENDIX 2

Table 10 – details of needs and gaps identified

MONITORING/EVALUATION / RESEARCH	CAPACITY/CAPACITY DEVELOPMENT/ KNOWLEDGE DEVELOPMENT	PARTNERSHIP/ PARTICIPATION/HIAP	FUNDING /OTHER RESOURCES
• Evaluation/monitoring/ evidence base needed • Independent, qualified and systematic evaluation of ongoing interventions in a way that results are used for effective improvements and cost effective evaluation criteria for development, application and sharing • Criteria for measurement of effectiveness , cost effectiveness needed • Evaluation procedures based on relevant measurable criteria, developed at strategic level • Limited research and results insufficiently communicated to policy and decision makers and taken up in practice. • Articulating research priorities • No one body with responsibility for systematically identifying research and policy in primary prevention of chronic diseases • Lack of research on primary prevention • 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 interventionsDevelop /apply coordinated mechanisms for development/ Implementation monitoring and evaluation • Increase computerisation of medical services/ centralisation of information. • Applying the obtained data and results for planning strategies and policies	• Lack of human and financial resources as prevention is not always a priority for decision makers • Building organisational model based on sharing of knowledge and objectives- all areas of competence within the various sectors as part of a continuum using an organisational model based on sharing knowledge and objectives • Competence and personnel • High competence required in and enough--and properly educated personal to be able to undertake the required tasks • Multidisciplinary primary care teams that address primary prevention/health promotion do not exist • Capacity development of human resources • Increasing capacity and status of • relevant organisations • Opportunities for education /training/professional growth in health promotion • Qualification, commitment and continuous training of human resources in health care/other sectors that directly relate to healthy lifestyle factors. • Health care professionals receive training and education on health promotion and prevention only at post graduate or continuous education level. • Real investment in training and capacity building for public health professionals and other actors in health promotion • A virtual platform for knowledge management and transfer in health promotion	• Incorporating a Multidisciplinary Approach for strategy on NDC Prevention and Disease Control • Reinforcing cross governmental action through improved coordination • Despite actions with potential impact for public health being developed there is a lack of synergy in institutional planning • Cross sectoral approaches that reflect the numerous determinants of health • Effective Partnerships between the health care sector and other sectors related to the socio economic determinants of health • A legal framework that supports formal Partnership • Partnerships- structures, development, capacity • Participatory methods for assessment planning research, evaluation and communication • Needs more in-depth integration of intersectoral action toward s HIAP • Resources to support international collaboration • No multidisciplinary teams in primary care that address health promotion and prevention • Need for better coordination among stakeholders to better invest in HIAP • Developing and applying coordinated mechanisms for development. Implementation monitoring and evaluation of health promotion and prevention	• Changes in financial incentives to aid the process of reaching more health promotion in primary prevention • Explicit funding for the development of projects selected on the basis of agreed good practice criteria • Funding for participatory community based/action research health projects on chronic diseases • Resources to support international collaboration • Resources for effective collection. collation, analysis dissemination of health data • Predictable stable and adequate funding for health promotion and disease prevention allowing medium and long term planning of chronic disease prevention • Involvement of academic staff and research institutions and use of the data they develop • Financial resources for health promotion and primary prevention limited compared to care and cure. • Health education is underfunded resulting in few examples of good practice • Resources for health promotion and primary prevention are insufficient • The resources allocated to prevention and health promotion within the German health system are relatively small in comparison to curative medicine • Surveillance systems and cancer registers require structural funding • Different allocation process and size of local budgets.

MONITORING/EVALUATION / RESEARCH	CAPACITY/CAPACITY DEVELOPMENT/ KNOWLEDGE DEVELOPMENT	PARTNERSHIP/ PARTICIPATION/HIAP	FUNDING /OTHER RESOURCES
• In sufficient funds/ capacity to undertake cost effectiveness studies and the outcomes of those developed are not used to inform and revise practice • Producing evidence and outcomes – of effect (efficacy) the extent of the impact on outcomes (effectiveness) • Need for forecasting studies • Need to establish monitoring mechanisms through the introduction of education, data collection and quality circles • No studies on cost effectiveness or forecasting - funding • The involvement of academic staff /research institutions in the examination of interventions related to health promotion and disease prevention • Data management storage, retrieval, mining, dissemination and sharing • Shortage of forecasting and cost effectiveness studies • Insufficient awareness of and support for evaluating primary prevention • Evaluation/monitoring/ evidence base – development, application and sharing • Adaption of criteria to evaluate health promotion / prevention initiatives • Criteria for measurement of effectiveness, cost effectiveness • Data not as per international requirements • Data base of good practice/ effective projects • Good practice- developing, recording, sharing applying data	• On other sectors the type of professions number and experience are insufficient to act in the NCD field • Capacity of human resources limited and decreasing • Integration of Health promotion and disease prevention in basic training of health professionals • Lack of capacity, interest, experience/ knowledge in HP and Partnership work with other sectors. • Lack of opportunities for training and professional growth in the field of health promotion and disease prevention • Increasing the capacity and changing the status of structures which are responsible for the implementation of programmes • No opportunities/ incentives for professional development in public health, health promotion and prevention • Type of professions. Number and experience in other sectors insufficient to act in the NCD field Incentive mechanism for health promotion and prevention initiatives and continuous training. • Educations and training/ professional growth • Capacity development of human resources • Increasing capacity and status of relevant organisations • Integration of health promotion and disease prevention in the basic training of health professionals • No tradition of preparing public health reports	• Lack of Partnerships between different sectors / NGOs which leads to other problems such as ineffective resource use and inefficient programme implementation • Prevention and care have been considered to be separate strategies but there should be strategies that take into account all the factors that influence health and identify health promotion actions through a cross sectoral approach associated with health care delivery- an integrated network of prevention, diagnosis, treatment and rehabilitation services. • HIAP recognised and mechanisms in place it is still difficult to realise collaboration with other sectors. • Health promotion and primary prevention programme hardly ever integrated into health care practice. • Health in all policies – awareness and implementation • Need for effective strategic vision on activities in specific areas such as sustainable and long term planning processes with better communication, cross-sectoral coordination acting as the basis for a new type of health policy. • Health impact assessment – awareness and implementation • No health Impact Assessment Tools that are applied to evaluate the potential impact of other policies. • Plans and policies other than health do not acknowledge their implications and impact on population health.	• Publicly available information on the processes for allocating funds for primary prevention is not known/transparent • Lack of research on primary prevention with no studies on cost effectiveness or forecasting and this is strongly related to funding issues • Emphasis on private medicine with limited funding for prevention or health promotion. It is difficult to change this approach as it is supported by a large part of society and policy makers • Resources for effective collection., collation, analysis dissemination of health data

MONITORING/EVALUATION / RESEARCH	CAPACITY/CAPACITY DEVELOPMENT/ KNOWLEDGE DEVELOPMENT	PARTNERSHIP/ PARTICIPATION/HIAP	FUNDING /OTHER RESOURCES
• Findings published but not adopted for implementation – no guidelines, legislation or structural funding for implementation of best practice • Need implementation of good practice when developing policies • A data base of good practice projects selected on the basis of clear and transparent criteria • No evaluation policy in terms of impact • A great deal of scattered research related to NCDs but not collated to give comprehensive picture • Implementation of good practice when developing HP policies • Institutions that engage in research on health promotion/primary prevention do not exist or do not research under these terms. Findings do not reach policy makers -capacity for knowledge development is not fully exploited		• There are no cross governmental mechanism in place to ensure coordination and effective implementation of interventions • Coordination between different bodies in the health sector	

APPROACHES - SOCIAL DETERMINANTS/ INEQUALITIES / SETTINGS	COMMUNICATION/ COORDINATION	LEADERSHIP/POLITICAL COMMITMENT / STRATEGIC VISION	REORIENTING HEALTH SERVICES /MODELS OF HEALTH
• The health equity approach has to be implemented in an effective way in different policies/programmes • Need to identify the exact needs of vulnerable groups and develop targeted programmes to cover • Disaggregation of results according to socioeconomic variables and small geographic areas to adapt interventions towards health equality • Public health interventions not sensitive to the specific needs of the most vulnerable groups. • Adoption/application of socioeconomic models of health/social determinants • Variations in the extent of information on health equality across educational institutes. • Strengthening a comprehensive healthy lifestyles approach • Keeping the setting approach to the forefront – avoiding 'lifestyle drift' – where policy starts off recognising the need for upstream health determinants only to drift downstream and focus on individual lifestyle • Mechanisms to detect diseases with data on socioeconomic determinants of health. • Equity in heath is mentioned in documents but solutions remain focused mainly on the provision of health care • Questions if interventions specific/ sensitive to vulnerable groups/ gender/ age/culture are targeted to their needs • Training on health equity / determinants of health only available in one post graduate course	• Coordination and communication in sustainable planning processes • Developing and applying coordinated mechanisms for development/ Implementation monitoring and evaluation of policies and programmes • Coordination to strengthen the work and avoid duplications • No centralised coordination for screening programmes -use different communication approaches not all of which are effective. • Developing coordinating and applying procedures and mechanisms for coordinated implementation of strategies and programmes • An environment of sharing the evaluation of 'best buy' programmes in different settings and countries would be useful • A virtual platform for knowledge management and transfer in health promotion • A great deal of scattered research related to NCDs available but not collated to give comprehensive picture • Coordination between different bodies in the health sector, institutes and NGOs is not adequate	• Political commitment needed (at all levels) this was further developed to highlight the lack of governmental support for interventions unfavourable to industry (minimum alcohol pricing, plain packaging for cigarettes, fat content in food). • Primary prevention on some topics/ areas not afforded the same policy priority as tobacco • No clearly identifiable leaders in the public health sector to advocate for health promotion and primary prevention as a whole • The willingness and preparedness of institutions and key figures from different health care areas to take leadership roles in shifting the focus of treatment and secondary prevention to health promotion and disease prevention • Leadership and strategic vision needed • Leadership 'strategic vision there are clearly identified leaders and policy framework but the impact of economic austerity had lead to challenges • 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.	• Integrating health promotion and disease prevention into health care practice • Reorienting the health services from a curative to a health promoting/ preventative model • Adoption/application of socioeconomic models of health/social determinants • Need to continue reorientation of health system toward health promotion , prevention • The willingness and preparedness of institutions and key figures from different health care areas to take leadership roles in shifting the focus of treatment and secondary prevention to health promotion and disease prevention

QUALITY ASSURANCE, COMPETENCE, STANDARDS	OTHER
• Quality standards and assurance (NOR) including continuous education of medical doctors and accreditation and quality based funding of primary care services, in particular in relation to integrated acre, performance criteria etc. • Building organisational model based on sharing of knowledge and objectives- all areas of competence must operate harmoniously within the various sectors as part of a continuum using an organisational model based on sharing knowledge and objectives • Competence and personnel • High competence required in municipalities and enough--and properly educated personal to be able to undertake the required tasks. • No guidelines for implementation of the most effective methods of health promotion and prevention	• To promote public recognition of good practice in health promotion • Policy frameworks on health promotion and primary prevention available but not always on a structural basis. • While national policy reports are available on health promotion and prevention local policy documents are not always available • The culture of evaluation programme and policies is still not completely incorporated in day to day work • Lack of clear mechanisms for health promotion and risk factor related programmes implementation at municipal level. • No clear policy frameworks